Oregon Health Authority

2023 External Quality Review Technical Report

April 2024

HSAG HEALTH SERVICES ADVISORY GROUP

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Abbreviations and Acronyms Used in This Report

42 CFR	Title 42 of the Code of Federal Regulations
AL/ADLs	Aggregate Lifetime and Annual Dollar Limits
ASL	American Sign Language
BH	Behavioral Health
BIPOC	Black, Indigenous, and People of Color
CASS	Coding Accuracy Support System
CCO	Coordinated Care Organization
CCV	Claim Count Verification
CDT	Current Dental Terminology
CHIP	Children's Health Insurance Program
CMHC	Community Mental Health Center
CMHP	Community Mental Health Provider
CMR	Compliance Monitoring Review
CMS	Centers for Medicare & Medicaid Services
COVID-19	Coronavirus Disease 2019
CP	Community Partner
CRD	Cardiology
CR	Concurrent Review
CTE	Career Technical Education
CY	Calendar Year
DME	Durable Medical Equipment
DNR	Do Not Report
DRG	Diagnosis-Related Group
DSN	Delivery System Network
EC	Emergency Care
ED	Emergency Department
EDI	Electronic Data Interchange
EDV	Encounter Data Validation
END	Endocrinology
EQR	External Quality Review
EQRO	External Quality Review Organization

FFS ..... Fee-for-Service
FQHC ..... Federally Qualified Health Center
FR ..... Financial Requirement
FWA ..... Fraud, Waste, and Abuse
HALO ..... Health Assistance, Linkage, and Outreach
HB 3046 ..... Oregon House Bill 3046
HEDIS®,[1] ..... Healthcare Effectiveness Data and Information Set
HOSP ..... Hospital
HPSY ..... Hospital, Acute Psychiatric Care
HSAG ..... Health Services Advisory Group, Inc.
IC ..... Imaging Center/Clinic
ICC ..... Intensive Care Coordination
ICN ..... Internal Control Number
ID ..... Identification
IHS/THC ..... Indian Health Service/Tribal Health Center
IP ..... Inpatient
ISCA ..... Information Systems Capabilities Assessment
ISCAT ..... Information Systems Capabilities Assessment Tool
LTSS ..... Long-Term Services and Supports
MCE ..... Managed Care Entity
MCO ..... Managed Care Organization
MH ..... Mental Health
MHP ..... Mental Health Parity
MHPAEA ..... Mental Health Parity and Addiction Equity Act of 2008
MMIS ..... Medicaid Management Information System
MOTS ..... Measures and Outcomes Tracking System
MRR ..... Medical Record Review
M/S ..... Medical/Surgical
MY ..... Measurement Year
NA ..... Not Applicable
NAV ..... Network Adequacy Validation, also referred to as Validation of Network Adequacy
NCQA ..... National Committee for Quality Assurance
NEMT ..... Non-Emergent Medical Transportation
NEPH ..... Nephrology

[1] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

NEUR ..... Neurology
NOABD ..... Notice of Adverse Benefit Determination
NOAR ..... Notice of Appeal Resolution
NPI ..... National Provider Identifier
NQTL ..... Non-quantitative Treatment Limitations
NUCC ..... National Uniform Claim Committee
OAR ..... Oregon Administrative Rules
OB/GYN ..... Obstetrics/Gynecology Provider
OHA ..... Oregon Health Authority
OHP ..... Oregon Health Plan
ONC ..... Oncology
OP ..... Outpatient
OPT ..... Ophthalmology/Optometry
OT ..... Occupational Therapy
PA .....
PAHP ..... Prepaid Ambulatory Health Plan
PCCM ..... Primary Care Case Management
PCD ..... Primary Care Dentist
PCP ..... Primary Care Provider
PDT ..... Pacific Daylight Time
PHE ..... Public Health Emergency
PHN ..... Personal Health Navigator
PIHP ..... Prepaid Inpatient Health Plan
PIP ..... Performance Improvement Project
PMV ..... Performance Measure Validation
POD ..... Podiatry
PSV ..... Primary Source Verification
PSY ..... Psychiatry
PT ..... Physical Therapy
PUL ..... Pulmonology
Q ..... Quarter
QA ..... Quality Assurance
QAPI ..... Quality Assessment and Performance Improvement
QHCI ..... Qualified Health Care Interpreter
QI ..... Quality Improvement
QTL ..... Quantitative Treatment Limitations

R.....Reportable
Rx.....Pharmacy
RY.....Remeasurement Year
SDOH.....Social Determinants of Health
SHCN.....Special Health Care Needs
SLP.....Speech Language Pathology
SNF.....Post-Hospital Skilled Nursing Facility
SUD.....Substance Use Disorder
THW.....Traditional Health Worker
TNAA.....Third Next Available Appointment
UCC.....Urgent Care Center
UM.....Utilization Management
URL.....Uniform Resource Locator

1. Executive Summary

Report Purpose and Overview

States with Medicaid managed care delivery systems are required to annually provide an assessment of managed care entities' (MCEs') performance related to the quality, timeliness, and accessibility of health care services they provide, as mandated by Title 42 of the Code of Federal Regulations (42 CFR) §438.364. The MCEs may include managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs), or primary care case management (PCCM) entities (described in 42 CFR §438.310[c][2]). To meet this requirement, the Oregon Health Authority (OHA) has contracted with Health Services Advisory Group, Inc. (HSAG) to perform the assessment and produce this annual report.

Under Oregon's 2017–2022 Section 1115(a) Medicaid demonstration waiver approved by the Centers for Medicare & Medicaid Services (CMS) on January 12, 2017, OHA contracts with 16 coordinated care organizations (CCOs) to deliver managed care physical, behavioral, and oral health benefits to members enrolled in the State Medicaid program ("members"), referred to as the Oregon Health Plan (OHP). The CCOs are accountable for providing integrated physical, behavioral, and oral health care benefits to members enrolled in the State's Medicaid managed care program. Each CCO is responsible for ensuring that services are delivered in a manner that complies with legal, contractual, and regulatory obligations to provide effective care.

The 16 CCOs contracted with OHA during calendar year (CY) 2023 are displayed in Table 1-2.

Table 1-1—List of CCOs

CCO Plan Name	CCO Short Name
Advanced Health	AH
AllCare CCO, Inc.	AllCare
Cascade Health Alliance, LLC	CHA
Columbia Pacific CCO, LLC	CPCCO
Eastern Oregon CCO, LLC	EOCCO
Health Share of Oregon	Health Share
InterCommunity Health Network	IHN
Jackson Care Connect	JCC
PacificSource Community Solutions–Central Oregon	PCS-CO
PacificSource Community Solutions–Columbia Gorge	PCS-CG
PacificSource Community Solutions–Lane	PCS-Lane
PacificSource Community Solutions–Marion Polk	PCS-MP
Trillium Community Health Plan, Inc.–North	TCHP-North

CCO Plan Name	CCO Short Name
Trillium Community Health Plan, Inc.–South	TCHP-South
Umpqua Health Alliance, LLC	UHA
Yamhill Community Care Organization	YCCO

Scope of External Quality Review

As set forth in 42 CFR §438.358, HSAG conducted all external quality review (EQR)-related activities in compliance with the *CMS External Quality Review (EQR) Protocols, February 2023* (CMS EQR Protocols).[1-2] For the CY 2023 assessment, HSAG used findings from the mandatory and optional EQR activities displayed in Table 1-2 to derive conclusions and make recommendations about the quality, timeliness, and accessibility of health care services provided by the CCOs. Detailed information about each activity methodology is provided in Section 3 of this report.

Table 1-2—EQR Activities

Activity	Description
Compliance Monitoring Review (CMR)	This activity determines the extent to which the CCO is in compliance with federal standards and associated state-specific requirements, when applicable.
Validation of Performance Improvement Projects (PIPs)	This activity verifies whether a PIP conducted by a CCO used sound methodology in its design, implementation, analysis, and reporting.
Performance Measure Validation (PMV)	This activity assesses whether performance measures calculated by the state are accurate based on measure specifications and reporting requirements.
Validation of Network Adequacy (NAV)	This activity determines the extent to which a CCO's Delivery System Network (DSN) has adequate provider networks in service areas to deliver timely care and an appropriate breadth of health care services to its managed care members and evaluates appointment availability through access and availability surveys conducted by secret shopper and revealed shopper survey methods.
Encounter Data Validation (EDV)	This activity evaluates the CCO's processes for collecting, maintaining, and submitting accurate and complete encounter data.
Mental Health Parity (MHP) Evaluation	This activity determines whether coverage and access to mental health (MH)/substance use disorder (SUD) benefits were provided in parity with medical/surgical (M/S) benefits.

[1-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, February 2023*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 21, 2024.

Aggregating and Analyzing Statewide Data

HSAG follows a four-step process to aggregate and analyze data collected from all EQR activities and draw conclusions about the quality, timeliness, and accessibility of health care services furnished by each CCO, as well as the program overall. To produce Oregon's 2023 annual EQR technical report, HSAG performed the following steps to analyze the data obtained and draw statewide conclusions about the quality, timeliness, and accessibility of health care services provided by the CCOs:

Step 1: HSAG analyzed the quantitative results obtained from each EQR activity for each CCO to identify strengths and weaknesses in each domain of quality, timeliness, and accessibility of health care services furnished by each CCO for the EQR activity.

Step 2: From the information collected, HSAG identified common themes and the salient patterns that emerged across EQR activities for each domain and drew conclusions about overall quality, timeliness, and accessibility of health care services furnished by each CCO.

Step 3: From the information collected, HSAG identified common themes and the salient patterns that emerged across all EQR activities related to strengths and opportunities for improvement in one or more of the domains of quality, timeliness, and accessibility of health care services furnished by each CCO.

Step 4: HSAG identified any patterns and commonalities that exist across the program to draw conclusions about the quality, timeliness, and accessibility of health care services for the program.

Quality, Timeliness, and Access

CMS has identified the domains of quality, timeliness, and access as keys to evaluating plan performance. HSAG used the following definitions to evaluate and draw conclusions about the performance of the plans in each of these domains.



Quality	Timeliness	Access
as it pertains to EQR, means the degree to which an MCO, PIHP, PAHP, or PCCM entity (described in §438.310[c][2]) increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics, the provision of services that are consistent with current professional, evidence-based knowledge, and interventions for performance improvement.[1]	as it pertains to EQR, is described by the NCQA to meet the following criteria: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[2] It further discusses the intent of this standard to minimize any disruption in the provision of healthcare. HSAG extends this definition to include other managed care provisions that impact services to members and that require a timely response from the MCO (e.g., processing expedited member appeals and providing timely follow-up care).	as it pertains to EQR, means the timely use of services to achieve optimal outcomes, as evidenced by MCPs successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (network adequacy standards) and §438.206 (availability of services). Under §438.206, availability of services means that each state must ensure that all services covered under the state plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs in a timely manner.[1]

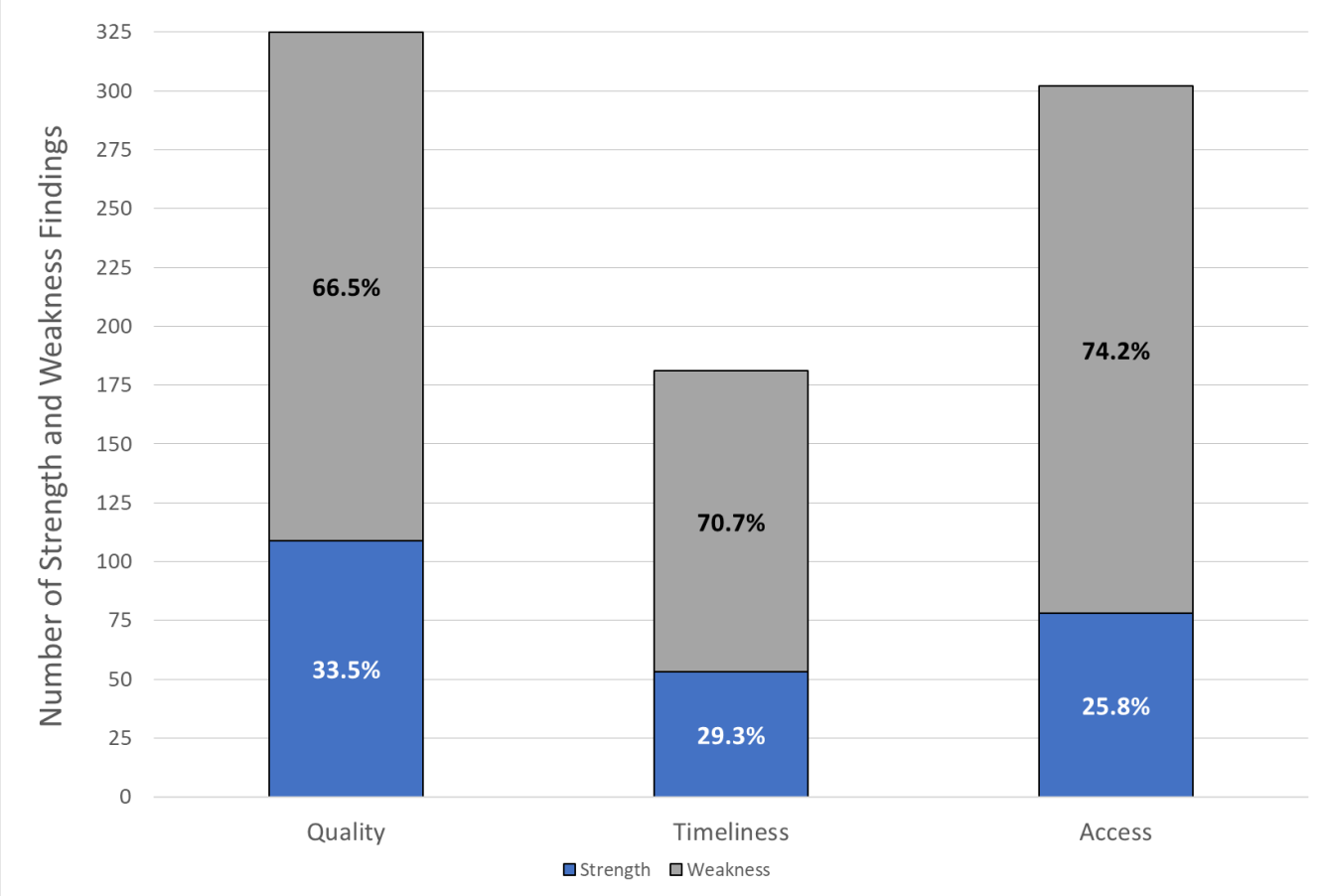
[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. Federal Register Vol. 81 No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27882. 42 CFR §438.320 Definitions; Medicaid Program; External Quality Review, Final Rule.
[2] National Committee for Quality Assurance. *2013 Standards and Guidelines for MBHOs and MCOs.*

Oregon Managed Care Program Conclusions and Recommendations

HSAG used its analyses and evaluations of EQR activity findings from CY 2023 to assess the CCOs' performance in providing quality, timely, and accessible health care services to Oregon Medicaid members as required in 42 CFR §438.364. For each CCO reviewed, HSAG provides a summary of its overall key findings, conclusions, recommendations, based on the CCO's performance, which can be found in Section 4 and Section 5 of this report. These findings include an assessment of the overall strengths and weaknesses based on the CCOs' performance as well as the degree to which the CCOs addressed the recommendations and/or findings issued during CY 2022 and unresolved findings from CY 2020 and CY 2021. The overall findings and conclusions for all plans were also compared and analyzed to develop overarching conclusions and recommendations for the Oregon managed care program.

Figure 1-1 illustrates the number of strengths exhibited by the CCOs relative to the number of weaknesses identified during the CY 2023 EQR activities across the three domains. The greater the proportion of weaknesses, the greater the opportunities for improvement relative to the CCOs' strengths.

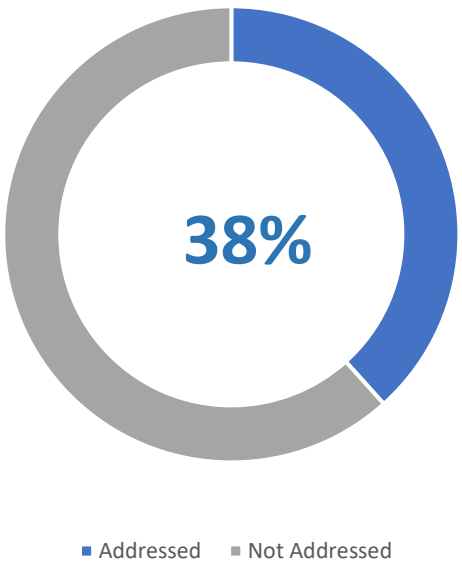
Figure 1-1—CCO Overall Number of Findings (Strengths and Weaknesses) by Domain



Overall, the results show a greater number of weaknesses were identified in the CCOs across all three domains. The relative percentage of weaknesses was at least 30 percentage points greater than the identified strengths. This finding suggests considerable room for improvement across the CCOs.

Figure 1-2 illustrates the degree to which the CCOs sufficiently addressed the recommendations for quality improvement (QI) made by HSAG during the CY 2022 EQR.

Figure 1-2—Percentage of CY 2022 EQR Recommendations Addressed by the CCOs



Overall, HSAG's assessment of the CCOs' responses and/or improvement plan outcomes revealed the CCOs were only able to sufficiently address 38 percent of the recommendations for QI made during the CY 2022 EQR. Each CCO had an opportunity to describe the activities and/or interventions implemented to address specific recommendations that were not evaluated by HSAG through the CY 2023 EQR activities. Seven CCOs (CHA, IHN, PCS-CO, PCS-CG, PCS-Lane, PCS-MP, and TCHP-South) did not provide responses, and TCHP-North addressed only one of the recommendations. The CCOs not addressing identified findings and opportunities for improvements are at risk of remaining out of compliance with their contracts.

The overall findings and conclusions for all CCOs were ultimately compared and analyzed to develop overarching conclusions and recommendations for OHA. Table 1-3 highlights substantive findings and actionable state-specific recommendations, when applicable, for OHA to target the goals and objectives in Oregon's Medicaid Quality Strategy (quality strategy)[1-3] to further promote improvement in the quality, timeliness, and accessibility of health care services furnished to Oregon Medicaid members.

[1-3] Oregon Health Plan. 2017–2022 Accountability Plan. Part II: Quality Strategy. Available at: https://www.oregon.gov/oha/HPA/DSI/QIDocs/2017-2022-Oregon-Health-Plan_Oregon-Accountability-Plan.pdf. Accessed on: Feb 21, 2024.

Table 1-3—Oregon Managed Care Program Substantive Findings

Program Strengths	Domain(s)[1-4]
OHA has continued to invest significant resources to provide guidance and technical assistance on contract deliverables to the CCOs, including the development of tools and supplemental instructional materials. OHA also provided clarification on State and federal rule and contract requirements to better inform the CCOs' understanding and implementation of policies, procedures, and operations.	
OHA has worked extensively with the CCOs to improve the quality of their provider capacity data, including ongoing technical assistance. Activities included the development of a provider specialty matrix to support the reliable and valid collection and reporting of provider network data and adequacy monitoring.	
OHA continued to implement, manage, and facilitate meetings and workgroups to support overall QI activities, including: monthly encounter data discussions and updates via the All Plan System Technical Workgroup, monthly QI meetings via the Quality Health Outcomes Committee, monthly regulatory meetings to review rule and contract requirements via the CCO Contracts and Compliance meeting, and monthly meetings to discuss oral health concerns via the Oral Health Forum.	
OHA has dedicated resources to enhance subcontractor performance monitoring and reporting.	
OHA and the CCOs have demonstrated continued collaboration in the development of methodologically sound designs for both statewide PIPs, and the CCOs and OHA worked to develop relevant, community-driven PIP topics through monthly statewide collaborative meetings and other statewide communications.	
The *Mental Health Service Access Monitoring* PIP addresses member needs identified as priorities for the state in response to the coronavirus disease 2019 (COVID-19) public health emergency (PHE).	
The *Initiation, Engagement, and Treatment of Alcohol and Other Drug Use Disorders* PIP allows the CCOs to focus plan resources on improving the treatment of members with SUD as part of the broader health care goals outlined in Oregon's 1115 SUD demonstration waiver.	
OHA discussed the results of the CY 2023 access and availability surveys with the CCOs and required the CCOs to use case-level data analytic files to review and correct provider directory discrepancies. In addition, OHA contracted with HSAG to conduct access and availability surveys in CY 2024 to continue monitoring the accuracy of CCO provider directory information and appointment availability.	
The EDV activity revealed the CCOs have the capability to collect, process, and transmit claims and encounter data to OHA in alignment with encounter data submission requirements. Overall, encounter data element omission rates were low for most evaluated elements, and a high level of element accuracy was observed for records that could be matched.	

[1-4]  = Quality,  = Timeliness,  = Access

Program Strengths	Domain(s)[1-4]
OHA fully implemented a centralized deliverable tracking system to monitor the submission of deliverables required by the CCO contract. This system was created to serve as a central repository for CCO deliverable submissions and evaluations completed by OHA staff members.	
The Oregon managed care program continued to demonstrate compliance with federal and State requirements requiring parity between the administration of MH/SUD and M/S covered benefits. Although the evaluation identified several opportunities for improvement, results did not identify systemic issues that negatively affected parity between MH/SUD and M/S services. Rather, findings frequently highlighted general regulatory compliance issues concerning both MH/SUD and M/S benefits uniformly.	
Several CCOs demonstrated ongoing improvement in performance on the *Child and Adolescent Well-Care Visits*, *Oral Evaluation for Adults With Diabetes*, and *Members Receiving Preventive Dental or Oral Health Services* measures since MY 2020.	

Program Weaknesses	Domain(s)
The Oregon managed care program demonstrated numerous opportunities for improvement during the CMR activity, resulting in required improvement plans to ensure corrective actions are implemented to achieve compliance with federal and State regulations. Additionally, none of the CCOs successfully resolved all of their CY 2022 CMR improvement plan findings, resulting in some CMR findings remaining noncompliant since the CY 2020 CMR audit.	
Although OHA developed member notice and model member handbook templates, the CCOs were not required to use the state-developed templates as required by 42 CFR §438.10(c)(4)(ii). Subsequently, the CY 2023 CMR activity identified one or more language, format, and/or content issues with member notices and member handbooks across all CCOs statewide.	
The Oregon managed care program was comprised of CCOs that relied heavily on multilayered, delegated arrangements to conduct core managed care functions outlined in the CCO contract. Due to the lack of sufficient oversight, numerous opportunities for improvement were identified across multiple EQR activities.	
The CCOs participating in Oregon's managed care program continued to experience challenges describing and demonstrating effective systems to assess and monitor the adequacy of their provider networks, including the collection and use of provider, member, and network adequacy data to drive network adequacy monitoring and decision-making. Some CCOs continued to monitor specialty providers as a single provider category rather than individual specialty types. Additionally, regional CCOs frequently reported provider networks globally limiting the assessment of provider networks available to members within specific geographic service areas.	
The CCOs participating in the Oregon managed care program have implemented a variety of approaches to monitoring appointment availability and using the data collected with widely varying degrees of relevance, rigor, and utility. As a result,	

Program Weaknesses	Domain(s)
data are not comparable across plans and, in some cases, are of limited value to support monitoring of network adequacy by individual CCOs and the overall Oregon managed care program. In addition, findings from the CY 2023 access and availability surveys exhibited long wait times for primary care, preventive dental, and outpatient behavioral health (BH) providers for the CCOs' members.	
The Oregon managed care program continued to experience challenges with the quality, accuracy, and completeness of data reported across all EQR activities. Most notable data quality and accuracy issues were observed during the DSN activities related to provider capacity data, which are the same data used to populate the CCOs' provider directories. Substantial discrepancies in the provider data resulted in a high percentage of unreachable provider offices during the access and availability surveys, representing potential barriers to members seeking health care services.	
OHA was delayed in distributing the monthly, statewide *Substance Use Disorder—Initiation, Engagement, and Treatment of Alcohol and Other Drug Use Disorders* PIP indicator data affecting the CCOs' ability to conduct analyses and implement effective interventions.	
With a few exceptions, most CCOs failed to achieve statistically significant improvement in overall indicator results from baseline to remeasurement year (RY) 1 for the *Mental Health Service Access Monitoring* PIP.	

Program Recommendations	
Recommendation	**Associated Quality Strategy Goals to Target for Improvement**
Identify additional clinical and operational goals that align with OHA's long-term objectives for improving the quality of equitable care among Medicaid members.	This recommendation does not apply to current quality strategy goals. It is an overarching recommendation for OHA to consider adding goals and objectives to its quality strategy that can be directly targeted to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid members.
Identify non-CCO incentive-based quality measures that are tied to OHA's quality strategy objectives and set specific targets or benchmarks to assess performance and progress on the established goals.	**Goal 1:** Improve the BH system and address barriers to access to and integration of care. **Goal 2:** Increase value and pay for performance. **Goal 3:** Focus on social determinants of health (SDOH) and health equity. **Goal 4:** Maintain sustainable cost growth and ensure financial transparency.
Require all CCOs to use the state-developed model member handbook and member notice templates to ensure compliance with 42 CFR §438.10(c)(4)(ii).	**Goal 1:** Improve the BH system and address barriers to access to and integration of care. **Goal 2:** Increase value and pay for performance.
Strengthen and clarify requirements and expectations of the CCOs with regard to	**Goal 1:** Improve the BH system and address barriers to access to and integration of care.

Program Recommendations	
oversight and compliance of their subcontractors.	**Goal 2:** Increase value and pay for performance. **Goal 3:** Focus on SDOH and health equity. **Goal 4:** Maintain sustainable cost growth and ensure financial transparency.
Ensure CCO-specific PIP performance indicator data are provided at the earliest opportunity so that the CCOs can use community-level data to guide root cause analyses, identify high-priority barriers to improvement, and develop innovative and appropriate interventions. OHA should ensure that indicator data updates are clearly communicated to the CCOs to facilitate effective, data-driven assessment of progress toward achieving improvement.	**Goal 1:** Improve the BH system and address barriers to access to and integration of care. **Goal 2:** Increase value and pay for performance. **Goal 3:** Focus on SDOH and health equity.
Establish guidelines for the CCOs implementing acceptable methodologies for measuring appointment wait times, as well as develop performance thresholds for determining provider network compliance with appointment availability standards.	**Goal 1:** Improve the BH system and address barriers to access to and integration of care. **Goal 2:** Increase value and pay for performance.
Develop compliance thresholds for CMR standards and DSN provider data quality and reporting to monitor and hold the CCOs accountable for findings that remain unresolved for multiple review years.	**Goal 1:** Improve the BH system and address barriers to access to and integration of care. **Goal 2:** Increase value and pay for performance. **Goal 3:** Focus on SDOH and health equity.

2. Introduction

Managed Care in Oregon

OHP is the source of health coverage for approximately 1.3 million Oregonians for physical, behavioral, and dental services, with most care provided through the CCOs.[2-1] Members who receive services through the State's fee-for-service (FFS) program are excluded from this report; only members receiving services from the CCOs fall under the purview of this annual EQR technical report.

CCOs are networks of health care providers who work together in their local communities to serve members who receive health care coverage under OHP. The CCOs' coordinated care model is focused on prevention and managing chronic conditions to reduce costs and support better health. In 2022, there were 16 CCOs providing physical, behavioral, and oral health care services to OHP members in Oregon. All CCO contracts with Medicaid expansion began January 1, 2020, with the exception of TCHP-North, which was awarded a contract in September 2020.

Table 2-1 displays the CCOs and their enrollment totals as of December 2023.[2-2] The numbers in the table were provided by OHA's Health Analytics Division and were considered preliminary at the time of this report.

Table 2-1—OHP Enrollment by CCO

CCO	Total Members
AH	27,196
AllCare	64,064
CHA	25,854
CPCCO	36,489
EOCCO	74,731
Health Share	443,282
IHN	82,537
JCC	64,342
PCS-CO	75,202
PCS-CG	17,943
PCS-Lane	90,645

[2-1] Oregon Health Authority. Medicaid Monthly Population Report for Oregon, Eligibility & Enrollment Physical Health Data for: Jan 2024, All Age Groups, Updated January 28, 2024, Available at: https://app.powerbigov.us/view?r=eyJrIjoiMTRhMmNhZDktYzY4OS00MzIxLTg4NTAtNjc4NmVlNjA1NzI4IiwidCI6IjY1OGU2M2U4LThkMzktNDk5Yy04ZjQ4LTEzYWRjOTQ1MmY0YyJ9&pageName=ReportSection98726d2ddac33b27095f. Accessed on: Feb 21, 2024.

[2-2] Ibid.

CCO	Total Members
PCS-MP	149,682
TCHP-North	53,071
TCHP-South	35,366
UHA	37,713
YCCO	36,172
Total Enrolled in a CCO	**1,314,289**

Oregon's Medicaid Quality Strategy

In accordance with 42 CFR §438.340, OHA implemented a written quality strategy for assessing and improving the quality of health care services furnished by the CCOs to Oregon Medicaid members under the Oregon managed care program.

OHA's mission is helping people and communities achieve optimum physical, mental, and social well-being through partnerships, prevention, and access to quality and affordable health care. OHA's quality strategy identifies goals and objectives, using the Institute of Healthcare Improvement Triple Aim framework, intended to achieve better care, better health, and reduce the cost of care. Table 2-2 describes OHA's quality strategy goals and objectives.

Table 2-2—OHA Quality Strategy Goals and Objectives

Triple Aim Dimension	OHA Goals	Objectives and Strategies to Achieve Goals
Improving the member experience of care	1. Improve the BH system and address barriers to access to and integration of care	• Integrate behavioral, physical, and oral health to allow members to receive the right care at the right time and in the right place • Focus on BH (MH and SUD) services • Assure needs of children with serious BH 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 • Align payment reforms with other State and federal efforts
Improving the health of Oregonians	3. Focus on SDOH and health equity	• Build stronger relationships between the CCOs and other sectors

Triple Aim Dimension	OHA Goals	Objectives and Strategies to Achieve Goals
		• Align outcomes between health care and other social systems to improve health equity • Encourage a greater investment in prevention and addressing social factors that impact health
Reducing costs of health care	4. Maintain sustainable cost growth and ensure financial transparency	• Continue to operate with a sustainable budget • Address the major cost drivers in the system • Ensure ongoing transparency and accountability

OHA evaluates progress in meeting its quality strategy goals through:

- Regular monitoring of the health plans' compliance programs.
- Member experience of care surveys.
- Calculating and reporting performance measures.
- Monitoring quality payment programs.
- Participation in mandatory EQR activities.
- Participation in custom-developed, optional EQR activities designed to further specific OHA goals and objectives.

Annual Quality Strategy Evaluation

OHA has developed a comprehensive program to transform the health care delivery system and improve health outcomes by providing access to comprehensive, cost-effective, and quality health care services. To ensure health plan accountability and improve health outcomes, OHA works collaboratively with various stakeholders, committees, and oversight bodies:

- Oregon Health Policy Board—develops strategic direction of health system transformation.
- OHA Quality Council—monitors clinical quality performance, health system transformation, and QI.
- Medicaid Advisory Committee—advises OHA on the policies, procedures, and operation of OHP.
- Health Systems Division CCO Quality Assurance and Contract Oversight Department—monitors the CCOs for contract compliance, EQR, and quality assurance (QA) elements (complaints, fraud, waste, abuse).
- Quality Management Committee—provides overall structure for OHP quality governance to monitor and improve quality initiatives.
- Health delivery system (partnership committees with delivery system and OHA).
  - 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 CCOs (including FFS).
- CCO Operations Collaborative and Contracts and Compliance Workgroup—monitors compliance with CCO contract requirements and provides guidance on the operational implementation of requirements.

OHA uses monthly, quarterly, and annual reporting from its external quality review organization (EQRO) and CCOs to monitor its success in meeting the key goals/measures of the quality strategy.

HSAG made recommendations in the CY 2022 EQR technical report for OHA based on the conclusions drawn from activities conducted. Table 2-3 is a summary of the follow-up actions that OHA completed in response to HSAG's recommendations during CY 2022. The information included within the OHA Action column of this table was provided by OHA.

Table 2-3—HSAG Recommendations With OHA Actions

HSAG CY 2022 Recommendation	OHA Action
Identify CCO-reported quality measures that are tied to OHA's quality strategy objectives and set specific targets or benchmarks to assess performance and progress on the established goals.	Quality measure targets and benchmarks are set annually for the incentive measures set forth by the metrics and scoring committee and can be found on the OHA CCO metrics website.[2-3] Measures may or may not be included in a CCO-selected PIP for performance monitoring at the discretion of the CCO. To align with the 2022–2027 Medicaid 1115 Demonstration Waiver, OHA is focusing on creating a new set of equity-driven CCO performance metrics for upstream health factors. The identification and implementation of clinical and operational goals and performance measures in Oregon's quality strategy continue to be a recommendation to support continued improvement, including the establishment of CCO standards and thresholds to better assess improvement toward reaching established goals.
Ensure CCO-specific PIP performance indicator data are provided at the earliest opportunity to allow sufficient time for the CCOs to use community-level data to guide root cause analyses, identify high-priority barriers to improvement, and develop innovative and appropriate interventions. In addition, OHA should ensure that indicator data updates are clearly communicated to the CCOs to facilitate	Alignment with the 2022–2027 Medicaid 1115 Demonstration Waiver and continued focus on the Oregon Statewide Mental Health Services Access Monitoring PIP. As noted in the CY 2023 EQR findings, OHA continued to experience challenges providing accurate and timely data to the CCOs in support of statewide PIP activities.

[2-3] Oregon Health Authority, Office of Health Analytics. CCO Metrics Program Resources. Available at: https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/CCO-Metrics.aspx. Accessed on: Feb 29, 2024.

HSAG CY 2022 Recommendation	OHA Action
effective use of the data and drive the assessment of progress toward achieving improvement.	
Encourage the CCOs to conduct root cause analyses for all key measures that fell below established performance or improvement thresholds to identify specific factors affecting performance. Once identified, targeted interventions should be developed, implemented, and evaluated to ensure effective improvement strategies are adopted to increase performance over time. OHA could use the Quality and Health Outcomes Committee as a forum for the CCOs to collaborate and discuss improvement strategies.	OHA has focused on discussion and collaboration via the Quality and Health Outcomes Committee, including technical assistance from the Transformation Center, more robust communication between workgroups, updated documentation, and a more streamlined approach to agenda setting and sharing meeting materials. OHA has dedicated significant resources to refining its improvement plan and corrective action plan processes, with a particular focus on highlighting and improving subcontractor performance.
Develop compliance thresholds for the CMR standards and consider implementing a performance standard to monitor and hold CCOs accountable for findings that remain unresolved for multiple review years.	OHA has developed and implemented internal processes to identify and escalate compliance issues, including aligning its CCO QA priorities with CMR standards and findings, dedicating two QA staff to capturing concerns and potential issues arising during CMR site visits, and focusing efforts to identify downstream effects in other areas of compliance and quality strategy.
Develop network performance metrics to support the ongoing monitoring of the CCOs' delivery system networks, and support improvement in the quality of provider data and reporting.	OHA has expanded its efforts to ensure the collection of reliable and accurate provider network data to support ongoing monitoring, including the: • Analysis of member geographic designations and comparison to CMS Medicare Advantage standards for primary care, cardiology, allergy, and immunology. • Finalization of a provider specialty matrix to support consistency and clarity in provider network reporting. • Revision of network adequacy rule language by the Rules Advisory Committee. • Continued use and improvement of quality metrics to evaluate the completeness and validity of the DSN information reported by the CCOs. • Revision of quarterly DSN analysis to examine provider-to-member ratios (across CCO network and those providers represented in the claims and encounter data considered "active") and provider languages spoken.

HSAG CY 2022 Recommendation	OHA Action
	• Analysis of provider participation in the Medicaid program based on submitted claims/encounters within the past 18 months. • Comparison of National Provider Identifier (NPI) number to its Medicaid Management Information System (MMIS) database to determine the validity of providers' NPI numbers and inclusion of network metrics.
Work with the CCOs to establish and implement effective and meaningful mechanisms for measuring and ensuring timely access to care, including network provider compliance with regulatory access standards.	Revision of network adequacy rule language included an exceptions process for when networks do not meet time and distance standards. While the process is still in development, it is intended to assist in facilitating development of mechanisms for measuring and ensuring timely access to care.
Continue to critically evaluate the accuracy of the CCOs' encounter data and ensure the CCOs implement standard quality controls and develop standard extraction procedures to ensure the accuracy of encounter data.	OHA has implemented processes to address encounter data accuracy, which include: • Sharing reports with the CCOs weekly. • Development of additional reporting and data evaluations, including focused reviews on subcontractor-initiated data. • Addition of an "Allowed Amount," or FFS equivalent amount, for each procedure code billed on a provider's claim. This implementation will ensure accuracy for rate setting and enhance the assessment of sub-capitated expenditures.
Encourage the CCOs to investigate the root cause for the medical record omissions and consider performing periodic medical record reviews (MRRs) of submitted claims to verify appropriate coding and data completeness, where appropriate.	OHA has provided guidance and technical assistance to the CCOs, including monthly encounter data discussions and updates via the All Plan System Technical Workgroup.

In CY 2023, OHA continued to work collaboratively with CMS on its alignment of the quality strategy with the 2022–2027 Medicaid 1115 Demonstration Waiver. OHA also focused significant efforts on redesigning the CCO contract deliverables process, including:

- Conducting multiple reviews and surveys to identify which contract deliverables have high impact and value for both the CCOs and OHA, and which deliverables can be consolidated, reformatted, or eliminated.
- Working with subject matter experts to better understand and refine the information that is being requested for evaluation and monitoring of CCO performance.
- Collaborating with the CCOs to ensure their concerns and feedback help drive the deliverable redesign process.

- Developing multiple internal trainings and tools for OHA evaluators, and creating an informational hub to provide ease of access.
- Providing guidance and clarification of rule (state and federal) and contract requirements to inform the CCOs' policies, procedures, and operations.

Building upon efforts in CY 2022, OHA implemented the CCO Contract Deliverables Portal, which provided a centralized platform for the CCOs to submit, track, and review deliverable documentation and evaluation results. The CCO portal includes notifications and reminders for both CCO and OHA staff who work on coordinating deliverables. In addition, one of the highlights of the CCO Contract Deliverables Portal project is the continuous improvement cycle of review, prioritization, and implementation of system updates requested by CCO and OHA staff. This allows OHA to be responsive to changing and expanding needs. Additionally, OHA updated member notice templates and created a model member handbook. However, OHA has not fully implemented federal requirements for mandatory use of the member notices and/or model member handbook by the CCOs.

To support ongoing improvement in the quality, timeliness, and accessibility of health care services for Medicaid beneficiaries, OHA will continue to use the results and recommendations generated from HSAG's EQR-related activities and set, monitor, and evaluate the established goals and objectives outlined in the quality strategy. OHA plans to continue building upon its CY 2023 initiatives, including OHA strongly encouraging the CCOs to participate in technical assistance calls for deliverable evaluations that require corrections. This process has already begun to show improvement in the collaboration between OHA and the CCOs, as well as reduce the number of resubmissions required.

3. Methodology

This section describes the manner in which each activity was conducted and how the resulting data were aggregated and analyzed.

Compliance Monitoring Review

Background

CMRs assess CCO compliance with the federal compliance review standards outlined in 42 CFR §438.358(b)(1)(iii) and related State contract requirements. CY 2023 began the new three-year review cycle for the CCOs, and HSAG will complete the comprehensive review of compliance with all federal requirements stipulated in 42 CFR §438.358(b)(1)(iii) in CY 2025. HSAG's CY 2023 CMR of member-focused standards included the following:

- Standard III—Coordination and Continuity of Care
- Standard IV—Coverage and Authorization of Services
- Standard VII—Member Rights and Protections
- Standard X—Grievance and Appeal Systems
- Standard XIV—Member Information
- Standard XVI—Emergency and Poststabilization Services

Table 3-1 outlines the three-year CMR cycle and standards with associated regulations.

Table 3-1—Oregon CMR Three-Year Cycle for the CCOs

Standard[1]	Federal Requirements Included	Year of Review		
		2023	2024	2025
Standard I—Availability of Services	42 CFR §438.206		✓	
Standard II—Assurances of Adequate Capacity and Services	42 CFR §438.207		✓	
Standard III—Coordination and Continuity of Care	42 CFR §438.208	✓		
Standard IV—Coverage and Authorization of Services	42 CFR §438.210	✓		
Standard V—Provider Selection	42 CFR §438.12 42 CFR §438.214		✓	
Standard VI—Subcontractual Relationships and Delegation	42 CFR §438.230		✓	

Standard[1]	Federal Requirements Included	Year of Review		
		2023	2024	2025
Standard VII—Member Rights and Protections	42 CFR §438.100– 42 CFR §438.102	✓		
Standard VIII—Confidentiality	42 CFR §438.224			✓
Standard IX—Enrollment and Disenrollment	42 CFR §438.3 42 CFR §438.56			✓
Standard X—Grievance and Appeal Systems	42 CFR §438.228; 42 CFR §438.400– 42 CFR §438.424	✓		
Standard XI—Practice Guidelines	42 CFR §438.236		✓	
Standard XII—Quality Assessment and Performance Improvement	42 CFR §438.330			✓
Standard XIII—Health Information Systems, including Information Systems Capabilities Assessment (ISCA)	42 CFR §438.242			✓
Standard XIV—Member Information	42 CFR §438.10	✓		
Standard XVI—Emergency and Poststabilization Services	42 CFR §438.114	✓		

[1] Standard XV previously represented Program Integrity, which was removed from the EQR CMR scope of work and the numbering system had not been updated at the time of this report.

Objectives

The objective of the CMR was to provide meaningful information to OHA and the CCOs regarding:

- The CCOs' compliance with federal managed care regulations, Oregon Administrative Rules (OAR), and contract requirements in the standard areas reviewed.
- Strengths, opportunities for improvement, recommendations, or required actions to bring the CCOs into compliance with federal managed care regulations and State requirements with the standard areas reviewed.
- The quality, timeliness, and accessibility of health care services furnished by the CCOs, as addressed within the specific areas reviewed.
- Possible additional interventions recommended to improve the quality of the CCOs' care provided and services offered related to the areas reviewed.

Technical Methods of Data Collection

To assess for the CCOs' compliance with regulations, HSAG conducted the five activities described in CMS' EQR *Protocol 3. Review of Compliance With Medicaid and CHIP* [Children's Health Insurance Program] *Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023 (EQR Protocol 3).[3-1] Table 3-2 describes the five protocol activities and the specific tasks that HSAG performed to complete each activity.

Table 3-2—Protocol Activities Performed for Assessment of Compliance With Regulations

Protocol Activities	Steps Associated With Protocol Activities
Activity 1:	**Establish Compliance Thresholds**
	• Conducted before the review to assess compliance with federal managed care regulations and OHA requirements: – HSAG and OHA participated in meetings to determine the timing and scope of the reviews, as well as scoring strategies. – HSAG developed and submitted the CMR Protocol, tools, and technical assistance webinar slides to OHA for review and approval. – HSAG forwarded the CMR Protocol, tools, and applicable guidance to the CCOs. – HSAG scheduled the virtual onsite reviews and distributed the detailed meeting agendas to the CCOs to facilitate preparation for the reviews.
Activity 2:	**Perform Preliminary Review**
	• HSAG conducted a pre-review technical assistance session with the CCOs. • The HSAG review team reviewed all documentation submitted prior to the virtual onsite webinar to increase its knowledge and understanding of the CCO's operations, identify areas needing clarification, and begin compiling information before the virtual onsite review.
Activity 3:	**Conduct Virtual Onsite Review**
	• HSAG conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG's one-day virtual onsite review activities. • HSAG reviewed additional documents requested and made available by the CCOs during the interview sessions. • HSAG reviewed the data systems used in the CCOs' operations such as utilization management (UM), care coordination, and enrollment and disenrollment. • HSAG conducted interviews with the CCOs' key administrative and program staff members. • HSAG conducted a closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Feb 21, 2024.

Protocol Activities	Steps Associated With Protocol Activities
Activity 4:	**Compile and Analyze Findings**
	• HSAG used the CY 2023 CMR report template to compile the findings and incorporate information from the CMR activities. • HSAG analyzed the findings and calculated final scores based on pre-established scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	**Report Results to OHA**
	• HSAG populated and submitted the draft reports to OHA and the CCOs for review and comment. • HSAG incorporated the feedback, as applicable, and finalized the reports. • HSAG included a pre-populated improvement plan template along with the final report for all requirements determined to be out of compliance with managed care regulations (i.e., received a score of *Partially Met* or *Not Met*). • HSAG distributed the final reports to the CCOs and OHA.

Description of Data Obtained

The following are examples of documents reviewed and sources of the data obtained:

- Written policies and procedures
- Staff training materials and documentation of training attendance
- Committee charters, meeting agendas, and minutes
- Management/monitoring reports and audits
- Member handbook and informational materials, including provider directory, drug formulary, etc.
- Provider manual, provider contracts, and informational materials
- Applicable sample correspondence or template communications
- Interviews with key CCO staff members
- Narrative and/or data reports across a broad range of performance and content areas.
- Member-level files (e.g., care management records, grievances, appeals, and denials)

How Data Were Aggregated and Analyzed

HSAG used ratings of *Met*, *Partially Met*, and *Not Met* to indicate the degree to which each CCO's performance complied with the requirements. This scoring methodology is in alignment with CMS' EQR Protocol 3. HSAG compiled all submitted documentation and conducted a final review, considering the intent of the regulations, and applied a rating for each element based on the following definitions:

Met indicates full compliance, defined as:

- All documentation listed under a regulatory provision, or component thereof, is present; and
- CCO staff provide responses to reviewers that are consistent with each other and with the documentation.

Partially Met indicates partial compliance, defined as:

- There is compliance with all documentation requirements, but CCO staff are unable to consistently articulate evidence of compliance during interviews; or
- CCO staff can describe and verify the existence of compliant practices during the interview, but documentation is found to be incomplete or inconsistent with practice.

Not Met indicates noncompliance, defined as:

- No documentation is present, and staff members have minimal or no knowledge of processes or issues addressed by the regulatory provisions; or
- No documentation is present and staff members have little or no knowledge of processes or issues that comply with key components (as defined by OHA) of a multi-component regulatory provision, regardless of compliance determinations for remaining, non-key components of a regulatory provision.

From the scores assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each of the four standards and an overall percentage-of-compliance score across the four standards. HSAG calculated the total score for each standard by totaling the number of *Met* (1 point) elements, the number of *Partially Met* (0.5 points) elements, and the number of *Not Met* (0 points) elements, then dividing the summed score by the total number of applicable elements for that standard.

HSAG determined the overall percentage-of-compliance score across the areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the total values of the scores and dividing the result by the total number of applicable elements).

How Conclusions Were Drawn

Using the following standardized methodology, HSAG assigned a confidence level based upon the total percentage-of-compliance score for each of the standards and an overall percentage-of-compliance score across all standards to indicate the degree to which the CCOs achieved compliance with the standards reviewed:

- ***High Confidence*** = Compliance Score ≥ 95 percent
- ***Moderate Confidence*** = Compliance Score ≥ 85 percent and < 95 percent
- ***Low Confidence*** = Compliance Score ≥ 75 percent and < 85 percent
- ***No Confidence*** = Compliance Score < 75 percent

To draw conclusions about the quality, timeliness, and accessibility of health care services provided by the CCOs, HSAG assigned each of the components reviewed for assessment of compliance with regulations to one or more of those domains of care. Each standard may involve the assessment of more than one domain of care due to the combination of individual requirements within each standard. HSAG then analyzed, to draw conclusions and make recommendations, the individual requirements within each standard that assessed the quality, timeliness, or accessibility of health care services provided by the CCOs. Table 3-3 depicts assignment of the standards reviewed in CY 2023 to the domains of care.

Table 3-3—Assignment of Compliance Standards to the Quality, Timeliness, and Access Domains

Compliance Review Standard	Quality	Timeliness	Access
Standard III—Coordination and Continuity of Care	✓	✓	✓
Standard IV—Coverage and Authorization of Services	✓	✓	✓
Standard VII—Member Rights and Protections	✓		✓
Standard X—Grievance and Appeal Systems	✓	✓	✓
Standard XIV—Member Information	✓	✓	✓
Standard XVI—Emergency and Poststabilization Services		✓	✓

Validation of Performance Improvement Projects

Background

The purpose of conducting PIPs is to achieve—through ongoing measurements and intervention—significant, sustained improvement in clinical or nonclinical areas. This structured method of assessing and improving health plan processes was designed to have favorable effects on health outcomes and member satisfaction.

Objectives

The primary objective of PIP validation was to determine each CCO's compliance with requirements set forth in 42 CFR §438.330(d), including:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement in performance.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

The goal of HSAG's PIP validation was to ensure that OHA and key stakeholders can have confidence that any reported improvement was related and reasonably linked to the QI strategies and activities the CCO conducted during the PIP. HSAG's scoring methodology evaluated whether the CCO executed a methodologically sound PIP.

Technical Methods of Data Collection

HSAG, as the State's EQRO, validated the PIPs through an independent review process. In its PIP evaluation and validation, HSAG used CMS' EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019 (EQR Protocol 1).[3-2]

HSAG's evaluation of each PIP included two key components of the QI process:

1. HSAG evaluated the technical structure of the PIP to ensure the CCO designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., PIP Aim statement, population, sampling techniques, performance indicator, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this

[3-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Feb 22, 2024.

component ensures that reported PIP results are accurate and capable of measuring sustained improvement.

2. HSAG evaluated the implementation of the PIP. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluated how well the CCO improves indicator results through the implementation of effective processes (i.e., barrier analyses, interventions, and evaluation of results).

Description of Data Obtained

HSAG's methodology for PIP validation provided a consistent, structured process and a mechanism for providing the CCOs with specific feedback and recommendations. The CCOs used a standardized PIP submission form to document information on the PIP design, completed PIP activities, and performance indicator results. HSAG evaluated the documentation provided in the PIP submission form to conduct the annual validation.

HSAG's PIP submission form allows the CCOs to document the data collection methods used to obtain performance indicator results for monitoring improvement achieved through each PIP. Table 3-4 summarizes the performance indicator description and data sources used for each PIP topic.

Table 3-4—CCO PIP Topics, Performance Indicators, and Data Sources

PIP Topic	Performance Indicator	Data Source
Statewide CCO PIPs		
Mental Health Service Access Monitoring	Percentage of members with a MH service need who received MH services.	Administrative
Initiation, Engagement, and Treatment of Alcohol and Other Drug Use Disorders PIP also referred to as the *Substance Use Disorder* PIP	1. Percentage of new SUD episodes that were followed by treatment initiation within 14 days. 2. Percentage of new SUD episodes that were followed by treatment engagement within 34 days of treatment initiation.	Administrative

How Data Were Aggregated and Analyzed

Using the PIP validation tool and standardized scoring, HSAG scored each PIP on a series of evaluation elements and scored each evaluation element within a given activity as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designated some of the evaluation elements pivotal to the PIP process as "critical elements." For a PIP to produce valid and reliable results, all critical elements needed to achieve a *Met* score. HSAG assigned each PIP an overall percentage score for all evaluation elements (including critical elements), calculated by dividing the total number of elements scored as *Met* by the sum of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculated a critical

element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*. The outcome of these calculations determined the validation status of *Met*, *Partially Met*, or *Not Met*.

How Conclusions Were Drawn

Using a standardized scoring methodology, HSAG assigned an overall validation status and reported the overall validity and reliability of the findings as one of the following:

- ***Met*** = High confidence/confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 100 percent of all evaluation elements were *Met* across all activities.
- ***Partially Met*** = Low confidence in reported PIP results. All critical evaluation elements were *Met*, and 60 percent to 79 percent of all evaluation elements were *Met* across all activities; or one or more critical evaluation elements were *Partially Met*.
- ***Not Met*** = Reported findings are not credible. All critical evaluation elements were *Met*, and less than 60 percent of all evaluation elements were *Met* across all activities; or one or more critical evaluation elements were *Not Met*.

PIPs that accurately addressed EQR Protocol 1 requirements were determined to have high validity and reliability. "Validity" refers to the extent to which the data collected for a PIP measured its intent. "Reliability" refers to the extent to which an individual could reproduce the study results. For each completed PIP, HSAG assessed threats to the validity and reliability of PIP findings and determined whether a PIP was not credible.

To draw conclusions about the quality, timeliness, and accessibility of health care services provided by the CCOs, HSAG assigned each of the components reviewed for PIP validation to one or more of these three domains. While the focus of an CCO's PIP may have been to improve performance related to health care quality, timeliness, or accessibility, PIP validation activities were designed to evaluate the validity and quality of the CCO's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. In addition, all PIP topics were also assigned to other domains as appropriate. This assignment to domains is shown in Table 3-5.

Table 3-5—Assignment of PIPs to the Quality, Timeliness, and Access Domains

PIP Title	Quality	Timeliness	Access
Statewide CCO PIPs			
Mental Health Service Access Monitoring	✓		✓
Substance Use Disorder	✓	✓	✓

Performance Measure Validation

Background

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

Objectives

The primary objectives of the PMV activities were to:

- Evaluate the accuracy of the performance measure data collected.
- Determine the extent to which the specific performance measures calculated by OHA (on the behalf of the CCOs) followed the specifications established for each performance measure.
- Identify overall strengths and areas for improvement in the performance measure calculation process.

Technical Methods of Data Collection

OHA selected and calculated the performance measures by using a number of data sources, including claims/encounter data and enrollment/eligibility data. During the CY 2023 PMV activity, HSAG evaluated the accuracy and validity of OHA's calculation of four measurement year (MY) 2022 (i.e., January 1, 2022, through December 31, 2022) performance measures for the CCOs in accordance with CMS' EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023 (EQR Protocol 2).[3-3] HSAG collected information using several methods including interviews, system demonstrations, review of data output files, primary source verification (PSV), observation of data processing, and review of data reports.

HSAG's process for PMV for OHA included the following steps.

[3-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf. Accessed on: Feb 22, 2024.

Pre-Onsite Review Activities: Based on the measure definitions and reporting guidelines provided by OHA, HSAG:

- Developed and forwarded an Information Systems Capabilities Assessment Tool (ISCAT) that was used to collect the necessary background information on OHA's information systems, policies, processes, and data needed for the virtual performance of validation activities.
- Scheduled virtual onsite review date.
- Conducted kick-off call to introduce the audit team, discuss the virtual onsite review agenda, provide guidance on PMV processes, and ensure that OHA was aware of important deadlines.
- Reviewed completed ISCAT to assess OHA's information systems.
- Reviewed source code used for calculating the performance measure rates to ensure compliance with the technical specifications.
- Conducted preliminary rate review to assess data completeness and accuracy.

Virtual Onsite Review Activities: HSAG conducted a virtual onsite visit for OHA to validate the processes used for calculating measures. The virtual onsite review included:

- An opening conference to review the purpose, required documentation, basic meeting logistics, and queries to be performed.
- Evaluation of system compliance, including a review of the ISCAT, focusing on the processing of claims, encounters, and member and provider data.
- PSV on a random sample of members, validating enrollment and encounter data for a given date of service within both the membership and encounter data systems.
- Evaluation of the processes used to collect and calculate performance measure data, including accurate numerator and denominator identification, and algorithmic compliance to determine if rate calculations were performed correctly.
- A review of processes used for collecting, storing, validating, and reporting the performance measure data.
- An overview of data integration and control procedures, including discussion and observation of source code logic and a review of how all data sources were combined.
- A closing conference to summarize preliminary findings from the review of the ISCAT and the virtual onsite review, and to revisit the documentation requirements for any post-review activities.

Post-Onsite Review Activities: Following the virtual onsite review, HSAG:

- Received and reviewed additional documentation requested during the virtual onsite review. Worked collaboratively to resolve any outstanding item, if applicable.
- Assigned audited result to each selected measure.
- Produced and provided a final audit report containing a summary of all audit activities.

Description of Data Obtained

As identified in EQR Protocol 2, the following key types of data were obtained from OHA and reviewed as part of the PMV activity:

1. **ISCAT:** Provided information on OHA's information systems, policies, processes, and data in preparation for the virtual validation activities.
2. **Source Code (Programming Language) for Performance Measures:** Reviewed to determine compliance with the performance measure definitions.
3. **Supporting Documentation:** Provided additional information needed by HSAG reviewers to complete the validation process, including performance measure definitions, file layouts, system flow diagrams, system log files, policies and procedures, data collection process descriptions, and file consolidations or extracts.
4. **Current Performance Measure Results:** Reviewed results from the measures OHA calculated to determine CCO performance.
5. **Virtual Interviews and Demonstrations:** Provided additional information through interaction, discussion, and formal interviews with key OHA staff members as well as through system demonstrations.

How Data Were Aggregated and Analyzed

HSAG performed a performance validation audit of the OHA-selected measures calculated on behalf of the CCOs. HSAG evaluated several aspects involved in the calculation of performance measure data including data integration, data control, and documentation of performance measure calculations. These processes were evaluated through an ISCAT, source code review, virtual onsite review, performance measure rate review, and PSV of selected samples of performance measure data. The results were aggregated and utilized to determine validation results for the OHA-selected performance measures.

How Conclusions Were Drawn

HSAG analyzed OHA's ISCAT responses; source code (i.e., programming language) for performance measures; and supporting documentation including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. Based on this analysis and the virtual audit review of data integration, data control, and performance measure documentation, HSAG determined results for each performance measure and assigned each an indicator designation of "Reportable (R)" or "Do Not Report (DNR)" as defined in Table 3-6. In the context of validation of performance measures, bias is based on the extent to which the data sources used to calculate the denominator and numerator were complete and accurate, and degree to which the calculation of the performance measure adhered to the specifications for all components of the reporting requirements. HSAG based each validation finding on the magnitude of errors detected for the measure's evaluation elements, not by the number of elements determined to be noncompliant. Consequently, it was possible that an error for a single element resulted in a designation of "DNR" because the impact of the error

biased the reported performance measure by more than 5 percentage points. Conversely, it was also possible that errors for several elements had little impact on the reported rate and that the indicator was thereby given a designation of "R."

Table 3-6—Validation Results for Performance Indicators

Reportable (R)	Indicator was compliant with the measure specifications and the rate can be reported.
Do Not Report (DNR)	Indicator was materially biased and should not be reported.

To draw conclusions about the quality, timeliness, and accessibility of health care services provided by the Medicaid CCOs, HSAG assigned each of the measures reviewed for PMV to one or more of three domains of care. This assignment to domains of care is depicted in Table 3-7.

Table 3-7—Assignment of Performance Measures to the Quality, Timeliness, and Access Domains

Performance Measure	Quality	Timeliness	Access
CCOs			
Child and Adolescent Well-Care Visits—Ages 3 to 6 Years		✓	✓
Initiation and Engagement of Substance Use Disorder Treatment—Ages 13 to 17 Years and *Ages 18 Years and Older*	✓	✓	✓
Members Receiving Preventive Dental or Oral Health Services—Ages 1 to 5 Years and *Ages 6 to 14 Years*		✓	✓
Oral Evaluation for Adults With Diabetes	✓	✓	✓

Validation of Network Adequacy

Delivery System Network Evaluation

Background

According to federal and State regulations governing Medicaid services,[3-4] each managed care contractor is required to maintain a network of appropriate health care providers to ensure all services covered under the State plan are available and accessible to members in a timely manner. Each CCO must demonstrate the capacity to serve its current and expected membership within its service area and submit documentation to the State Medicaid authority.

To meet oversight requirements, OHA contracted with HSAG to conduct an evaluation of the CCOs' DSNs to assess network adequacy and compliance with Oregon's standards for access to care. To assess CCO compliance with State network adequacy and availability of services requirements, HSAG:

- Conducted a review of the CCOs' network monitoring processes and procedures for ensuring the adequacy of its provider network, including members' access to care and the availability of services.
- Assessed the CCOs' network capacity and geographic distribution of providers relative to member populations.
- Evaluated, summarized, and presented aggregate findings from OHA's quarterly *DSN Provider Capacity Reports*.

HSAG conducted the DSN Evaluation in alignment with guidance outlined in CMS' network access and adequacy toolkit[3-5] and the CMS EQR Protocols released in February.

Objectives

The objectives of the DSN Evaluation were to provide meaningful information to OHA and the CCOs regarding:

- The CCOs' compliance with the OARs and contract requirements for monitoring CCO DSNs.
- The adequacy of CCO provider networks and the CCOs' compliance with OHA-defined time and distance access standards.
- The completeness and quality of CCO provider data.

[3-4] 42 CFR §438.206 and §438.207; Oregon Administrative Rules (OAR) 410-141-3515; and OHA CCO Health Plan Services Contract.

[3-5] Centers for Medicare & Medicaid Services. Promoting Access in Medicaid and CHIP Managed Care: A Toolkit for Ensuring Provider Network Adequacy and Service Availability, April 2017. Available at: https://www.medicaid.gov/medicaid/downloads/adequacy-and-access-toolkit.pdf. Accessed on: Sep 14, 2023.

- Program-level recommendations for OHA, including future technical assistance and operational improvements for overseeing the adequacy of CCO provider networks.
- CCO-specific findings and recommendations necessary to improve network adequacy monitoring capabilities and compliance with OHA's network adequacy standards.

To accomplish its objectives, HSAG developed data collection tools, network adequacy summary metrics, and evaluation criteria to assess and document the CCOs' compliance with State rules and CCO contract requirements.

In 2023, HSAG's evaluation included three components:

- DSN Narrative Review
- Network Capacity and Adequacy Assessment
- *DSN Provider Capacity Report* Findings

Technical Methods of Data Collection

The key 2023 DSN Evaluation activities are described below.

1. **Protocol Development and Dissemination:** HSAG developed the 2023 DSN Evaluation protocol to describe the scope and methodology for conducting the DSN analysis and provide guidance to the CCOs on their participation. HSAG also developed data collection tools to support information gathering on the CCOs' network monitoring processes and procedures.

    - **DSN Narrative Template**—Standardized tool the CCOs used to submit documentation of compliance with key federal and State regulations and contract requirements across four domains: DSN Governance Structure, Member Needs and Population Management, DSN Monitoring and Analysis, and Network Response Strategy.

2. **DSN Technical Assistance Webinar:** HSAG hosted webinar on May 16, 2023, for the CCOs to review the 2023 DSN Evaluation timeline, required documentation and submission guidelines, analysis, reporting processes, and to allow an opportunity for questions and answers.
3. **Documentation Submission:** The CCOs completed the 2023 *DSN Narrative Template* and submitted all applicable supporting documentation. All requested data and documentation were due on or before July 31, 2023.
4. **Desk Review and Analysis:** HSAG conducted a desk review of each organization's documentation and data to evaluate the CCOs' network adequacy and compliance with the OARs and contract requirements for monitoring DSNs. The desk review enabled HSAG reviewers to increase their knowledge and understanding of each CCO's operations, identify areas needing clarification, and begin compiling information needed to make a formal assessment. HSAG performed an analysis of the quarterly provider capacity data to assess the adequacy, availability, and timeliness of access to providers and health care services. The evaluation incorporated a multi-dimensional approach using a series of measures to support DSN reporting. HSAG also summarized findings from OHA's

quarterly *DSN Provider Capacity Reports* to identify and report on the quality and adequacy of CCO provider networks.

5. **Follow-up Interviews:** HSAG conducted follow-up interviews with organizations when desk review results or data analysis identified areas where additional information and/or clarification was required.
6. **Report Production:** HSAG compiled all information obtained from the desk review and data analysis to derive DSN findings for each CCO. HSAG summarized the results of its review and presented the findings to OHA in a draft report; the CCOs had the opportunity to review CCO-specific findings and recommendations. Upon receipt of feedback from OHA and the CCOs, HSAG drafted a final DSN Evaluation report for submission to OHA.

Description of Data Obtained

To assess each CCO's DSN, HSAG obtained information from multiple documents and sources completed and submitted by each organization.

- CCO *DSN Narrative Template* and supplemental documentation used to assess compliance with OARs and CCO contract requirements.
- CCO CY 2022 ISCAT used to assess the capabilities of the CCOs to collect, manage, analyze, and report provider-related data.
- CCO *DSN Provider Capacity Report* data used in conjunction with member enrollment data to support the calculation of network adequacy metrics.
- Member eligibility and enrollment files from OHA used in conjunction with *DSN Provider Capacity Report* data files to support the calculation of network adequacy metrics.
- Unique list of members associated with MH and SUD claims in CY 2022 obtained from the CCOs' submission of the CY 2023 *MHP Data Submission Template* containing data used to support the CY 2023 MHP Evaluation.
- OHA *DSN Provider Capacity Reports* used to summarize the quality of the CCOs' provider network data and the capacity of CCO provider networks.

How Data Were Aggregated and Analyzed

HSAG generated both qualitative and quantitative results based on submitted documentation in order to assess network adequacy during the 2023 DSN Evaluation.

DSN Narrative Review

In alignment with Exhibit G of the CCO contract, the DSN Narrative review assessed the CCOs' compliance with the OARs and contract requirements for monitoring CCO DSNs. Data collection relied on CCO responses and supplemental documentation collected through the 2023 *DSN Narrative Template*. In collaboration with OHA, the 2023 *DSN Narrative Template* was revised to align with OHA's overall objectives for monitoring network adequacy and the recently released CMS EQR protocol for validating network adequacy.

Table 3-8 describes the four domains that comprised the *DSN Narrative Template*.

Table 3-8—*DSN Narrative Template* Domains and Descriptions

Domain	Description
DSN Governance Structure	Required the CCO to provide documentation that described the operational infrastructure responsible for oversight and monitoring the adequacy of its DSN. Supporting documentation and responses included: • CCO organization charts, roles and responsibilities, and committee structure. • Policies, procedures, and processes outlining oversight of subcontractors' delegated network-related managed care functions. • Documentation of CCO provider data information systems used to collect, store, validate, calculate, and report network provider data and metrics (e.g., data system documentation, process flows).
Member Needs and Population Management	Required the CCO to provide documentation that described processes for monitoring current and anticipated membership and service needs. Supporting documentation and responses included: • Policies, procedures, and processes supporting member monitoring programs, population metrics, and reporting mechanisms. • Sample reports (e.g., service utilization, disease prevalence).
DSN Monitoring and Analysis	Required the CCO to provide documentation that described the CCO's processes for monitoring and analyzing its DSN, including the collection, calculation, and reporting of network performance measures. Supporting documentation and responses included: • Documentation of CCO network performance measures (e.g., technical specification, reporting templates). • Sample reports and network performance results (e.g., time and distance reports, provider-to-member ratios, appointment availability).
Network Response Strategy	Required the CCO to provide documentation that described actions taken to address network findings related to ongoing monitoring of network adequacy. Supporting documentation included: • Identification of barriers to access. • Short- and long-term interventions, including follow-up to findings. • Implementation of corrective actions based on prior DSN evaluations.

HSAG used the ratings of *Met*, *Partially Met*, and *Not Met*, as defined in Table 3-9, to indicate the degree to which each CCO addressed the reporting requirements and submitted the required documentation. A designation of *Not Applicable* (NA) was used when a specific reporting element on the review tool was not applicable to a CCO.

Table 3-9—DSN Narrative Evaluation Rating Criteria

Rating	Rating Description
Met	Indicates *all* components were present and complete: • Narrative response fully addressed reporting requirements of the element; and • Required documentation/data (when applicable) was submitted, complete, and relevant to the elements and/or review period.
Partially Met	Indicates *at least one* component was missing or incomplete: • Narrative response fully addressed reporting requirements of the element, but required documentation/data **was not** submitted, complete, or relevant to the elements and/or review period. • Required documentation/data (when applicable) was submitted, complete, and relevant, but the narrative response **did not** fully address the reporting requirement.
Not Met	Indicates *none* of the components were present and complete: • Narrative response **did not** address the element or the CCO indicated the reporting requirement was not conducted; and • Required documentation/data (when applicable) **was not** submitted, complete, or relevant to the elements and/or review period.

From the ratings assigned to each of the reporting requirements, HSAG calculated a total score for each domain. HSAG calculated the total score for each organization by totaling the number of *Met* (1 point) elements, the number of *Partially Met* (0.5 points) elements, and the number of *Not Met* (0 points) elements. Elements scored NA were not included in the total score. HSAG determined the overall percentage-of-compliance score across the areas of review by summing the total values of the scores and dividing the result by the total number of applicable elements.

Network Capacity and Adequacy Assessment

To understand the capacity and adequacy of CCO provider networks, HSAG assessed two interrelated dimensions of access: network capacity and geographic distribution. While network capacity addresses the underlying infrastructure of a provider network, geographic distribution addresses whether the distribution of available providers and services is adequate to facilitate access to all members. All analyses were limited to a subset of core individual and facility-based providers selected in collaboration with OHA to represent fundamental health services covered by the CCOs and relevant to OHA's quality strategy and network adequacy objectives. Table 3-10 presents the provider types included in the 2023 DSN Evaluation.

Table 3-10—Provider Types Included in the 2023 DSN Evaluation

Individual Practitioners	Facility/Service Providers
• Primary Care Provider (PCP), Adult and Pediatric[1] • Primary Care Dentist (PCD), Adult and Pediatric[2] • Mental Health (MH Provider), Adult and Pediatric[1] • Substance Use Disorder (SUD) Provider, Adult and Pediatric[1] • Specialty Providers, adult and pediatric[1,4] – Cardiology (CRD) – Endocrinology (END) – Nephrology (NEPH) – Neurology (NEUR) – Obstetrics/Gynecology Provider[1] (OB/GYN) – Occupational Therapy (OT) – Oncology (ONC) – Ophthalmology/Optometry (OPT) – Physical Therapy (PT) – Podiatry (POD) – Psychiatry (PSY) – Pulmonology (PUL) – Speech Language Pathology (SLP) – Traditional Health Worker (THW)	• Durable Medical Equipment (DME) • Hospital[3] (HOSP) • Imaging Center/Clinic (IC) • Indian Health Services/Tribal Health Center (IHS/THC) • Pharmacy[3] (Rx) • Skilled Nursing Facility (SNF)

[1] These provider types are defined in 42 CFR §438.68 and include stratification by providers serving adult and pediatric members.
[2] This provider type is defined in 42 CFR §438.68 for the pediatric population only.
[3] These provider types were defined in 42 CFR §438.68 without stratification by adult or pediatric member populations.
[4] Individual specialty providers included in the 2023 DSN Evaluation were based on OHA's time and distance tier designations and alignment with OHA's quality strategy and internal goals and objectives.

Measures of network capacity assess whether health services are available to members through a sufficient supply and variety of providers. Using provider network data obtained from OHA, HSAG aggregated data and reported three metrics based on participating providers in, or contiguous to, CCO service areas:

- Provider Counts—the number and percentage of providers and facilities by provider type.
- Network Stability—the percentage of change in provider counts (by provider type) between 2022 and 2023.
- Provider-to-Member Ratios—the number of providers relative to the number of members by provider type.

Key measures for assessing the geographic distribution of providers included time and distance analyses and compliance with network adequacy requirements. When combined with member and provider characteristics, these analyses determined the extent to which the supply of providers was distributed appropriately relative to the member population. HSAG assessed the geographic distribution of

providers relative to member populations as the percentage of members having access to a provider within the current OHA-defined time and distance standards. These standards included the average travel time (in minutes) and driving distance (in miles) to the nearest provider by provider type. All study results were stratified by CCO, provider type, applicable member population, and urbanicity. Table 3-11 outlines OHA's time and distance standards.

Table 3-11—DSN Time and Distance Standards by Provider Type

Geographic Classification	Definition	Time Standard	Distance Standard	Standard (% of Members With Access)
Urban	A geographic area that is less than 10 map miles from a population center of 30,000 people or more.	30 Minutes	30 Miles	95%
Rural	A geographic area that is 10 or more map miles from a population center of 30,000 people or less.	60 Minutes	60 Miles	95%

Except where standards exist, the assessment of provider capacity and geographic distribution was used to observe key patterns associated with the structure of CCO provider networks.

DSN Provider Capacity Report Findings

The *DSN Provider Capacity Report* is an inventory of individual practitioners (i.e., physicians, mid-level practitioners, or other practitioners) and facility/service providers, whether employed by or under subcontract with a CCO, who agree to provide health care services to Medicaid CCO members. The CCOs were required to follow a reporting instruction data file template and report all required and optional demographic (e.g., name, address, identification [ID], specialty) and practice-related (e.g., hours of operation, contract status) data elements.

The collection and reporting of the *DSN Provider Capacity Reports* was managed by OHA. OHA processed, cleaned, and evaluated the data provided by the CCOs to monitor the CCOs' DSNs and compliance with data quality and network adequacy standards. In general, OHA *DSN Provider Capacity Reports* included results highlighting three domains:

- **Quality of DSN Provider Capacity Reporting**—The CCO's ability to provide complete and accurate provider network data in the required format.
- **Provider Network Capacity**—The underlying infrastructure of each CCO's DSN, including whether health services are available to members through a sufficient supply and variety of providers.
- **Provider Accessibility**—The degree to which contracted services are accessible to each CCO's member population.

Using OHA's quarterly *DSN Provider Capacity Reports*, HSAG assessed and summarized CCO performance across these three domains.

Quality of Provider Network Data

The ability of the CCOs to collect, integrate, and report high quality provider data is critical to the ongoing monitoring and assessment of network adequacy. The completeness, accuracy, and timeliness of CCO provider data is also important in determining the accuracy of the CCOs' provider directories. Drawing upon the quarterly DSN Provider Capacity data submitted by the CCOs, OHA evaluated the quality of incoming provider data files based on the percentage of data elements that demonstrated whether:

- Data values were present for required data elements, and
- If present, the data were in a valid format, and
- If in a valid format, the data contained valid values.

HSAG aggregated and summarized OHA's findings on the quality of CCO data based on a review of key data elements using the criteria above. These results were used to assess the overall quality of the CCOs' provider data and derive a level of confidence in the data to support network adequacy monitoring. To better understand the impact of data quality, results were grouped and categorized based on importance in production of the CCOs' provider directories and general monitoring activities. The key provider data elements included in this meta-analysis are presented in Table 3-12.

Table 3-12—Data Elements Assessed for Data Quality by Tier

Data Elements	
Provider Directory Focused	**Network Adequacy Focused**

• Provider Name (First and Last)
• Business Name
• Provider Address (i.e., Address, City, State, ZIP Code)
• Provider Phone Number
• Provider Taxonomy Code
• Accepting New Patients Indicator
• PCP Indicator
	• Provider Name (First and Last)
	• Business Name
	• NPI
	• Division of Medical Assistance Programs (DMAP) ID
	• Provider Address (Address, City, State, ZIP Code)
	• Provider Phone Number
	• Provider Taxonomy Code
	• Service Area Indicator
	• Participation Status
	• Accepting New Patients Indicator
	• PCP Indicator
	  – Member Capacity
	  – Members Assigned

HSAG used the ratings of *High Confidence*, *Moderate Confidence*, and *Low Confidence*, as defined in Table 3-13, to indicate the level of confidence in the quality of data for each CCO.

Table 3-13—Data Quality Confidence Ratings

Confidence Rating	Description
High Confidence	• **Definition:** The CCO's provider data are complete and accurate; they are sufficient to support the monitoring of network adequacy. • **Criteria:** All CCO data quality scores (i.e., Percent Present, Percent Valid Format, and Percent Valid Value) are **greater than or equal to 90 percent**.
Moderate Confidence	• **Definition:** Some of the CCO's provider data are not complete or contain inaccurate data values; overall data quality may impact the CCO's ability to accurately monitor the adequacy of its provider network. • **Criteria:** The CCO data quality scores (i.e., Percent Present, Percent Valid Format, and Percent Valid Value) include: – One or more scores **less than 90 percent**, and – All scores **greater than or equal to 75 percent**.
Low Confidence	• **Definition:** Most of the CCO's provider data are not complete and contain inaccurate data values; overall data quality will impact the CCO's ability to accurately monitor the adequacy of its provider network. • **Criteria:** The CCO data quality scores (i.e., Percent Present, Percent Valid Format, and Percent Valid Value) include one or more scores **less than 75 percent**.

Provider Network Capacity

Provider counts, stratified by provider type, describe the underlying infrastructure of each CCO's DSN, including whether health services are available to members through a sufficient supply and variety of providers. In alignment with prior evaluations, HSAG used OHA's *DSN Provider Capacity Reports* to identify the extent to which CCO provider data were missing core individual and facility-based providers (i.e., provider count by type is zero) to identify whether systemic gaps exist in CCO networks.

Additionally, beginning in 2023, OHA implemented new network performance metrics into its reports. These analyses included the following:

- Percentage of Providers With Active Status

Following its review of the CCOs' quarter (Q) 1 2023 *DSN Provider Capacity Reports*, HSAG collaborated with OHA to summarize and report these results in the 2023 DSN Evaluation. The data presented in this analysis were used to observe and report key patterns associated with the structure of CCO provider networks.

Provider Accessibility

Provider accessibility describes the degree to which contracted providers and services are accessible to CCO member populations. In alignment with prior evaluations, HSAG used OHA's *DSN Provider Capacity Reports* to summarize CCO performance via two measures:

- The Percentage of PCPs Accepting New Members
- The Number of Providers Speaking a Non-English Language

The percentage of providers that accept new members serves as a key measure of members' accessibility to critical primary care and specialty health care services. For the 2023 DSN Evaluation, HSAG synthesized OHA's findings across key health care provider groups, including primary care services (physical and oral), MH and SUD providers, OB/GYN providers, and specialists. The reported categories were unweighted percentages calculated based on the number of individual practitioners within each category. The analysis also indicated, where possible, whether the change from 2022 to 2023 resulted in a substantial increase (i.e., ↑, or 10 percentage points) or decrease (i.e., ↓, or 10 percentage points) in the number of PCPs accepting new patients.

The second measure of accessibility reflects the number of providers who speak a non-English language. Although a proxy measure for language access, this metric is useful in understanding the ability of the CCOs' provider networks to render linguistically accessible and culturally responsive services. The CCOs are required to provide qualified health care interpreter (QHCI) services and typically accomplish this via an interpretation services vendor.

Beginning in 2023, OHA implemented several new accessibility performance metrics for PCPs, including the following:

- Percentage of PCPs With Capacity
- Percentage of Providers Within the Service Area

Pending its review of the CCOs' Q1 2023 *DSN Provider Capacity Reports*, HSAG collaborated with OHA to summarize and report these results in the 2023 DSN Evaluation. The data presented in this analysis were used to observe and report key patterns associated with the structure of CCO provider networks.

How Conclusions Were Drawn

HSAG used the quality metrics to draw conclusions about data quality and the completeness of the DSN Provider Capacity Reporting data submissions. The DSN Provider Narrative responses were used to draw conclusions regarding the completeness, sufficiency, and accessibility of the provider networks. The Time and Distance Analysis was used to draw conclusions regarding the CCOs' compliance with the State's time and distance access standards.

To draw conclusions about the quality, timeliness, and accessibility of health care services provided by the CCOs, HSAG assigned each of the components reviewed for the DSN activities to one or more of three domains of care. This assignment to domains of care is depicted in Table 3-14.

Table 3-14—Assignment of the DSN Evaluation Activity to the Quality, Timeliness, and Access Domains

NAV Activity	Quality	Timeliness	Access
DSN Evaluation	✓	✓	✓

Specific findings may be associated with one or more of the quality, timeliness, and access domains.

Secret Shopper Survey

Background

Federal and State regulations require each CCO to maintain a network of appropriate health care providers to ensure adequate access to all services covered under the Medicaid contract. OHA contracted with HSAG to evaluate whether the CCOs' network providers are meeting state-established appointment availability standards.

During CY 2023, HSAG conducted a secret shopper telephone survey of PCP and PCD locations contracted with one or more CCOs. A secret shopper is a person employed to pose as a client or patient to evaluate the availability of services or the validity of information (e.g., accurate location information). The secret shopper telephone survey allows for objective data collection from health care providers without potential bias introduced by knowing the identity of the surveyor. The primary purpose of the secret shopper survey was to collect appointment availability for new OHP members for routine primary care or dental services.

Objectives

The primary objectives of the secret shopper survey activities were to:

- Determine accuracy of PCP and PCD location information (i.e., phone number and service address).
- Determine whether PCP and PCD locations offered the requested services.
- Determine whether PCP and PCD locations accepted the CCO.
- Determine whether the service locations accepted OHP.
- Determine whether the PCP and PCD locations accepted new patients.
- Determine appointment availability for primary care visits and routine dental at PCP and PCD locations, respectively.

Technical Methods of Data Collection

To evaluate appointment availability, HSAG conducted a secret shopper telephone survey of providers' offices and facilities that offer primary care or dental services.

Study Population

HSAG used the CCOs' *DSN Provider Capacity Report* data (Q1 2023) submitted to OHA by the CCOs, to identify a sample of PCP and PCD locations to be surveyed. The *DSN Provider Capacity Report* data reflected each CCO's active and contracted providers and any contracted providers pending Medicaid enrollment and/or credentialing as of March 31, 2023. The data included the following fields for use in the secret shopper study:

- Demographics (e.g., provider's NPI, Division of Medical Assistance Programs ID (DMAP ID), name, address, county, and phone number)
- Provider taxonomy
- Service area indicator
- Provider participation status
- Provider new patient acceptance status

Upon receipt of the aggregated network provider data from OHA, HSAG reviewed key data fields to assess potential duplication and completeness. Key data fields included, but were not limited to, service telephone number, service street address, provider name, provider NPI, DMAP ID, service area indicator, PCP indicator, and new patient acceptance indicator.

Following HSAG's review of the *DSN Provider Capacity Report* data, HSAG collaborated with OHA to determine whether geographic restrictions were required. HSAG then used the criteria noted in Table 3-15 or an indicator (i.e., PCP_Ind = "Y") to identify PCPs and PCDs for CCOs.[3-6]

Table 3-15—PCP and PCD Identification Criteria for CCOs

Display Name	Taxonomy Code
Primary Care Providers	
FAMILY MEDICINE PHYSICIAN	207Q00000X
ADOLESCENT MEDICINE (FAMILY MEDICINE) PHYSICIAN	207QA0000X
ADULT MEDICINE PHYSICIAN	207QA0505X
GERIATRIC MEDICINE (FAMILY MEDICINE) PHYSICIAN	207QG0300X
GENERAL PRACTICE PHYSICIAN	208D00000X

[3-6] Primary Care Clinics and Centers were excluded from the sample frame since the secret shopper survey was conducted by service location, not by individual practitioner. Instead, facilities and clinics offering primary care were included based on the identification of individual PCP and PCD practitioners affiliated with unique locations.

Display Name	Taxonomy Code
INTERNAL MEDICINE PHYSICIAN	207R00000X
GERIATRIC MEDICINE (INTERNAL MEDICINE) PHYSICIAN	207RG0300X
PEDIATRICS PHYSICIAN	208000000X
PEDIATRIC ADOLESCENT MEDICINE PHYSICIAN	2080A0000X
PRIMARY CARE NURSE PRACTITIONER	363LP2300X
ADOLESCENT MEDICINE (INTERNAL MEDICINE) PHYSICIAN	207RA0000X
PHYSICIAN ASSISTANT	363A00000X
Primary Care Dental Providers	
DENTIST	122300000X
PUBLIC HEALTH DENTIST	1223D0001X
DENTAL HYGIENIST	124Q00000X
GENERAL PRACTICE DENTISTRY	1223G0001X
PEDIATRIC DENTIST	1223P0221X

Sampling Strategy

The following random sampling approach was used to generate a list of PCP and PCD service locations (i.e., "cases") from each CCO for inclusion in the survey:

- **Step 1:** HSAG assembled the sample frame using records from all PCP and PCD service locations identified by each CCO. HSAG aggregated individual practitioner records into location-based cases.
  - To minimize duplicated provider records within each CCO, HSAG standardized the providers' address data to align with the United States Postal Service Coding Accuracy Support System (CASS). Address standardization did not affect the survey population; provider records requiring address standardization remained in the eligible population. The original provider address data values were retained for locations where potential CASS address changes may have impacted data validity (e.g., the address was standardized to a different city or county).
  - Service locations that did not accept new patients were excluded from the sample frame. New patient acceptance was identified from an indicator (i.e., Accept_Ind = "Y" or missing) in the CCOs' *DSN Provider Capacity Reports*.
  - Service locations that did not accept patients for routine primary care or dental services (e.g., hospitalists that only see patients at a hospital) were excluded from the sample frame. Out-of-service locations identified as bordering Oregon in California, Idaho, Washington, and Nevada were included in the sample frame.
- **Step 2:** HSAG used the sample frame to determine the number of unique provider locations. In order to minimize the number of repeat phone calls to providers, HSAG identified locations based on unique phone numbers. If a phone number was associated with multiple addresses across CCOs,

HSAG randomly assigned the number to a single CCO and standardized address, prioritizing assignment to the least represented CCOs.

- **Step 3**: Using the list of sampled CCO provider locations generated in Step 2, HSAG divided each CCO's sample into two groups (i.e., PCP and PCD) and randomly assigned each sampled provider location to an appointment scenario for either an annual checkup or a routine dental visit

Description of Data Obtained

Data obtained from OHA included:

- CCO *DSN Provider Capacity Report* data.
- Responses to survey questions collected during secret shopper survey calls.

How Data Were Aggregated and Analyzed

Telephone Survey Process

Trained interviewers collected survey responses using a standardized script approved by OHA. Callers were instructed to conduct the survey as though they are moving to the area and trying to arrange an appointment for themselves or a family member. Survey callers requested appointment availability for only the sampled location. Due to the secret shopper nature of the calls, callers improvised during actual calls as needed. Callers were instructed not to leave voicemail messages or schedule appointments.

HSAG interviewers made two attempts to contact each survey case during standard business hours (i.e., 9 a.m. to 5 p.m. Pacific Daylight Time [PDT]).[3-7] If put on hold at any point during the call, the caller waited on hold for five minutes before ending the call. If a call attempt was answered by an answering service or voicemail during normal business hours, the caller made a second call attempt on a different day and at a different time of day. A survey case was considered nonresponsive if any of the following criteria were met:

- Disconnected/invalid telephone number (e.g., the telephone number in the CCO's data file connected to a fax line or a message that the number was no longer in service).
- Telephone number connected to an individual or business unrelated to a medical practice or facility.
- The caller was unable to speak with office personnel during either call attempt (e.g., the call went to voicemail or answering service that prevented the interviewer from speaking with office staff members).

Interviewers received project-specific training with a dedicated HSAG analytics manager to standardize caller outreach, and data were captured in a web-based data collection tool. To aid in abstraction, the

[3-7] HSAG did not consider a call attempted when the interviewer reached an office outside of the office's usual business hours. For example, if the interviewer called and reached a recording that stated the office was closed for lunch, the call attempt did not count toward the two attempts to reach the office. The interviewer attempted to contact the office up to two times outside of the known lunch hour.

data collection tool controlled skip logic between survey elements. HSAG conducted oversight of the calls to verify callers used the web-based tool and script as intended and that survey data were accurately documented in the web-based tool.

Data inconsistencies identified in the data collection tool resulted in follow-up with the original caller by the HSAG analytics manager. If necessary, callers contacted the service location to resolve any potential data issues. When situations occurred where the issue could not be resolved through internal discussion or follow-up, HSAG contacted OHA for guidance (e.g., systematically incorrect telephone numbers for a CCO or group of practices).

Survey Indicators

HSAG classified survey indicators into two domains: provider data accuracy and appointment availability. Provider data accuracy was evaluated based on whether demographic information from the provider capacity data matched survey responses. For data collected on the first available appointment, the average wait time was calculated based on the date of the completed secret shopper call and earliest appointment date.

HSAG collected the following information pertaining to provider data accuracy:

- Telephone number
- Address
- Provider location's services
- Affiliation with OHP
- Affiliation with the requested CCO

HSAG collected the following access-related information when calling sampled cases:

- Information concerning whether the provider location was accepting new patients
- Next available appointment date with any practitioner at the sampled location for a new patient with a non-urgent or routine visit (i.e., dental cleaning or annual checkup)
- Any limitations to accepting new patients or scheduling an appointment. Limitations included, but were not limited to, the following:
  - Location required a review of the member's medical records prior to offering an appointment
  - Location required registration with the practice prior to offering an appointment
  - Location required verification of the member's Medicaid eligibility prior to offering an appointment

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of health care services provided by the CCOs, HSAG assigned the secret shopper survey activity to one or more of three domains of care. This assignment to domains of care is depicted in Table 3-16.

Table 3-16—Assignment of the Secret Shopper Survey Activity to the Quality, Timeliness, and Access Domains

NAV Activity	Quality	Timeliness	Access
Secret Shopper Survey	✓	✓	✓

Specific findings may be associated with one or more of the quality, timeliness, and access domains.

Revealed Telephone Survey

Background

Federal and State regulations require each CCO to maintain a network of appropriate health care providers to ensure adequate access to all services covered under the Medicaid contract. OHA contracted with HSAG to evaluate whether the CCOs' network providers are meeting state-established appointment availability standards.

During CY 2023, HSAG conducted a revealed telephone survey of outpatient BH locations contracted with one or more CCO. The primary purpose of the survey was to collect appointment availability for OHP members for outpatient BH services.

Objectives

The primary objectives of the revealed telephone survey activities were to:

- Determine accuracy of outpatient BH service location information (i.e., phone number and service address).
- Determine whether outpatient BH service locations offered the requested services.
- Determine whether outpatient BH service locations accepted the CCO.
- Determine whether outpatient BH service locations accepted OHP.
- Determine whether outpatient BH service locations accepted new patients.
- Determine appointment availability for outpatient BH services for new and existing patients, and for routine and urgent visits.
- Determine whether outpatient BH locations offered translation or interpreter services.

Technical Methods of Data Collection

To evaluate appointment availability, HSAG conducted a revealed telephone survey of providers' offices and facilities that offer outpatient BH services.

Study Population

HSAG used the CCOs' *DSN Provider Capacity Report* data (Q1 2023) submitted to OHA by the CCOs, to develop the stratified, random sample of outpatient BH locations to be surveyed. The *DSN Provider Capacity Report* data reflected each CCO's active and contracted providers and any contracted providers pending Medicaid enrollment and/or credentialing as of March 31, 2023. The data are included the following fields for use in the revealed shopper study:

- Demographics (e.g., provider's NPI, DMAP ID, name, address, county, and phone number)
- Provider taxonomy
- Service area indicator
- Provider participation status
- Provider new patient acceptance status

Upon receipt of the aggregated network provider data from OHA, HSAG reviewed key data fields to assess potential duplication and completeness. Key data fields included, but were not limited to, service telephone number, service street address, provider name, provider NPI, DMAP ID, service area indicator, BH indicator, and new patient acceptance indicator.

Following HSAG's review of the *DSN Provider Capacity Report* data, HSAG collaborated with OHA to determine whether geographic restrictions were required. HSAG then used the criteria noted in Table 3-17 to identify outpatient BH providers for CCOs.

Table 3-17—Outpatient BH Provider Identification Criteria for CCOs

Display Name	Taxonomy Code
COUNSELOR	101Y00000X
MENTAL HEALTH COUNSELOR	101YM0800X
PROFESSIONAL COUNSELOR	101YP2500X
MARRIAGE AND FAMILY THERAPIST	106H00000X
PSYCHOANALYST	102L00000X
CLINICAL SOCIAL WORKER	1041C0700X
ADOLESCENT AND CHILDREN MENTAL HEALTH CLINIC/CENTER	261QM0855X
ADULT MENTAL HEALTH CLINIC/CENTER	261QM0850X
MENTAL HEALTH CLINIC/CENTER (INCLUDING COMMUNITY MENTAL HEALTH CENTER)	261QM0801X

Sampling Strategy

The following random sampling approach was used to generate a list of outpatient BH service locations (i.e., "cases") from each CCO for inclusion in the survey:

- **Step 1:** HSAG assembled the sample frame using records from all outpatient BH service locations identified by each CCO. HSAG aggregated individual practitioner records into location-based cases.
  - To minimize duplicated provider records within each CCO, HSAG standardized the providers' address data to align with the United States Postal Service CASS. Address standardization did not affect the survey population; provider records requiring address standardization remained in the eligible population. The original provider address data values were retained for locations where potential CASS address changes may have impacted data validity (e.g., the address was standardized to a different city or county).
  - Service locations that did not accept new patients were excluded from the sample frame. New patient acceptance was identified from an indicator (i.e., Accept_Ind = "Y") in the CCOs' *DSN Provider Capacity Reports*. Out-of-service locations identified as bordering Oregon in California, Idaho, Washington, and Nevada were included in the sample frame.
  - Service locations that did not accept patients for outpatient BH services (e.g., hospitalists that only see patients at a hospital) were excluded from the sample frame.
- **Step 2:** HSAG used the sample frame to determine the number of unique provider locations. In order to minimize the number of repeat phone calls to providers, HSAG identified locations based on unique phone numbers. If a phone number was associated with multiple addresses across CCOs, HSAG randomly assigned the number to a single CCO and standardized address, prioritizing assignment to the least represented CCOs.

Description of Data Obtained

Data obtained from OHA included:

- CCO *DSN Provider Capacity Report* data.
- Responses to survey questions collected during revealed telephone survey calls.

How Data Were Aggregated and Analyzed

Telephone Survey Process

Trained interviewers collected survey responses using a standardized script approved by OHA and interviewers were instructed not to schedule actual appointments. Interviewers contacted each telephone number ("case"), abstracting data into a web-based data collection tool.[3-8]

[3-8] To minimize the burden on the providers' office staff, the survey script in the data collection tool allowed interviewers to efficiently obtain responses across CCOs for providers contracted with one or more CCO.

HSAG interviewers made two attempts to contact each survey case during standard business hours (i.e., 9 a.m. to 5 p.m. PDT).[3-9] If put on hold at any point during the call, the caller waited on hold for five minutes before ending the call. If a call attempt was answered by an answering service or voicemail during normal business hours, the caller made a second call attempt on a different day and at a different time of day. A survey case was considered nonresponsive if any of the following criteria were met:

- Disconnected/invalid telephone number (e.g., the telephone number in the CCO's data file connected to a fax line or a message that the number was no longer in service).
- Telephone number connected to an individual or business unrelated to a medical practice or facility.
- The caller was unable to speak with office personnel during either call attempt (e.g., the call went to voicemail or answering service that prevented the interviewer from speaking with office staff members).

Interviewers received project-specific training with a dedicated HSAG analytics manager to standardize caller outreach, and data were captured in a web-based data collection tool. To aid in abstraction, the data collection tool controlled skip logic between survey elements. HSAG conducted oversight of the calls to verify callers were using the web-based tool and script as intended and that survey data were accurately documented in the web-based tool.

Data inconsistencies identified in the data collection tool resulted in follow-up with the original caller by the HSAG analytics manager. If necessary, callers contacted the service location to resolve any potential data issues. When situations occurred where the issue could not be resolved through internal discussion or follow-up, HSAG contacted OHA for guidance (e.g., systematically incorrect telephone numbers for a CCO or group of practices).

Survey Indicators

HSAG classified survey indicators into two domains: provider data accuracy and appointment availability. Provider data accuracy was evaluated based on whether demographic information from the provider capacity data matched survey responses. For data collected on the first available appointment, the average wait time was calculated based on the date of the completed revealed shopper call and earliest appointment date.

HSAG collected the following information pertaining to provider data accuracy:

- Telephone number
- Address
- Provider location's services

[3-9] HSAG did not consider a call attempted when the interviewer reached an office outside of the office's usual business hours. For example, if the interviewer called and reached a recording that stated the office was closed for lunch, the call attempt did not count toward the two attempts to reach the office. The interviewer attempted to contact the office up to two times outside of the known lunch hour.

- Affiliation with OHP
- Affiliation with the requested CCO

HSAG collected the following access-related information when calling sampled cases:

- Information concerning whether the provider location was accepting new patients
- Next available appointment date with any practitioner at the sampled location for a new patient with a non-urgent or routine visit
- Information concerning whether the provider location offered translation or interpreter services
- Any limitations to accepting new patients or scheduling an appointment. Limitations included, but were not limited to, the following:
  - Location required a review of the member's medical records prior to offering an appointment
  - Location required registration with the practice prior to offering an appointment
  - Location required verification of the member's Medicaid eligibility prior to offering an appointment

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of health care services provided by the CCOs, HSAG assigned the revealed telephone survey activity to one or more of three domains of care. This assignment to domains of care is depicted in Table 3-18.

Table 3-18—Assignment of the Revealed Telephone Survey Activity to the Quality, Timeliness, and Access Domains

NAV Activity	Quality	Timeliness	Access
Revealed Telephone Survey	✓	✓	✓

Specific findings may be associated with one or more of the quality, timeliness, and access domains.

Encounter Data Validation

Background

Federal regulations under 42 CFR §438.242 require OHA to ensure that each of its CCOs maintain a health information system that collects, analyzes, integrates, and reports data on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment. OHA must also review and validate encounter data collected, maintained, and submitted by the CCOs to ensure these data are a complete and accurate representation of the services provided to its Medicaid members. Accurate and complete encounter data are critical to the success of a managed care program; submission of high-quality encounter data can accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information.

During CY 2023, OHA contracted with HSAG to conduct an EDV study. HSAG's approach to conducting EDV studies is tailored to address the specific needs of its clients by customizing elements outlined in and in alignment with CMS' EQR *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, February 2023 (EQR Protocol 5).[3-10]

For CY 2023, the EDV study focused on the CCOs' delegated subcontractors responsible for the administration, payment, and processing of dental claims. HSAG conducted the following activities for the EDV study:

- Targeted assessment of encounter data information systems and processes—administered a targeted questionnaire to gather information on the CCOs' and their subcontractors' information systems to assess their ability to promote and maintain quality encounter data. This activity corresponds to *Activity 2: Review the MCO's Capability* in CMS' EQR Protocol 5.
- Comparative analysis—conducted an analysis of OHA's dental encounter data completeness and accuracy by comparing OHA's electronic dental encounter data and the data extracted from the CCOs' subcontractors' data systems. This activity corresponds to *Activity 3: Analyze Electronic Encounter Data* in CMS' EQR Protocol 5.

[3-10] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 22, 2024.

Objectives

The primary objectives of the EDV task were:

- Assess the subcontractors' capacity to ensure high-quality dental encounter data for submission to OHA.
- Evaluate the extent to which dental encounters submitted to OHA by the CCOs, directly or indirectly, via their subcontractors are complete and accurate, based on corresponding information stored in the CCOs' subcontractors' claims data systems.

Technical Methods of Data Collection

Targeted Assessment of Encounter Data Information Systems and Processes

HSAG understands that the CCOs contracted with dental subcontractors to collect, process, and submit dental encounter data to OHA. As such, HSAG gathered information on the CCOs' and their subcontractors' information systems to assess their ability to promote and maintain high-quality dental encounter data. To ensure the collection of critical information, HSAG developed a customized questionnaire to gather information regarding each organization's information systems and data processing procedures. After receiving the completed questionnaires from the CCOs and their vendors, HSAG conducted further follow-up via emails or meetings, as necessary, to clarify any questions from the questionnaire responses.

Comparative Analysis

The goal of the comparative analysis was to evaluate the extent to which dental encounters submitted to OHA by the CCOs, directly or indirectly, via their subcontractors were complete and accurate, based on corresponding information stored in the CCOs' subcontractors' claims data systems. The dental encounter data were considered complete if the data reflected all services rendered to members, and all data within the CCOs' subcontractors' data systems had been submitted and successfully imported into OHA's data system. For dental encounter data to be considered accurate, the data that the CCOs and their subcontractors maintained must represent the actual services rendered; when they were rendered (i.e., the date of service); to whom they were rendered (i.e., the member); by whom they were rendered (i.e., the provider); and, if a payment was rendered in connection to the service, how much was paid.

HSAG developed data submission requirements documents to request dental encounter/claims data from both OHA and the CCOs' subcontractors. These documents included a brief description of the EDV study, a description of the review period, specifications of the dental claims/encounter data, required data fields, and procedures for submitting the requested data files to HSAG. OHA and the CCOs' dental subcontractors were requested to submit dental claims and encounters with dates of service from **January 1, 2022**, through **December 31, 2022**, and only to include dental claims and encounters that were in a final, fully adjudicated status as of May 31, 2023.

HSAG conducted a technical assistance webinar with the CCOs to facilitate the accurate and timely submission of requested data. Of note, the CCOs were responsible for coordinating with their subcontractors to extract the requested data. The technical assistance webinar occurred approximately one week after distributing the data requirements documents, allowing the CCOs time to review and prepare their questions in advance of the meeting. During the technical assistance webinar, HSAG's EDV team introduced the EDV study, reviewed the data submission requirements documents, and addressed questions related to data preparation and extraction. The CCOs and their subcontractors were given 90 days to extract and prepare the requested files for submission to HSAG.

Following receipt of OHA's and the CCOs' subcontractors' data submissions, HSAG conducted a preliminary file review to determine if any data issues existed in the data files that would warrant a resubmission. The preliminary file review included the following basic data quality checks:

- Data extraction—Extracted based on the data requirements document.
- Percentage present—Required data fields are present on the file and have values in those fields.
- Percentage of valid values—The values are the expected values (e.g., valid Current Dental Terminology [CDT] codes in the procedure code field).
- Evaluation of matching claim numbers—The percentage of claim numbers matching between the data submitted by OHA and the data submitted by the CCOs' subcontractors to HSAG.

Based on the results from the preliminary file review, HSAG generated CCO-specific reports that highlighted major findings requiring OHA or the CCOs' subcontractors to resubmit data.

Description of Data Obtained

Targeted Assessment of Encounter Data Information Systems and Processes

Representatives from each CCO completed the OHA-approved questionnaire and submitted their responses along with relevant supporting documentation to HSAG for assessment.

Comparative Analysis

HSAG obtained dental encounter claims and encounters from both OHA and the CCOs' dental subcontractors. These claims and encounters covered the date of service period from January 1, 2022, to December 31, 2022, and encompassed dental claims and encounters that had reached a final adjudicated status by May 31, 2023.

How Data Were Aggregated and Analyzed

Targeted Assessment of Encounter Data Information Systems and Processes

HSAG compiled findings from the review of the received questionnaire responses, identifying critical points that affected the submission of quality encounter data.

Comparative Analysis

Once HSAG received and processed the final set of data, HSAG conducted a series of analyses, which were divided into two analytic sections. First, HSAG assessed record-level data completeness using the following metrics for the dental encounter data:

- The number and percentage of records present in the files submitted by the CCOs' subcontractors but not found in the files submitted by OHA (**record omission**).
- The number and percentage of records present in the files submitted by OHA but not found in the files submitted by the CCOs' subcontractors (**record surplus**).

Second, based on the number of records present in both data sources, HSAG further examined completeness and accuracy for the key data elements listed in Table 3-19. The analyses focused on an element-level comparison for each data element.

Table 3-19—Key Data Elements for Comparative Analysis

Key Data Elements
Member ID
Detail Service From Date
Detail Service To Date
Header Service From Date
Header Service To Date
Billing Provider NPI
Rendering Provider NPI
CDT Code
Tooth Number
Oral Cavity Code
Tooth Surface (1 through 5)
Header Paid Amount
Detail Paid Amount

For the matching records identified during the first step, HSAG evaluated element-level completeness based on the following metrics:

- The number and percentage of records with values present in the files submitted by the CCOs' subcontractors but not present in the files submitted by OHA (**element omission**).

- The number and percentage of records with values present in the files submitted by OHA but not present in the files submitted by the CCOs' subcontractors (**element surplus**).
- The number and percentage of records with values missing from both files submitted by OHA and files submitted by the CCOs' subcontractors (**element missing values**).

Element-level accuracy was limited to those records with values present in both the files submitted by OHA and the files submitted by the CCOs' subcontractors. For each key data element, HSAG determined the number and percentage of records with the same values in both the files submitted by OHA and the files submitted by the CCOs' subcontractors (**element accuracy**).

Finally, for the records present in both the files submitted by OHA and the files submitted by the CCOs' subcontractors, HSAG evaluated the number and percentage of records with the same values for all key data elements relevant to dental encounter data type (**all-element accuracy**).

Technical Assistance

As a follow-up to the comparative analysis activity, HSAG provided technical assistance to OHA and the CCOs regarding the issues identified during the comparative analysis. First, HSAG drafted CCO-specific dental encounter data discrepancy reports highlighting key areas for investigation. Second, HSAG distributed the discrepancy reports to the CCOs, along with data samples to assist the CCOs and their subcontractors with their internal investigations. Based on the internal investigation by the CCOs and their subcontractors, the CCOs coordinated with their subcontractors to identify the potential root causes of the key issues and provided written responses to the data discrepancy reports. Lastly, once HSAG reviewed the written responses, it followed up with the CCOs for any further clarification, when appropriate.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of health care services provided by the CCOs, HSAG assigned each of the components reviewed for the EDV activities to one or more of three domains of care. This assignment to domains of care is depicted in Table 3-20.

Table 3-20—Assignment of EDV Activities to the Quality, Timeliness, and Access Domains

EDV Activities	Quality	Timeliness	Access
Targeted Information Systems Review	✓		
Comparative Analysis: Record Omission and Surplus	✓		
Comparative Analysis: Data Element Omission, Surplus, Missing Values, and Accuracy	✓		

Mental Health Parity

Background

MHP regulations are intended to ensure that coverage and access to services for the treatment of MH and SUD conditions are provided in parity with treatments provided for M/S conditions. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) governs how MH/SUD treatments delivered by MCOs and limitations on MH/SUD benefits must be comparable to and applied no more stringently than the limitations applied to M/S benefits. Provisions of the MHPAEA became applicable to OHP in October 2017 when the Medicaid Parity Final Rule (42 CFR §438 Subpart K) went into effect. The rule requires parity in the following key areas:

- Aggregate lifetime and annual dollar limits (AL/ADLs).
- Financial requirements (FRs—such as copays).
- Quantitative treatment limitations (QTLs—such as day and visit limits).
- Non-quantitative treatment limitations (NQTLs—such as prior authorization [PA] and provider network admission requirements).

Additional MHP regulations require that criteria for medical necessity determinations for MH/SUD benefits must be made available to beneficiaries and providers upon request, as well as the reason for denial of reimbursement or payment for MH/SUD benefits. States must also implement monitoring procedures to ensure continued compliance and to identify when changes in benefit design or operations could affect compliance and require an updated analysis. Finally, Oregon House Bill 3046 (HB 3046), enrolled in 2021 and effective in 2022, outlined additional MHP reporting requirements for CCOs and OHP FFS, culminating in the presentation of a comprehensive report to the Oregon Legislature annually.

To comply with federal and State requirements, OHA contracted with its EQRO, HSAG, to conduct an evaluation of parity for MH/SUD benefits as relative to M/S benefits provided under OHP managed care benefit packages in accordance with requirements in 42 CFR §438, Subpart K and Oregon HB 3046.

The 2023 analysis included a review of each CCO's and OHP FFS' treatment limitations used by the organization to manage MH/SUD and M/S benefits to ensure compliance with MHP requirements, a review of claims and UM data to identify key patterns and outcomes associated with the administration of covered benefits, a file review targeting service authorization denials and appeals to ensure accurate implementation of policies and procedures, and an evaluation of the adequacy of the provider network and timeliness of access to MH/SUD treatment and services. For the purposes of this annual EQR technical report, only the CCO-specific methodology and results are presented.

Objectives

The primary objectives of the MHP activity were:

- Conduct a review of the CCOs' treatment limitations on MH/SUD benefits to ensure they are comparable to and applied no more stringently than limitations applied to M/S benefits.
- Evaluate claims, UM data, and provider enrollment data to assess the impact of MH/SUD and M/S operations on claims and utilization decisions.
- Conduct a review of a sample of CCO service authorization denials and appeals encompassing both MH/SUD and M/S denials to ensure accurate implementation of policies and procedures.
- Complete an evaluation of the adequacy of the provider network and timeliness of access to MH/SUD treatment and services.
- Identify each CCO's performance strengths, opportunities for improvement, and areas requiring corrective action.
- Gather information and perspective regarding findings from the documentation review, data analysis, and compliance determinations during meetings with community partners (CPs).
- Identify potential areas of interest from CPs to inform the scope of the 2024 MHP activity.
- Prepare a comprehensive report inclusive of all 2023 MHP activity findings and input from CPs for OHA to submit to the Oregon Legislative Assembly as required by HB 3046.

The 2023 MHP Analysis identified and assessed the policies and standards, applied during CY 2022, governing limitations applied to MH/SUD services compared to M/S services. Differences in how limits were applied to MH/SUD services as compared to M/S services were evaluated for continued compliance with MHP regulations to ensure evidence-based, quality MH/SUD care.

Technical Methods of Data Collection

The 2023 MHP activities are described below.

1. **Protocol Development and Dissemination:** HSAG developed the 2023 MHP Analysis Protocol, which presented details and guidance to OHA and the CCOs on the process for conducting the 2023 MHP activity. The tools utilized for the analysis, identified below, were included with the protocol and were based on guidance outlined in the CMS' *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*.[3-11]

[3-11] Centers for Medicare & Medicaid Services. *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*, January 17, 2017. Available at: https://www.medicaid.gov/sites/default/files/2019-12/parity-toolkit.pdf. Accessed on: Feb 22, 2024.

- **MHP Treatment Limitation Review Tool**—A standardized questionnaire used by the CCOs to submit documentation demonstrating compliance with MHP treatment limitations; collects information on the policies, procedures, and/or practices that impact MH/SUD and M/S parity.

2. **MHP Data Submission Template**—A Microsoft Excel-based template used by the CCOs to report data on inpatient (IP), outpatient (OP), and pharmacy (Rx) claims and UM data; MH/SUD and M/S provider credentialing data; and member-level detail files.
3. **MHP Technical Assistance Webinar:** HSAG conducted a webinar to provide an overview of MHP regulations; details of the 2023 MHP Analysis Protocol and tools; an overview of the MHP Analysis timeline; a review of required documentation and submission guidelines, analysis, and reporting processes; and an opportunity for questions and answers. HSAG and OHA produced a Questions & Answers document to provide clarification to the CCOs on any questions received during and after the webinar.
4. **Documentation Submission:** The CCOs were required to submit the *MHP Treatment Limitation Review Tool* and all applicable supporting documentation, as well as submit claims, UM, and credentialing data through the *MHP Data Submission Template*.
5. **Desk Review and Analysis:** HSAG conducted a desk review of each CCO's submitted documentation and data to evaluate parity between MH/SUD and M/S services and benefits. HSAG performed an analysis of the claims, UM, and credentialing data to assess the impact of MH/SUD and M/S operations on claims and utilization decisions. Reported rates were validated against member level detail files and used to develop an administrative profile of each CCO. HSAG completed a file review of MH/SUD and M/S service authorization denials and appeals to further understand UM decision details and their impact on parity. HSAG also performed an assessment of the CCOs' MH/SUD provider networks to assess the adequacy, availability, and timeliness of access to MH/SUD services. The evaluation incorporated a multi-dimensional approach using a series of measures to support MHP reporting.
   - **Follow-up Inquiries:** HSAG conducted follow-up with each CCO when desk review results or data analysis identified areas that required additional information and/or clarification.
6. **Report Production:** HSAG compiled the preliminary results from all information obtained for each CCO. Per HB 3046, HSAG summarized the results of its review and presented the findings to OHA and its CPs to solicit input on the assessment of the CCOs' compliance with the requirement for parity between MH/SUD and M/S covered benefits, identifying areas in which MHP was not achieved and corrective actions were required to ensure future parity. HSAG received feedback from OHA and its CPs and drafted a final MHP Evaluation report for submission to OHA and the Oregon Legislature, no later than December 31, 2023.

Description of Data Obtained

To assess the CCOs' compliance with the federal, State, and contract requirements for parity between the MH/SUD and M/S covered benefits, HSAG obtained information from multiple documents and sources completed and submitted by each organization, including, but not limited to:

- A completed *MHP Treatment Limitation Review Tool*, including identification of all NQTLs used by the organizations to manage MH/SUD and M/S benefits for IP, OP, Rx, and emergency care (EC) services and supplemental documentation.
- A completed *MHP Data Submission Template*, including:
  - Membership counts.
  - Summary results for aggregated counts of claims, UM decisions, and provider enrollment and credentialing.
  - Detailed, member-level utilization data records.
- Clinical/administrative records for a selected sample of service authorization denials and member appeals.
- Documentation of the CCOs' appointment availability monitoring methodology and results.
- CCO grievance data.
- MH/SUD provider capacity and member enrollment data.

HSAG obtained additional information for the MHP Evaluation through interactions, discussions, and follow-up with each CCO's key staff members, as necessary. Furthermore, OHA convened meetings with three groups of CPs (i.e., consumers, CCOs, and providers) to solicit community input on the MHP Analysis and future studies. Feedback from these meetings was submitted to HSAG to integrate in this report.

How Data Were Aggregated and Analyzed

HSAG generated both qualitative and quantitative results based on submitted documentation in order to assess parity during the 2023 MHP Evaluation.

MHP Treatment Limitation Review Tool Analysis

For its review of the *MHP Treatment Limitation Review Tool*, HSAG assessed each CCO's responses across two evaluation domains:

- The comparability of the processes, strategies, evidentiary standards, and other factors (in writing and in operation) used in applying treatment limitations to MH/SUD benefits and M/S benefits.
- The stringency with which the processes, strategies, evidentiary standards, and other factors (in writing and operation) were applied to MH/SUD benefits and M/S benefits.

HSAG used the ratings of *Compliant*, *Partially Compliant*, and *Not Compliant*, as defined in Table 3-21, to indicate the degree to which each CCO's performance was compliant with parity requirements based on whether the treatment limitations on MH/SUD benefits identified by the organization were comparable to and applied no more stringently than the limitations applied to M/S benefits. A designation of *Not Applicable* (*NA*) was used when a specific limitation classification on the review tool was inapplicable to a CCO during the period covered by HSAG's review. This scoring methodology

aligned with CMS' *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*.[3-12] HSAG reviewed all submitted documentation to further clarify identified limitations, as well as information available from prior MHP analyses, as appropriate.

Table 3-21—Rating Definitions for MHP Compliance Determinations

Rating	Definition
Compliant	Indicates that the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was *comparable* with equivalent *stringency*.
Partially Compliant	Indicates that the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was: • *Comparable* but applied with different *stringency, or* • Not *comparable* but applied with equivalent *stringency*.
Not Compliant	Indicates that the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was not *comparable* and applied with different *stringency*.

From the ratings assigned to each of the limitations identified, HSAG calculated a total compliance score for each applicable treatment limitation. HSAG calculated the total score for each organization by totaling the number of *Compliant* (1 point) elements, the number of *Partially Compliant* (0.5 points) elements, and the number of *Not Compliant* (0 points) elements. Elements *Not Applicable* to the organization are scored *NA* and are not included in the total score.

Administrative Data Profiles

To further understand the impact of CCO policies and procedures on the management of MH/SUD and M/S benefits, HSAG analyzed CCO data collected between January 1, 2022, and December 31, 2022, across three key domains. The data included aggregate counts for claims/encounters and UM decisions for MH/SUD and M/S services as well as MH/SUD provider enrollment data and identification of members representing the MH, SUD, and M/S claims. HSAG reviewed all submitted data for consistency and conducted a comparative analysis to identify trends between MH/SUD and M/S services, between CCOs and statewide. Data collected to support the Administrative Data Profiles included services covered through four OHP benefit packages[3-13] (i.e., CCOA, CCOB, CCOE, and CCOB).

Although descriptive, the Administrative Data Profile was used to observe key patterns and outcomes associated with the administration of MH/SUD and M/S covered benefits. To further assess parity, HSAG evaluated the extent to which key claims/encounter and UM metrics differed between MH/SUD and M/S

[3-12] Ibid.

[3-13] OHP benefit levels include: CCOA (physical, behavioral, and oral health benefits), CCOB (i.e., physical and behavioral health benefits), CCOE (i.e., BH benefits only), and CCOG (i.e., behavioral and oral health benefits).

services. HSAG used deviation ratings of *None*, *Moderate*, and *Substantial*, as defined in Table 3-22, to indicate the degree to which each CCO's reported profile metrics differed across MH/SUD and M/S services.

Table 3-22—Deviation Rating Definitions for Administrative Data Profile

Deviation Rating	Definition
None	Difference between MH/SUD and M/S profile metric is **less than** 5 percentage points.
Moderate	Difference between MH/SUD and M/S profile metric is: • **greater than or equal** to 5 percentage points, and • **less than** 10 percentage points.
Substantial	Difference between MH/SUD and M/S profile metric is **greater than or equal to** 10 percentage points.

Adequacy of MH/SUD Provider Networks

The 2023 MHP Evaluation assessed the adequacy of the CCOs' MH/SUD provider networks by evaluating several interrelated measures of members' access to MH and SUD services.

Provider Network Capacity

HSAG conducted a review of the CCOs' provider network data files and synthesized the results to understand the provider network infrastructure in place to provide MH/SUD services to members. Using CCO data captured in OHA's quarterly *DSN Provider Capacity Reports*, HSAG aggregated the data and reported two core metrics:

- Provider Counts—The number and percentage of MH and SUD providers.
- Provider-to-Member Ratios—The ratio of MH and SUD providers to members with at least one MH/SUD claim during the measurement year.

Time and Distance

HSAG assessed the geographic distribution of MH and SUD providers relative to member populations as represented by the percentage of members having access to an MH and SUD provider within the OHA-defined time and distance standards. These standards included the average travel time (in minutes) and driving distance (in miles) to the nearest provider for each type of provider. To refine the time and distance measure, CCO members were limited to those reported in the *MHP Data Submission Template* based on the MH/SUD claims identified in each organization's summary claim counts. Table 3-23 outlines OHA's time and distance standards.

Table 3-23—Time and Distance Standards

Geographic Classification	Definition	Time Standard	Distance Standard	Percentage of Overall Member Access Standard
Urban	A geographic area that is less than 10 map miles from a population center of 30,000 people or more.	30 Minutes	30 Miles	100%
Rural	A geographic area that is 10 or more map miles from a population center of 30,000 people or less.	60 Minutes	60 Miles	100%

HSAG used Quest Analytics Suite software to calculate the duration of travel times and physical distances.

Appointment Availability

HSAG reviewed the CCOs' responses within the CY 2023 DSN Provider Narrative Template to understand how each organization monitored the availability of appointments to MH/SUD and M/S services and providers. HSAG qualitatively assessed the scope and consistency of each CCO's methodology and approach to monitoring appointment availability across MH/SUD and M/S services. Additionally, when available, HSAG reviewed and assessed appointment availability metrics presented by the CCOs to determine their compliance with federal and State requirements, as well as the extent to which performance across MH/SUD and M/S standards were comparable.

Access-Related Grievances

HSAG reviewed and assessed the percentage of access-related MH and SUD grievances to identify potential areas of concern with the availability of MH and SUD providers within each CCO's network. Although descriptive, the review of access-related grievances was used to observe patterns that may be associated with the adequacy of MH/SUD and M/S provider networks. Additionally, to assess parity, HSAG evaluated the extent to which the grievance metrics differed between MH/SUD and M/S services. HSAG used deviation ratings of *None*, *Moderate*, and *Substantial*, as defined in Table 3-24, to indicate the degree to which the CCO's reported profile metrics differed across MH/SUD and M/S services.

Table 3-24—Deviation Rating Definitions for Administrative Data Profile

Deviation Rating	Definition
None	Difference between MH/SUD and M/S profile metric is **less than** 5 percentage points.
Moderate	Difference between MH/SUD and M/S profile metric is: • **greater than or equal** to 5 percentage points, and • **less than** 10 percentage points.
Substantial	Difference between MH/SUD and M/S profile metric is **greater than or equal to** 10 percentage points.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of health care services provided by the Medicaid CCOs, HSAG assigned each of the components reviewed for the MHP evaluation activity to one or more of three domains of care. This assignment to domains of care is depicted in Table 3-25.

Table 3-25—Assignment of MHP Evaluation Activities to the Quality, Timeliness, and Access Domains

MHP Evaluation Activity	Quality	Timeliness	Access
MHP Treatment Limitation Review	✓	✓	✓
Administrative Data Profile Analysis	✓	✓	✓
Adequacy of MH/SUD Provider Networks		✓	✓
Appointment Availability Review		✓	✓
Access-Related Grievances Analysis		✓	✓

Compliance Monitoring Review

Results for Compliance Review

HSAG calculated the overall CCO performance for each of the six standards reviewed. Table 4-1 displays CCO percentage-of-compliance scores for each standard reviewed as well as the total percentage-of-compliance score and overall confidence level across the six standards. Appendix A provides a summary of CCO compliance findings for the past three reporting cycles (2019–2020, 2020–2021, and 2021–2022). Appendix B provides a comparison of CCO compliance scores for standards reviewed during the CY 2020 and CY 2023 review cycles. Appendix C shows unresolved compliance review findings from the past two reporting cycles based on HSAG's assessment of the CCOs' improvement plans, which were reviewed as part of the CY 2022 CMR activity. Due to the small number of elements associated with individual standards, a single *Partially Met* or *Not Met* rating may lead to substantive changes in the confidence level. As such, results at the standard level should be viewed as informational in support of the CCO's overall compliance score and confidence level.

Table 4-1—Summary of CY 2023 CCO CMR Results

CCO	Standard III—Coordination and Continuity of Care	Standard IV—Coverage and Authorization of Services	Standard VII—Member Rights and Protections	Standard X—Grievance and Appeal Systems	Standard XIV—Member Information	Standard XVI—Emergency and Poststabilization Services	Overall Compliance Score	Overall Confidence Level
AH	72.2%	63.9%	90.0%	79.6%	84.1%	70.8%	**76.3%**	*Low*
AllCare	88.9%	75.0%	60.0%	85.2%	70.5%	87.5%	**79.0%**	*Low*
CHA	72.2%	86.1%	70.0%	81.5%	65.9%	83.3%	**77.4%**	*Low*
CPCCO	88.9%	69.4%	50.0%	87.0%	68.2%	83.3%	**76.9%**	*Low*
EOCCO	83.3%	77.8%	70.0%	85.2%	79.5%	83.3%	**81.2%**	*Low*
Health Share	44.4%	44.4%	60.0%	77.8%	68.2%	62.5%	**62.9%**	*None*
IHN	88.9%	61.1%	70.0%	85.2%	86.4%	66.7%	**78.0%**	*Low*
JCC	88.9%	69.4%	50.0%	87.0%	68.2%	83.3%	**76.9%**	*Low*
PCS-CO	94.4%	75.0%	70.0%	88.9%	90.9%	87.5%	**86.0%**	*Moderate*
PCS-CG	88.9%	77.8%	70.0%	88.9%	90.9%	87.5%	**86.0%**	*Moderate*
PCS-Lane	88.9%	72.2%	70.0%	87.0%	90.9%	87.5%	**84.4%**	*Low*
PCS-MP	88.9%	75.0%	70.0%	88.9%	90.9%	87.5%	**85.5%**	*Moderate*
TCHP-North	94.4%	61.1%	70.0%	85.2%	77.3%	100%	**80.6%**	*Low*
TCHP-South	94.4%	61.1%	70.0%	83.3%	77.3%	100%	**80.1%**	*Low*

CCO	Standard III—Coordination and Continuity of Care	Standard IV—Coverage and Authorization of Services	Standard VII—Member Rights and Protections	Standard X—Grievance and Appeal Systems	Standard XIV—Member Information	Standard XVI—Emergency and Poststabilization Services	Overall Compliance Score	Overall Confidence Level
UHA	94.4%	86.1%	90.0%	92.6%	93.2%	100%	**92.5%**	*Moderate*
YCCO	88.9%	66.7%	80.0%	79.6%	77.3%	95.8%	**79.6%**	*Low*
Statewide CCO Compliance Rate	**85.1%**	**70.1%**	**69.4%**	**85.2%**	**80.0%**	**85.4%**	**80.2%**	***Low***

Total Compliance Score—Numeric scores were assigned to compliance findings as follows: *Met* = 1.0, *Partially Met* = 0.5, and *Not Met* = 0.0. The point values were totaled, and the sum was divided by the number of applicable elements to derive percentage scores for each CCO's standards and for the average CCO compliance rate.

Statewide Conclusions, Opportunities for Improvement, and Recommendations Related to Compliance Monitoring Review

For the CCOs statewide, the following conclusions were made:

- The statewide CCO compliance rates for all standards reviewed in CY 2023 ranged from 69.4 percent (Standard VII—Member Rights and Protections) to 85.4 percent (Standard XVI—Emergency and Poststabilization Services) with overall compliance scores for the CCOs individually ranging from 62.9 percent (Health Share) to 92.5 percent (UHA), revealing numerous opportunities for improvement with organizational structures, processes, and monitoring activities.
- Overall CCO compliance scores resulted in the assignment of a no confidence level for Health Share; moderate confidence levels for PCS-CO, PCS-CG, PCS-MP, and UHA; and low confidence levels for the remaining 11 CCOs. None of the CCOs received a high confidence level.
- Individual CCO compliance scores ranged from 44.4 percent to 94.4 percent (Standard III—Coordination and Continuity of Care), 44.4 percent to 86.1 percent (Standard IV—Coverage and Authorization of Services), 50 percent to 90 percent (Standard VII—Member Rights and Protections), 77.8 percent to 92.6 percent (Standard X—Grievance and Appeal Systems), and 65.9 percent to 93.2 percent (Standard XIV—Member Information).
- Three CCOs (TCHP-North, TCHP-South, and UHA) achieved full compliance (100 percent) in Standard XVI—Emergency and Poststabilization Services.
- AH and UHA performed at least 10 percentage points higher than the remaining CCOs, both receiving scores of 90.0 percent in Standard VII—Member Rights and Protections.
- UHA performed at or above the highest CCO individual compliance scores for all six standards reviewed, and its overall compliance score of 92.5 percent was 12.3 percentage points above the overall statewide CCO compliance rate.
- Health Share performed below all the CCOs in four of the six standards reviewed, with three of the four individual compliance scores and the CCO's overall compliance score falling at least 10 percentage points lower than the remaining CCOs. The most substantial scoring differences were

noted for Standard III—Coordination and Continuity of Care and Standard IV—Coverage and Authorization of Services, where the CCO scored 44.4 percent in both standards falling below the statewide CCO compliance rates by 40.7 percentage points and 25.7 percentage points, respectively.

- Half the CCOs demonstrated a decline in performance in Standard III—Coordination and Continuity of Care, with five CCOs (AH, Health Share, PCS-CG, PCS-Lane, and PCS-MP) showing a decline of 10 percentage points or more from CY 2020 to CY 2023. See Appendix B for comparative CMR scores from CY 2020 to CY 2023.
- All CCOs demonstrated a decline in performance in Standard IV—Coverage and Authorization of Services, with all CCOs except CHA showing a decline of 10 percentage points or more from CY 2020 to CY 2023. See Appendix B for comparative CMR scores from CY 2020 to CY 2023.
- All CCOs except AH demonstrated a decline in performance in Standard VII—Member Rights and Protections. Of those, all CCOs, with the exception of UHA, showed a decline of 10 percentage points or more from CY 2020 to CY 2023. See Appendix B for comparative CMR scores from CY 2020 to CY 2023.
- Half the CCOs demonstrated a decline in performance in Standard X—Grievance and Appeal Systems from CY 2020 to CY 2023. See Appendix B for comparative CMR scores from CY 2020 to CY 2023.
- All CCOs except IHN demonstrated a decline in performance in Standard XIV—Member Information with eight CCOs (AH, AllCare, CHA, CPCCO, Health Share, JCC, TCHP-South, and YCCO) showing a decline of 10 percentage points or more from CY 2020 to CY 2023. See Appendix B for comparative CMR scores from CY 2020 to CY 2023.
- All CCOs were required to develop an improvement plan based on the CY 2023 compliance review.

For the CCOs statewide, the most frequent opportunities for improvement were the following:

- Lack of operational structures and failure to implement effective systems to review, approve, or deny authorization requests, including the utilization of decision-makers with the appropriate level of expertise.
- Failure to consult requesting providers prior to rendering coverage decisions then overturning the denial decision following a conversation and additional documentation obtained from the requesting provider. Although not required, HSAG noted the CCOs at large were also not utilizing extensions to obtain the necessary documentation to support coverage decisions.
- Lack of sufficient oversight and monitoring of subcontractors. Most CCOs delegated coverage and authorization of services and care coordination responsibilities to one or more subcontractors who may, in turn, sub-delegate to a downstream entity. Subcontractors were often unable to demonstrate systems used to manage such responsibilities or demonstrate compliance with federal and State requirements. In most cases, the CCO relied on reviews of the subcontractor's policies and procedures or attestations when conducting oversight activities rather than monitoring the subcontractors' actual performance. This included a failure to review and ensure subcontractors were complying with language, format, and content requirements for notice of adverse benefit determination (NOABDs).

- Inability to demonstrate compliance with federal and State care coordination requirements regarding screening, assessments, reassessments, and care planning for members, including notifying members of the person formally designated as primarily responsible for coordinating the services accessed by the member.
- Failure to maintain and implement policies and procedures that aligned with federal and State requirements for member rights and protections, including specific requirements for advance directives, and failure to inform its members, subcontractors, and/or network providers of members' rights.
- Inability to demonstrate compliance with federal and State grievance and appeal requirements, including the failure to adhere to requirements for appropriate decision-makers, time frames for acknowledging and responding to grievances and/or appeals, and readability of notices.
- Failure to implement the most current state-issued NOABD and notice of appeal resolution (NOAR) templates resulting in numerous noncompliant findings.
- Failure to demonstrate implementation of appropriate processes and workflows, and monitoring mechanisms to ensure emergency and poststabilization services were provided to members in alignment with federal requirements. HSAG identified instances in which the CCOs denied emergency and poststabilization services due to the provider not obtaining PA or as a result of a retrospective review.
- Failure to resolve findings from CY 2020 through CY 2022 CMR activities. All CCOs had unresolved findings following HSAG's assessment of the CCOs' improvement plans during the CY 2023 CMR activity. The number of unresolved findings ranged from one each for PCS-CO, PCS-CG, PCS-Lane, and PCS-MP to 23 for Health Share. Four CCOs (EOCCO, Health Share, IHN, and YCCO) continued to have unresolved findings from the CY 2020 review, and all CCOs, with the exception of EOCCO, had at least one unresolved finding from the CY 2021 review. See Appendix C for the summary of unresolved compliance review findings from the past three reporting cycles.

For the CCOs statewide, the most common required actions and recommendations assigned were the following:

- Revise policies, procedures, and member and provider communications to align with federal and State requirements.
- Evaluate and revise current processes, as necessary, to ensure compliance with federal and State requirements with coordination and continuity of care, coverage and authorization of services, member rights and protections, grievance and appeal systems, emergency and poststabilization services, and member information standards.
- Implement appropriate oversight of subcontractors and their processes and materials to ensure adherence to federal and State requirements.
- Review the most recent versions of the notice templates to ensure minimum federal and State requirements are captured, discuss any omissions found in the template with OHA, and ensure implementation of the appropriate version of all templates at the CCO and subcontractor levels, as compliance will be assessed during the subsequent compliance review for the standards reviewed.

- Ensure a clear understanding of actions required to resolve noncompliant findings and seek technical assistance from HSAG, as needed, to ensure all EQR recommendations are fully addressed.
- Implement effective monitoring mechanisms to ensure the CCOs provide access to covered services and emergency and poststabilization services in alignment with State and federal requirements.

Validation of Performance Improvement Projects

Results for Performance Improvement Project Validations

The CCOs submitted baseline and RY 1 results of the statewide *Mental Health Service Access Monitoring* PIP in CY 2023 along with baseline results of the statewide *Initiation, Engagement, and Treatment of Alcohol and Other Drug Use Disorders* PIP. The HSAG PIP review team scored each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designated some of the evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements had to be *Met*. Table 4-2 displays the validation scores, overall validation status, and confidence levels HSAG assigned to each CCO's PIP submissions for the statewide *Mental Health Service Access Monitoring* PIP.

Table 4-2—2023 Statewide *Mental Health Service Access Monitoring* PIP Validation Results by CCO

CCO Name	Percentage of Evaluation Elements Scored *Met*	Percentage of Critical Elements Scored *Met*	Overall Validation Status	Confidence Level
AH	100%	100%	*Met*	*High Confidence/ Confidence*
AllCare	100%	100%	*Met*	*High Confidence/ Confidence*
CHA	85%	100%	*Met*	*High Confidence/ Confidence*
CPCCO	85%	100%	*Met*	*High Confidence/ Confidence*
EOCCO	90%	100%	*Met*	*High Confidence/Confidence*
Health Share	100%	100%	*Met*	*High Confidence/ Confidence*
IHN	85%	100%	*Met*	*High Confidence/ Confidence*
JCC	80%	100%	*Met*	*High Confidence/ Confidence*
PCS-CO	90%	100%	*Met*	*High Confidence/ Confidence*
PCS-CG	90%	100%	*Met*	*High Confidence/ Confidence*
PCS-Lane	90%	100%	*Met*	*High Confidence/ Confidence*

CCO Name	Percentage of Evaluation Elements Scored *Met*	Percentage of Critical Elements Scored *Met*	Overall Validation Status	Confidence Level
PCS-MP	90%	100%	*Met*	*High Confidence/ Confidence*
TCHP-North	90%	100%	*Met*	*High Confidence/ Confidence*
TCHP-South	80%	89%	*Partially Met*	*Low Confidence*
UHA	100%	100%	*Met*	*High Confidence/ Confidence*
YCCO	75%	89%	*Partially Met*	*Low Confidence*

Percentage Score for All Evaluation Elements Met—Total number of evaluation elements *Met* divided by the sum of all evaluation elements *Met*, *Partially Met*, and *Not Met*.
Percentage Score for Critical Elements Met—Total number of critical evaluation elements *Met* divided by the sum of all evaluation elements *Met*, *Partially Met*, and *Not Met*.
Validation Status/Confidence Level—*Met/High Confidence/Confidence* = All critical evaluation elements were *Met*, and 80 percent to 100 percent of all evaluation elements were *Met* across all steps. *Partially Met/Low Confidence* = All critical evaluation elements were *Met*, and 60 percent to 79 percent of all evaluation elements were *Met* across all steps; or one or more critical evaluation elements were *Partially Met*. *Not Met/No Confidence* = All critical evaluation elements were *Met*, and less than 60 percent of all evaluation elements were *Met* across all steps; or one or more critical evaluation elements were *Not Met*.
*Not assessed and not applicable element scores were removed from scoring calculations.

Table 4-3 displays the CCOs' baseline and RY 1 results, associated interventions, and whether the CCO's PIP showed clinical and/or programmatic improvement in performance over baseline for the statewide *Mental Health Service Access Monitoring* PIP with associated interventions.

Table 4-3—CCO PIP Performance Indicator Results, Improvement, and Interventions

CCO	Baseline Result 01/01/2021–12/31/2021	RY 1 Results 01/01/2022–12/31/2022	Indicator Results Demonstrated Statistically Significant Improvement*	Intervention Evaluation Results Demonstrated Clinically or Programmatically Significant Improvement**
AH	**55.3%**	**57.3%**	**Yes**	**Yes**
Interventions: • Promote and financially support recruitment and retention of providers in rural areas and providers representing diverse populations to increase equitable care. • Identify geographic areas in need of transportation services and collaborate with transportation partners to expand transportation options for underserved areas. • Develop and distribute a "Quick Guide" member resource to clearly communicate BH benefits.				
AllCare	**49.4%**	**51.2%**	**Yes**	**Yes**
Interventions: • Initiate direct contracts with BH providers to provide member services. • Develop a data exchange process with BH providers to increase BH data accuracy.				

CCO	Baseline Result 01/01/2021–12/31/2021	RY 1 Results 01/01/2022–12/31/2022	Indicator Results Demonstrated Statistically Significant Improvement*	Intervention Evaluation Results Demonstrated Clinically or Programmatically Significant Improvement**
CHA	**59.6%**	**58.9%**	**No**	**No**
Interventions: • BH education campaign for members ages 65 years and older, using easily accessible modes of communication for the targeted population, to increase knowledge of the value and availability of BH services among the elderly population. • Text message BH education campaign targeting members of all ages.				
CPCCO	**54.9%**	**55.5%**	**No**	**No**
Interventions: • Grant-based program for clinics to expand services (e.g., crisis intervention screening, outreach, skills training) for members waiting to engage in formal BH treatment. • Direct contract with telehealth agencies to increase equitable access to care by providing remote BH services for members in rural or frontier geographic areas. • Conduct BH provider rate setting and cost study to ensure adequate BH providers who offer culturally and linguistically specific care are recruited and retained.				
EOCCO	**58.5%**	**56.1%**	**No**	**Yes**
Interventions: • Collaborate with integrated care clinics, pediatric clinics, and the local community mental health provider (CMHP), providing outreach materials to educate and engage members in BH services in the primary care setting. • Offer the Unite Us online platform for members to access social services and supports and provide a BH service referral route from social service providers to CMHPs. • Develop and initiate a universal "warm handoff" referral process from PCPs to CMHPs to facilitate the transition from primary care to BH care.				
Health Share	**57.7%**	**58.5%**	**Yes**	**Yes**
Interventions: • Implement a caseload realignment action plan to optimize BH care access for members at the largest provider agencies. • Define services that can be covered and funded as part of outreach and engagement services to expand access for members who are waiting to engage in formal BH treatment. • Launched beta testing of a BH provider access and capacity dashboard to monitor and improve provider-specific timeliness and volume of BH services.				
IHN	**57.6%**	**56.3%**	**No**	**Yes**
Interventions: • Partner with community organizations to increase the number of individuals trained to provide family and peer support services.				

CCO	Baseline Result 01/01/2021–12/31/2021	RY 1 Results 01/01/2022–12/31/2022	Indicator Results Demonstrated Statistically Significant Improvement*	Intervention Evaluation Results Demonstrated Clinically or Programmatically Significant Improvement**
• Increase funding to BH organizations for providing crisis respite services in high-need geographic areas. • Partner with community organizations to increase BH care awareness and access for members ages 2 to 5 years and their parents/caregivers.				
JCC	**58.8%**	**58.5%**	**No**	**No**
Interventions: • Pilot-tested a grant-based program for clinics to expand services (e.g., crisis intervention screening, outreach, skills training) for members waiting to engage in formal BH treatment. • Direct contract with telehealth agencies to increase equitable access to care by providing remote BH services for members in rural or frontier geographic areas. • Conduct BH provider rate setting and cost study to ensure adequate BH providers who offer culturally and linguistically specific care are recruited and retained. • Direct contracts delivered to fund BH systems improvement and BH services including funding for MH counseling internships, qualified mental health associate positions, SUD peer drop-in groups for the Latinx community, and housing assistance.				
PCS-CO	**63.4%**	**63.2%**	**No**	**Yes**
Interventions: • Develop an emotional health campaign to improve outreach and education on MH service benefits and help reduce stigma of mental illness among the Latino/a/x population. • Collaborate with community partners through the Acute Care Council to obtain funding for a new secure residential treatment facility to improve access to BH services for rural members with serious and persistent mental illness. • Partner with CMHPs and other service organizations to facilitate expansion of youth MH services through financial and logistical support. • Develop and promote the BH Navigation Team, which aids providers and members in accessing and scheduling MH service appointments, referrals, and SDOH supports.				
PCS-CG	**55.7%**	**55.3%**	**No**	**Yes**
Interventions: • Develop an emotional health campaign to improve outreach and education on MH service benefits and help reduce stigma of mental illness among the Latino/a/x population. • Partner with CMHPs and PCPs to educate and engage members in the use of non-emergent medical transportation (NEMT) benefits to reduce transportation barriers to MH care access. • Develop and promote the BH Navigation Team, which aids providers and members in accessing and scheduling MH service appointments, referrals, and SDOH supports. • Targeted member outreach by personal health navigators (PHNs) to support members ages 65 years or older with a recent BH-related emergency department (ED) visit in addressing barriers to MH service access.				

CCO	Baseline Result 01/01/2021–12/31/2021	RY 1 Results 01/01/2022–12/31/2022	Indicator Results Demonstrated Statistically Significant Improvement*	Intervention Evaluation Results Demonstrated Clinically or Programmatically Significant Improvement**
PCS-Lane	**64.5%**	**63.4%**	**No**	**Yes**
Interventions: • Develop an emotional health campaign to improve outreach and education on MH service benefits and help reduce stigma of mental illness among the Latino/a/x population. • Develop and promote the BH Navigation Team, which aids providers and members in accessing and scheduling MH service appointments, referrals, and SDOH supports. • Targeted member outreach by PHNs to support members ages 65 years or older with a recent BH-related ED visit in addressing barriers to MH service access.				
PCS-MP	**58.0%**	**56.8%**	**No**	**Yes**
Interventions: • Develop an emotional health campaign to improve outreach and education on MH service benefits and help reduce stigma of mental illness among the Latino/a/x population. • Collaborate with Willamette Health Council to promote referrals to school-based health centers to provide BH care access for school-aged members. • Develop and promote the BH Navigation Team, which aids providers and members in accessing and scheduling MH service appointments, referrals, and SDOH supports. • Targeted member outreach by PHNs to support members ages 65 years or older with a recent BH-related ED visit in addressing barriers to MH service access.				
TCHP-North	**61.1%**	**52.1%**	**No**	**Yes**
Interventions: • Initiate an online platform to provide an enhanced closed loop referral process for care managers to better coordinate care and resources for members. • Partner with a contracted provider who specializes in offering culturally specific SUD services for the African-American community. • Increase provider reimbursement rates for MH and SUD services. • Expand a provider incentive program to provide financial incentives to BH providers for addressing member care gaps. • Develop an application on the provider portal platform that allows providers to identify members with a BH service need and prioritize outreach, coordination, or referral to close the BH care gap.				
TCHP-South	**58.9%**	**58.4%**	**No**	**Yes**
Interventions: • Collaborate with health care and education community partners to develop a career technical education (CTE) program, offering mentoring and career development opportunities specific to BH careers for Black, Indigenous, and People of Color (BIPOC) students. • Increase provider reimbursement rates for MH and SUD services. • Initiate an online platform to provide an enhanced closed loop referral process for care managers to better coordinate care and resources for members.				

CCO	Baseline Result 01/01/2021–12/31/2021	RY 1 Results 01/01/2022–12/31/2022	Indicator Results Demonstrated Statistically Significant Improvement*	Intervention Evaluation Results Demonstrated Clinically or Programmatically Significant Improvement**
• Expand a provider incentive program to provide financial incentives to BH providers for addressing member care gaps. • Develop an application on the provider portal platform that allows providers to identify members with a BH service need and prioritize outreach, coordination, or referral to close the BH care gap.				
UHA	**60.2%**	**62.0%**	**Yes**	**Yes**
Interventions: • Expansion of MH telehealth providers with prioritization of providers from diverse backgrounds, culturally specific practices, and language accessibility services. • Provide care coordination for children up to age 5 years with high medical complexity. • Partner with the community mental health center (CMHC) to engage members in the criminal justice system with MH and SUD services and reduce ED utilization among these members.				
YCCO	**58.3%**	**58.3%**	**No**	**Yes**
Interventions: • Establish a contract request process and offer provider training and certification support to expand the MH provider network. • Provider trainings on MH service documentation requirements. • Expanded MH provider network to include additional providers who speak a language other than English. • Increase meaningful language service access by connecting members with culturally appropriate service providers.				

***Statistically significant ($p < 0.05$, 95 precent confidence interval) improvement** in performance indicator results from baseline to Remeasurement 1.

Significant **clinical improvement in processes and outcomes or significant **programmatic improvement** in processes and outcomes was evaluated based on CCO assessment, reported intervention evaluation data, and supporting documentation.

Table 4-4 displays the validation scores, overall validation status, and confidence levels HSAG assigned to each CCO's PIP submissions for the statewide *Initiation, Engagement, and Treatment of Alcohol and Other Drug Use Disorders* PIP.

Table 4-4—2023 Statewide *Initiation, Engagement, and Treatment of Alcohol and Other Drug Use Disorders* PIP Validation Results by CCO

CCO Name	Percentage of Evaluation Elements Scored *Met*	Percentage of Critical Elements Scored *Met*	Overall Validation Status	Confidence Level
AH	100%	100%	*Met*	*High Confidence/ Confidence*
AllCare	100%	100%	*Met*	*High Confidence/ Confidence*

CCO Name	Percentage of Evaluation Elements Scored *Met*	Percentage of Critical Elements Scored *Met*	Overall Validation Status	Confidence Level
CHA	100%	100%	*Met*	*High Confidence/ Confidence*
CPCCO	100%	100%	*Met*	*High Confidence/ Confidence*
EOCCO	100%	100%	*Met*	*High Confidence/ Confidence*
Health Share	100%	100%	*Met*	*High Confidence/ Confidence*
IHN	100%	100%	*Met*	*High Confidence/ Confidence*
JCC	87%	89%	*Partially Met*	*Low Confidence*
PCS-CO	100%	100%	*Met*	*High Confidence/ Confidence*
PCS-CG	100%	100%	*Met*	*High Confidence/ Confidence*
PCS-Lane	100%	100%	*Met*	*High Confidence/ Confidence*
PCS-MP	100%	100%	*Met*	*High Confidence/ Confidence*
TCHP-North	100%	100%	*Met*	*High Confidence/ Confidence*
TCHP-South	100%	100%	*Met*	*High Confidence/ Confidence*
UHA	100%	100%	*Met*	*High Confidence/ Confidence*
YCCO	100%	100%	*Met*	*High Confidence/ Confidence*

Percentage Score for All Evaluation Elements Met—Total number of evaluation elements *Met* divided by the sum of all evaluation elements *Met*, *Partially Met*, and *Not Met*.

Percentage Score for Critical Elements Met—Total number of critical evaluation elements *Met* divided by the sum of all evaluation elements *Met*, *Partially Met*, and *Not Met*.

Validation Status/Confidence Level—*Met/High Confidence/Confidence* = All critical evaluation elements were *Met*, and 80 percent to 100 percent of all evaluation elements were *Met* across all steps. *Partially Met/Low Confidence* = All critical evaluation elements were *Met*, and 60 percent to 79 percent of all evaluation elements were *Met* across all steps; or one or more critical evaluation elements were *Partially Met*. *Not Met/No Confidence* = All critical evaluation elements were *Met*, and less than 60 percent of all evaluation elements were *Met* across all steps; or one or more critical evaluation elements were *Not Met*.

*Not assessed and not applicable element scores were removed from scoring calculations.

Table 4-5 displays the CCOs' baseline performance indicator results for the statewide *Initiation, Engagement, and Treatment of Alcohol and Other Drug Use Disorders* PIP with associated interventions.

Table 4-5—CCO PIP Performance Indicator Results and Interventions

PIP Topic: Statewide *Initiation, Engagement, and Treatment of Alcohol and Other Drug Use Disorders* PIP Validation Results by CCO		
CCO	**Performance Indicator 1:** ***Percentage of new SUD episodes that result in treatment and initiation within 14 days.*** **Baseline Result 01/01/2022–12/31/2022**	**Performance Indicator 2:** ***Percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.*** **Baseline Result 01/01/2022–12/31/2022**
AH	**34.1%**	**11.4%**
Interventions: • Targeted outreach to members with SUD diagnoses and high ED utilization by care management staff to support and facilitate re-engagement in SUD treatment. • Integration of peer support specialists to facilitate SUD treatment in alternative settings targeting services for youth, elderly, and members without stable housing. • Development of Coos Sobering Center—a safe place for members to receive housing if needed and to initiate and engage in SUD treatment.		
AllCare	**34.6%**	**13.5%**
Interventions: • Identifying members who have received SUD assessment services but have not initiated treatment and are waiting on access to residential treatment services. Partnering with SUD agencies to engage these members in accessing available SUD treatment options while they are waiting for access to higher levels of care. • Offering incentives through AllCare's alternative payment model for primary care and BH agencies that improve performance in SUD treatment initiation and engagement through member outreach, peer support services, and "warm handoff" referrals for SUD treatment. • Enhanced provider outreach to offer support to provider offices in improving SUD treatment initiation and engagement performance by providing care gap lists, providing SUD treatment agency resources, and educating on available referral pathways for SUD treatment services.		
CHA	**44.6%**	**23.3%**
Interventions: • Establish an automated system to notify PCPs when members have an SUD diagnosis event.		
CPCCO	**39.6%**	**13.9%**
Interventions: • Partnering with community mental health programs, public health agencies, and SUD treatment programs to increase prescribing of medication-assisted treatment for opioid use disorder and alcohol use disorder. • Partnering with hospitals, EDs, and providers to develop a workflow for increasing initiation of SUD treatment after an SUD-related ED visit.		

PIP Topic: Statewide *Initiation, Engagement, and Treatment of Alcohol and Other Drug Use Disorders* PIP Validation Results by CCO		
CCO	**Performance Indicator 1:** ***Percentage of new SUD episodes that result in treatment and initiation within 14 days.*** **Baseline Result 01/01/2022–12/31/2022**	**Performance Indicator 2:** ***Percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.*** **Baseline Result 01/01/2022–12/31/2022**
EOCCO	**38.1%**	**14.7%**
Interventions: • Weekly targeted provider outreach to coordinate SUD treatment initiation services for members who have a new SUD diagnosis. • Facilitated a provider learning collaborative that included information on how SUD treatment initiation and engagement performance is measured, as well as shared strategies for improving provider performance on measures, including provider outreach and peer sharing of successful treatment referral workflows.		
Health Share	**42.8%**	**15.5%**
Interventions: • Implement a caseload realignment action plan to optimize BH care access for members at the largest provider agencies. • Define services that can be covered and funded as part of outreach and engagement services to expand access for members who are waiting to engage in formal BH treatment. • Launch a BH network reporting strategy and processes to monitor BH care access more accurately.		
IHN	**39.3%**	**19.2%**
Interventions: • Promote provider use of PointClickCare, an electronic health information exchange platform that allows providers to identify when their patients have an ED visit or hospitalization, to facilitate initiation and engagement in SUD treatment. • Collaborate with BH providers in Benton, Lincoln, and Linn counties to identify successful models of care, such as care coordination and community-based referral pathways, for facilitating initiation and engagement in SUD treatment.		
JCC	**38.3%**	**14.2%**
Interventions: • Partnering with community mental health programs, public health agencies, and SUD treatment programs to increase prescribing of medication-assisted treatment for opioid use disorder and alcohol use disorder. • Developing an "SUD in the ED" pilot program that offers training and technical assistance to ED providers on SUD treatment best practices and medication-assistant treatment options. The program also provides funding for SUD treatment navigators to be based in local hospitals. • Partnering with the Oasis Center of the Rogue Valley, a community clinic that supports parents with SUD and their young children, JCC provides incentives to members who are engaged in medication-assisted treatment for opioid use disorder.		

PIP Topic: Statewide *Initiation, Engagement, and Treatment of Alcohol and Other Drug Use Disorders* PIP Validation Results by CCO		
CCO	**Performance Indicator 1:** ***Percentage of new SUD episodes that result in treatment and initiation within 14 days.*** **Baseline Result 01/01/2022–12/31/2022**	**Performance Indicator 2:** ***Percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.*** **Baseline Result 01/01/2022–12/31/2022**
PCS-CO	**46.5%**	**17.2%**
Interventions: • Provider education to increase provider confidence in discussing initiation of SUD treatment with members and connecting members to appropriate treatment services. • A live, staffed telephone service available to members, community-based organizations, and providers seeking assistance in connecting members with SUD treatment services. • Providing an OHA-approved QHCI training program to increase availability of QHCIs for facilitating SUD treatment options for members speaking a language other than English. • Provider education, coaching, and resources to increase provider knowledge of appropriate coding for SUD treatment initiation and engagement services.		
PCS-CG	**46.2%**	**15.8%**
Interventions: • Provider education to increase provider confidence in discussing initiation of SUD treatment with members and connecting members to appropriate treatment services. • A live, staffed telephone service available to members, community-based organizations, and providers seeking assistance in connecting members with SUD treatment services. • Providing an OHA-approved QHCI training program to increase availability of QHCIs for facilitating SUD treatment options for members speaking a language other than English. • Provider education, coaching, and resources to increase provider knowledge of appropriate coding for SUD treatment initiation and engagement services.		
PCS-Lane	**49.8%**	**18.7%**
Interventions: • Provider education to increase provider confidence in discussing initiation of SUD treatment with members and connecting members to appropriate treatment services. • A live, staffed telephone service available to members, community-based organizations, and providers seeking assistance in connecting members with SUD treatment services. • Providing an OHA-approved QHCI training program to increase availability of QHCIs for facilitating SUD treatment options for members speaking a language other than English. • Provider education, coaching, and resources to increase provider knowledge of appropriate coding for SUD treatment initiation and engagement services.		

PIP Topic: Statewide *Initiation, Engagement, and Treatment of Alcohol and Other Drug Use Disorders* PIP Validation Results by CCO		
CCO	**Performance Indicator 1:** ***Percentage of new SUD episodes that result in treatment and initiation within 14 days.*** **Baseline Result 01/01/2022–12/31/2022**	**Performance Indicator 2:** ***Percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.*** **Baseline Result 01/01/2022–12/31/2022**
PCS-MP	**45.9%**	**18.3%**
Interventions: • Provider education to increase provider confidence in discussing initiation of SUD treatment with members and connecting members to appropriate treatment services. • A live, staffed telephone service available to members, community-based organizations, and providers seeking assistance in connecting members with SUD treatment services. • Providing an OHA-approved QHCI training program to increase availability of QHCIs for facilitating SUD treatment options for members speaking a language other than English. • Provider education, coaching, and resources to increase provider knowledge of appropriate coding for SUD treatment initiation and engagement services.		
TCHP-North	**41.0%**	**15.8%**
Interventions: • Collaborate with health care and education community partners to develop a CTE program, offering mentoring and career development opportunities specific to BH careers for BIPOC students. • Increased reimbursement rates for BH services, including SUD treatment services. • Provider incentive program for closing SUD treatment care gaps for members, and provider outreach promoting the program. • Member outreach conducted by case management staff to address members' SUD treatment needs. • Implementing Health Assistance, Linkage, and Outreach (HALO), a quality-based integrated care model focused on identifying and supporting members with SUD treatment needs through collaborative provider-community partnerships. • Launched Connect Oregon/Unite Us online platform to provide an enhanced closed-loop referral process for care managers to better coordinate SUD treatment services and resources for members.		
TCHP-South	**42.3%**	**16.5%**
Interventions: • Collaborate with health care and education community partners to develop a CTE program, offering mentoring and career development opportunities specific to BH careers for BIPOC students. • Increased reimbursement rates for BH services, including SUD treatment services. • Provider incentive program for closing SUD treatment care gaps for members, and provider outreach promoting the program. • Member outreach conducted by case management staff to address members' SUD treatment needs.		

PIP Topic: Statewide *Initiation, Engagement, and Treatment of Alcohol and Other Drug Use Disorders* PIP Validation Results by CCO		
CCO	**Performance Indicator 1:** ***Percentage of new SUD episodes that result in treatment and initiation within 14 days.*** **Baseline Result 01/01/2022–12/31/2022**	**Performance Indicator 2:** ***Percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.*** **Baseline Result 01/01/2022–12/31/2022**
• Implementing HALO, a quality-based integrated care model focused on identifying and supporting members with SUD treatment needs through collaborative provider-community partnerships. • Launched Connect Oregon/Unite Us online platform to provide an enhanced closed-loop referral process for care managers to better coordinate SUD treatment services and resources for members.		
UHA	**40.5%**	**16.9%**
Interventions: • Promote and incentivize provider use of PointClickCare, an electronic health information exchange platform that allows providers to identify when their patients have an ED visit or hospitalization, to facilitate initiation and engagement in SUD treatment. • Partner with a local hospital and CMHC to facilitate effective SUD treatment referral pathways. • Provider and member education on peer-delivered SUD treatment services in partnership with Adapt peer support specialists and Rely Health PCNs. • Funding a scholarship for providers and staff to complete the OHA-approved QHCI training program to address the need for care that is provided in languages other than English.		
YCCO	**40.5%**	**16.9%**
Interventions: • Partnership with the Center for Addictions Triage and Treatment project to increase access to higher-level SUD care. • Enhanced SUD service directory based on lessons learned from the service director pilot program. • Provider education on SUD treatment initiation and engagement timeliness and measure requirements.		

Statewide Conclusions, Opportunities for Improvement, and Recommendations Related to Validation of Performance Improvement Projects

For the CCOs statewide, the following conclusions were made:

- HSAG's validation findings support the conclusion that the CCOs, in collaboration with OHA, developed methodologically sound designs for both statewide PIPs.
- Through monthly statewide collaborative meetings and other statewide communications, the CCOs and OHA worked together to develop relevant and community-driven PIP topics.
- The *Mental Health Service Access Monitoring* PIP responds to member needs identified as priorities for the state in response to the COVID-19 PHE.

- The *Initiation, Engagement, and Treatment of Alcohol and Other Drug Use Disorders* PIP allows the CCOs to further focus efforts on improving treatment for members with SUD as part of the broader efforts encompassed by the new 1115 SUD demonstration waiver.
- Most CCOs conducted accurate and complete data analyses and interpretation of RY 1 indicator results for the *Mental Health Service Access Monitoring* PIP, and the CCOs conducted methodologically sound improvement strategies. Within the Outcomes stage, 13 of 16 CCOs documented significant clinical or programmatic improvement based on intervention evaluation results.
- All but one of the CCOs received a *Met* score for 100 percent of applicable evaluation elements in the Implementation stage of the *Initiation, Engagement, and Treatment of Alcohol and Other Drug Use Disorders* PIP, demonstrating strong performance in analysis and interpretation of baseline indicator results as well as initial improvement strategies.

For the CCOs statewide, the following opportunities for improvement were identified:

- Three CCOs received an overall *Partially Met* validation status (i.e., TCHP-South and YCCO—*Mental Health Service Access Monitoring* PIP and JCC—*Initiation, Engagement, and Treatment of Alcohol and Other Drug Use Disorders* PIP) for reporting indicator results in their PIP submission forms that differed from the final indicator data that OHA provided to the CCOs and HSAG within Step 7: Data Analysis and Interpretation of Results.
- Only four of 16 CCOs (i.e., AH, AllCare, Health Share, and UHA) reported statistically significant improvement of overall indicator results from baseline to RY 1 for the *Mental Health Service Access Monitoring* PIP.
- Three CCOs (i.e., CHA, CPCCO, and JCC) did not provide any documentation in their *Mental Health Service Access Monitoring* PIP submission forms related to the assessment of significant clinical or programmatic improvement.

To facilitate meaningful improvement of accurate data analyses and interpretations for the CCOs statewide, the following recommendations were identified:

- OHA and the CCOs should continue its collaborative relationship and work together to identify barriers to improving access to MH services and SUD treatment for members with an identified need.
- The CCOs should ensure a clear understanding of the performance indicator data files received from OHA so that progress toward improvement goals can be effectively assessed and reported throughout the duration of the project. The CCOs should reach out to OHA for clarification on data files, if needed.
- The CCOs should review and ensure internal communication processes exist to receive monthly data distribution notifications from OHA. The CCOs should also use monthly indicator data results to evaluate progress on improving performance throughout the measurement year in relation to interventions being conducted. The monthly data files should inform the CCOs of whether their current interventions are having a positive impact on performance, prior to the end of the

measurement, and support decisions about continuing, revising, or replacing interventions, based on interim performance. Member-level data provided by OHA in the monthly data files can also allow the CCOs to conduct drill-down analyses to identify member sub-populations (by geographic area, race/ethnicity, age group, gender, etc.) with greater needs and to develop tailored or targeted interventions to improve disparate performance across different sub-populations.

- The CCOs should identify or develop evidence-based and culturally appropriate improvement strategies that are expected to directly impact and improve performance indicator outcomes. The CCOs should use intervention-specific evaluation results and performance indicator results to monitor the impact of improvement efforts and gauge progress toward achieving improvement goals.
- The CCOs should design methodologically sound evaluation processes to test the effectiveness of each intervention, using process-level evaluation results to guide refinement of improvement strategies for optimal improvement. Intervention-specific evaluations should be conducted during the measurement year to allow mid-course corrections prior to obtaining final annual performance indicator results.
- The CCOs should revisit root cause analyses identifying barriers to improving access to MH services and use intervention-specific evaluation results to guide decisions about continuing, revising, or discontinuing interventions to promote effective resource use and achievement of improvement goals.

Performance Measure Validation

Results From Information Systems Standards Review

HSAG evaluated OHA's accuracy of performance measure reporting that is conducted on behalf of the CCOs and determined the extent to which the reported rates followed measure technical specifications and reporting requirements. All measures were calculated by OHA using data submitted by the CCOs. Source data for all measures were integrated from multiple sources, including claims/encounter, enrollment/eligibility, and ancillary data (e.g., appointment logs).

Several aspects involved in the calculation of performance measure data were crucial to the validation process. These included data integration, data control, and documentation of performance measure calculations. For the current reporting period, HSAG determined that the data collected and reported by OHA followed State specifications and reporting requirements; and the rates were valid, reliable, and accurate.

Results for Performance Measures

Table 4-6 shows the summary of validation results for OHA's incentive measure rates validated during the CY 2023 PMV activity.

Table 4-6—Summary of OHA/CCO PMV Results

Performance Measure	Validation Rating
Child and Adolescent Well-Care Visits—Ages 3 to 6 Years	R
*Initiation and Engagement of Substance Use Disorder Treatment—Ages 13 to 17 Years and Ages 18 Years and Older**	R
Members Receiving Preventive Dental or Oral Health Services—Ages 1 to 5 Years and *Ages 6 to 14 Years*	R
Oral Evaluation for Adults With Diabetes	R

*For this measure, OHA incentivizes CCO performance only for the 18 years and older age group.
R—Reportable; measures were compliant with OHA specifications.

Table 4-7 through Table 4-10 display the final OHA-calculated rates audited by HSAG for each of the four performance measures. Each table presents MY 2020, MY 2021, and MY 2022 rates for individual CCOs, the statewide aggregate rate for each measurement year, the OHA benchmark for each measurement year, and the magnitude of change in performance between measurement years. The larger the number, the greater the difference between the MY 2021 and MY 2022 rates. Green shading indicates an MY 2022 rate that was substantially greater than the statewide aggregate (i.e., 5 percentage points or more), while yellow shading indicates a rate greater than the statewide aggregate (i.e., greater than, but less than 5 percentage points). The tables also indicate, for each CCO, whether the change from MY 2021 to MY 2022 resulted in substantial improvement (i.e., ↑ or 5 percentage points) or decline (i.e., ↓ or 5 percentage points) in performance.

Table 4-7—CCO Results for the *Child and Adolescent Well-Care Visits—Ages 3 to 6 Years*

CCO	MY 2020	MY 2021	MY 2022	Difference[1]
Statewide Aggregate	**59.2%**	**64.1%**	**63.1%**	**-1.0%**
OHA Benchmark[2]	**78.5%**	**54.6%**	**64.1%**	**9.5%**
AH	62.8%	64.2%	64.8%	0.7%
AllCare	56.2%	55.3%	55.3%	0.0%
CHA	71.3%	59.8%	56.6%	-3.3%
CPCCO	54.6%	55.1%	59.3%	4.3%
EOCCO	56.1%	64.2%	64.6%	0.4%
Health Share	59.4%	65.6%	64.4%	-1.2%
IHN	54.6%	65.2%	64.5%	-0.8%
JCC	54.6%	63.7%	58.0%	-5.7% ↓
PCS-CO	64.2%	68.4%	69.3%	0.9%
PCS-CG	64.8%	71.4%	76.0%	4.6%
PCS-Lane	58.1%	59.5%	57.8%	-1.7%
PCS-MP	61.7%	66.2%	62.9%	-3.3%
TCHP-North[3]	—	45.6%	46.3%	0.7%
TCHP-South	43.2%	51.5%	51.9%	0.5%
UHA	64.1%	65.1%	71.0%	5.9% ↑
YCCO	62.2%	65.3%	68.2%	2.8%

[1] For this measure, substantial improvement or decline in performance between the measurement years is defined as an increase or decrease of 5 percentage points or more between MY 2021 and MY 2022 rates.
[2] The MY 2020 benchmark (2019 national Medicaid 75th percentile) originally set by OHA was changed to "report only" due to the COVID-19 PHE. The MY 2021 benchmark (2020 CCO 25th percentile) was reduced by OHA due to PHE-related external factors (Source: OHA 2021 CCO Performance Metrics Dashboard). The MY 2022 benchmark set by OHA is the 2020 CCO 75th percentile for the 3 to 6 years age group.
[3] TCHP-North was not contracted by OHA until September 2020; member onboarding was initiated in December 2020. As such, OHA did not calculate an MY 2020 rate for this CCO.

Notes:

— Indicates that the rate is not available for a given measurement year.

Table 4-8—CCO Results for the *Initiation and Engagement of SUD Treatment—Ages 13 to 17 Years* and *Ages 18 Years and Older*

CCO	Initiation of SUD Treatment (13–17)	Engagement of SUD Treatment (13–17)	Initiation of SUD Treatment (18 and Older)	Engagement of SUD Treatment (18 and Older)
	MY 2022	MY 2022	MY 2022	MY 2022
Statewide Aggregate	**36.7%**	**20.3%**	**42.4%**	**16.1%**
OHA Benchmark[1]	**N/A**	**N/A**	**43.0%**	**13.9%**
AH	17.6%	5.9%	34.5%	11.6%
AllCare	35.5%	21.1%	34.5%	13.3%
CHA	34.0%	28.3%	45.2%	23.0%
CPCCO	52.8%	33.3%	39.2%	13.4%
EOCCO	29.9%	11.1%	38.5%	14.9%
Health Share	38.9%	19.5%	42.9%	15.4%
IHN	29.9%	20.1%	39.7%	19.2%
JCC	26.7%	16.0%	38.6%	14.1%
PCS-CO	36.5%	20.3%	47.1%	17.0%
PCS-CG	46.2%	30.8%	46.2%	15.4%
PCS-Lane	44.1%	17.6%	50.0%	18.7%
PCS-MP	35.1%	22.2%	46.3%	18.1%
TCHP-North	30.0%	30.0%	41.2%	15.6%
TCHP-South	29.5%	15.9%	42.6%	16.5%
UHA	51.3%	33.8%	40.0%	16.2%
YCCO	35.5%	23.7%	40.8%	16.5%

* The NCQA recommended a break in trending for the *Initiation and Engagement of Substance Use Disorder Treatment* (IET) measure due to major specification changes for MY 2022[4-1]. This table presents only CCOs' MY 2022 rates on the IET measure.

[1] The MY 2022 benchmarks set by OHA are the 2020 national Medicaid median for the applicable age groups. Note that OHA incentivizes CCO performance only for the 18 years and older age group.

[4-1] HEDIS® MY 2022 Measure Trending Determinations, June 2022. Available at: https://www.ncqa.org/wp-content/uploads/2022/06/HEDIS-MY2022-Measure-Trending-Determinations.pdf. Accessed on: Feb 23, 2024.

Table 4-9—CCO Results for the *Members Receiving Preventive Dental or Oral Health Services—Ages 1 to 5 Years* and *Ages 6 to 14 Years*

CCO	Ages 1 to 5 Years				Ages 6 to 14 Years			
	MY 2020	MY 2021	MY 2022	Difference[1]	MY 2020	MY 2021	MY 2022	Difference[1]
Statewide Aggregate	**37.5%**	**47.2%**	**49.9%**	**2.7%**	**46.8%**	**54.8%**	**59.0%**	**4.2%**
OHA Benchmark[2]	**54.6%**	**33.7%**	**43.1%**	**9.4%**	**67.6%**	**43.1%**	**52.0%**	**8.9%**
AH	33.2%	44.9%	52.3%	7.4% ↑	40.1%	47.8%	60.4%	12.5% ↑
AllCare	43.5%	50.5%	57.5%	7.1% ↑	47.2%	52.2%	60.0%	7.8% ↑
CHA	44.4%	55.9%	54.1%	-1.8%	48.5%	47.9%	61.0%	13.1% ↑
CPCCO	32.7%	42.1%	42.4%	0.3%	35.1%	45.3%	53.3%	8.0% ↑
EOCCO	35.3%	45.9%	48.2%	2.3%	47.7%	58.5%	64.8%	6.3% ↑
Health Share	36.1%	45.3%	49.0%	3.8%	43.1%	53.4%	54.8%	1.4%
IHN	37.8%	52.5%	53.2%	0.8%	44.3%	53.9%	56.4%	2.5%
JCC	43.1%	47.5%	53.6%	6.1% ↑	52.1%	54.5%	61.0%	6.5% ↑
PCS-CO	33.8%	43.5%	48.0%	4.5%	46.6%	51.5%	57.2%	5.7% ↑
PCS-CG	33.7%	40.9%	40.9%	0.0%	52.0%	60.4%	59.0%	-1.5%
PCS-Lane	39.9%	53.3%	51.0%	-2.3%	52.1%	60.2%	65.6%	5.5% ↑
PCS-MP	40.3%	50.1%	52.8%	2.8%	54.0%	62.7%	68.6%	5.9% ↑
TCHP-North[3]	—	26.1%	33.6%	7.5% ↑	—	28.1%	32.8%	4.8%
TCHP-South	35.6%	49.8%	47.0%	-2.8%	41.2%	49.4%	53.8%	4.4%
UHA	25.6%	40.4%	44.3%	3.9%	50.8%	50.8%	56.1%	5.3% ↑
YCCO	44.2%	48.9%	48.3%	-0.6%	49.2%	56.4%	59.7%	3.3%

[1] For this measure, substantial improvement or decline in performance between the measurement years is defined as an increase or decrease of 5 percentage points or more between MY 2021 and MY 2022 rates.

[2] The MY 2020 benchmark (2019 national Medicaid 75th percentile) originally set by OHA was changed to "report only" due to the COVID-19 PHE. The MY 2021 benchmark (2020 CCO 25th percentile) was reduced by OHA due to PHE-related external factors (Source: OHA 2021 CCO Performance Metrics Dashboard). The MY 2022 benchmark set by OHA is the 2020 CCO 75th percentile for the 1 to 5 years and 6 to 14 years age groups.

[3] TCHP-North was not contracted by OHA until September 2020; member onboarding was initiated in December 2020. As such, OHA did not calculate an MY 2020 rate for this CCO.

Notes:

— Indicates that the rate is not available for a given measurement year.

Table 4-10—CCO Results for the *Oral Evaluation for Adults With Diabetes*

CCO	MY 2020	MY 2021	MY 2022	Difference[1]
Statewide Aggregate	**20.3%**	**24.7%**	**24.6%**	**-0.1%**
OHA Benchmark[2]	**26.8%**	**17.3%**	**20.4%**	**3.1%**
AH	16.1%	18.4%	22.1%	3.7%
AllCare	18.3%	22.2%	21.4%	-0.8%
CHA	16.6%	19.7%	20.5%	0.8%
CPCCO	16.8%	21.3%	24.7%	3.4%
EOCCO	20.3%	22.1%	23.0%	0.9%
Health Share	22.1%	28.8%	27.6%	-1.3%
IHN	17.7%	21.5%	20.4%	-1.2%
JCC	20.5%	22.2%	23.5%	1.3%
PCS-CO	17.9%	21.2%	25.2%	4.0%
PCS-CG	26.9%	33.2%	30.4%	-2.9%
PCS-Lane	18.6%	23.2%	23.4%	0.3%
PCS-MP	22.6%	23.9%	23.1%	-0.8%
TCHP-North[3]	—	22.7%	20.6%	-2.1%
TCHP-South	15.9%	20.1%	20.2%	0.2%
UHA	18.9%	20.8%	25.2%	4.4%
YCCO	18.1%	23.6%	24.9%	1.3%

[1] For this measure, substantial improvement or decline in performance between the measurement years is defined as an increase or decrease of 5 percentage points or more between MY 2021 and MY 2022 rates.
[2] The MY 2020 benchmark (2019 national Medicaid 75th percentile) originally set by OHA was changed to "report only" due to the COVID-19 PHE. The MY 2021 benchmark (2020 CCO 25th percentile) was reduced by OHA due to PHE-related external factors (Source: OHA 2021 CCO Performance Metrics Dashboard). The MY 2022 benchmark set by OHA is the 2020 CCO 75th percentile.
[3] TCHP-North was not contracted by OHA until September 2020; member onboarding was initiated in December 2020. As such, OHA did not calculate an MY 2020 rate for this CCO.
Notes:
— Indicates that the rate is not available for a given measurement year.

Statewide Conclusions, Opportunities for Improvement, and Recommendations Related to Performance Measure Rates and Validation

For the CCOs statewide, the following conclusions were made:

- Based on HSAG's analysis and review of OHA's data integration, data controls, and documentation on performance measures, HSAG determined that rates for all four performance measures in the CY 2023 PMV scope were *Reportable*.

- The statewide CCO performance on the *Child and Adolescent Well-Care Visits* measure declined slightly statewide from MY 2021 to MY 2022 (1 percentage point). The performance of six CCOs (CHA, Health Share, IHN, JCC, PCS-Lane, and PCS-MP) declined in MY 2022 compared to MY 2021. Two CCOs (Health Share and IHN) demonstrated a decline in performance from MY 2021 to MY 2022 despite having MY 2022 rates that were greater than the statewide aggregate rate. One CCO (JCC) demonstrated a substantial decline in its rate from MY 2021 to MY 2022 (-5.7 percentage points). The performance of four CCOs (PCS-CO, PCS-CG, UHA, and YCCO) improved in MY 2022 compared to MY 2021. All four CCOs had MY 2022 rates that were substantially greater than the statewide aggregate rate. One CCO (UHA) demonstrated a substantial improvement in its rate from MY 2021 to MY 2022 (5.9 percentage points). Additionally, seven CCOs (AH, EOCCO, PCS-CO, PCS-CG, TCHP-South, UHA, and YCCO) demonstrated ongoing improvement since MY 2020.
- For the *Initiation and Engagement of Substance Use Disorder (SUD) Treatment* measure, HSAG did not compare MY 2022 rates to rates from previous measurement years due to the NCQA-recommended break in trending because of major changes to the measure's specifications. Among members ages 13 to 17 years, four CCOs (CPCCO, PCS-CG, PCS-Lane, and UHA) had MY 2022 rates that were substantially greater than the statewide aggregate rate on the *Initiation of SUD Treatment* measure indicator. Additionally, five CCOs (CHA, CPCCO, PCS-CG, TCHP-North, and UHA) had MY 2022 rates that were substantially greater than the statewide aggregate rate on the *Engagement of SUD Treatment* measure indicator. Three CCOs (CPCCO, PCS-CG, and UHA) performed substantially better than the statewide aggregate on both indicators for members ages 13 to 17 years. Among members ages 18 years and older, one CCO (PCS-Lane) had an MY 2022 rate that was substantially greater than the statewide aggregate rate and OHA benchmark on the *Initiation of SUD Treatment* measure indicator, and another CCO (CHA) had an MY 2022 rate substantially greater than the statewide aggregate rate and OHA benchmark on the *Engagement of SUD Treatment* measure indicator. Three CCOs (AH, AllCare, and CPCCO) performed below the OHA benchmark on both indicators for members ages 18 years and older.
- The statewide CCO performance on the *Members Receiving Preventive Dental or Oral Health Services* measure demonstrated ongoing improvement since MY 2020 for members ages 1 to 5 and 6 to 14 years. For members ages 1 to 5 years, four CCOs (AH, AllCare, JCC, and TCHP-North) demonstrated substantial improvements in their rates from MY 2021 to MY 2022. With the exception of PCS-CG, all CCOs demonstrated improvement in their rates from MY 2021 to MY 2022 for members ages 6 to 14 years, with 10 of those CCOs showing substantial improvement.
- Statewide, there was little change in the statewide CCO performance on the *Oral Evaluation for Adults With Diabetes* measure from MY 2021 to MY 2022 (-0.1 percentage points). One CCO (PCS-CG) continued its strong performance on the measure, with three consecutive years of rates substantially greater than the statewide aggregate rate; however, the CCO also demonstrated a decline in its rate from MY 2021 to MY 2022. Five additional CCOs (CPCCO, Health Share, PCS-CO, UHA, and YCCO) demonstrated an MY 2022 rate that was greater than the statewide aggregate rate. Of these five CCOs, one (Health Share) also demonstrated a decline in performance from MY 2021 to MY 2022.

For the CCOs statewide, the following opportunities for improvement were identified:

- Of the 16 CCOs reporting on the *Child and Adolescent Well-Care Visits* measure, six CCOs (37.5 percent) performed worse on the measure in MY 2022 compared to MY 2021. The performance of one of these six CCOs (JCC) decreased by nearly 6 percentage points (-5.7 percentage points) between MY 2021 and MY 2022, although the CCO had substantially improved its performance on this measure in MY 2021 compared to MY 2020 (9.1 percentage points). Additionally, CHA continued its downward trend in performance on this measure from MY 2020 to MY 2022.
- The statewide CCO performance on the *Oral Evaluation for Adults With Diabetes* measure declined slightly (0.1 percent) between MY 2021 and MY 2022. Six CCOs demonstrated a decline between MY 2021 and MY 2022, including two CCOs (Health Share and PCS-CG) that demonstrated a substantial improvement in rates between MY 2020 and MY 2021 (6.7 percentage points and 6.3 percentage points, respectively) but declined in performance in MY 2022 (-1.3 percentage points and -2.9 percentage points, respectively).

For the CCOs statewide, the following recommendations were identified:

- The statewide CCO decline in performance on the *Child and Adolescent Well-Care Visits* measure suggests that fewer eligible members (i.e., children ages 3 to 6 years) had a well-care visit with a PCP in MY 2022 compared to MY 2021. HSAG recommends that the CCOs whose performance declined in MY 2022 conduct a root cause analysis to identify the member, provider, or operational factors affecting their performance on this measure. Based on the results of this review, the CCOs should design, implement, and assess appropriate interventions to improve the delivery of services to children.
- Although most CCOs demonstrated ongoing improvement in performance on the *Oral Evaluation for Adults With Diabetes* measure between MY 2021 and MY 2022, the decline in performance for the remaining CCOs suggests potential challenges providing oral evaluations to adult members with diabetes in MY 2022. HSAG recommends that the CCOs whose performance declined in MY 2022 conduct a root cause analysis to identify the member, provider, or operational factors affecting their performance on this measure. Based on the results of this review, the CCOs should design, implement, and assess appropriate interventions to improve the delivery of services to adults.
- HSAG recommends all CCOs performing below the OHA benchmarks set for the *Initiation and Engagement of Substance Use Disorder (SUD) Treatment* measure indicators for MY 2022 conduct root cause analyses to identify specific factors affecting performance on this measure and develop, implement, and evaluate targeted interventions to ensure improvement strategies are adopted. Additionally, the CCOs should monitor their provider networks to identify gaps in access to care and work with providers to identify alternative approaches for ensuring the timeliness and accessibility of health care services (e.g., telehealth strategies, mobile clinics).

Validation of Network Adequacy

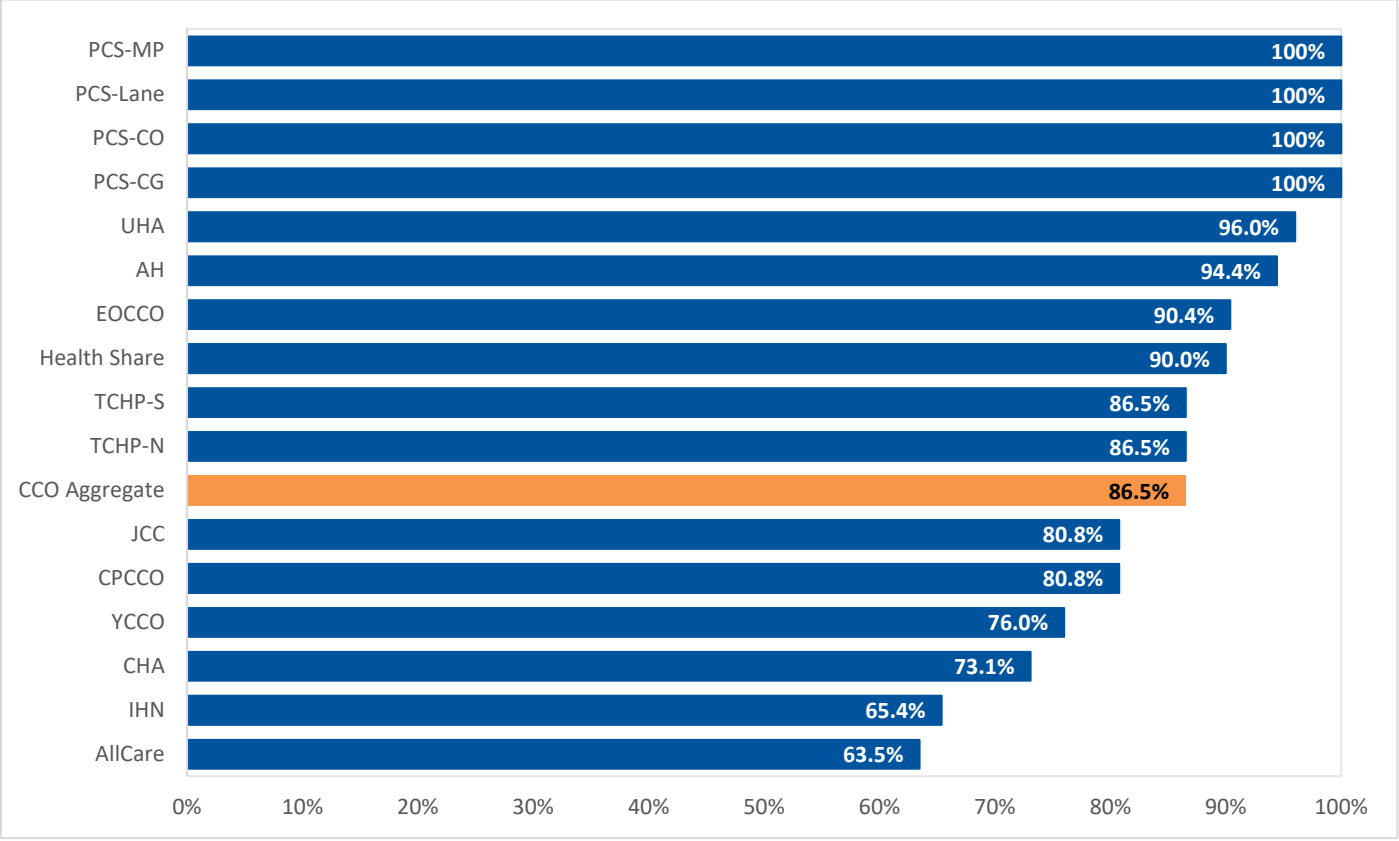
Delivery System Network Evaluation Results

This section contains the results from the CY 2023 DSN Evaluation and includes the qualitative and quantitative findings associated with the DSN Provider Narrative and DSN Provider Capacity Reports. Together, these analyses assessed the adequacy of CCO provider networks, their monitoring activities, and overall compliance with State and federal requirements.

DSN Narrative Review

HSAG reviewed CCO submissions across 28 total elements representing four domains—i.e., *DSN Governance Structure*, *Member Needs and Population Management*, *DSN Monitoring and Analysis*, and *Network Response Strategy*. Figure 4-1 displays each CCO's overall DSN Provider Narrative compliance score relative to the CCOs' aggregate score. All CCO compliance scores are ranked from highest to lowest, including the overall CCO aggregate score, within the domain.

Figure 4-1—Overall DSN Provider Narrative Results by CCO



A summary of CCO compliance results for the individual DSN Provider Narrative domains is presented in Table 4-11.

Table 4-11—Summary of CCO Compliance Results for DSN Provider Narrative Domains

CCO	DSN Governance Structure	Member Needs and Population Management	DSN Monitoring and Analysis	Network Response Strategy
AH	100%	100%	85.0%	100%
AllCare	75.0%	56.3%	50.0%	91.7%
CHA	100%	81.3%	70.0%	58.3%
CPCCO	100%	93.8%	60.0%	91.7%
EOCCO	100%	87.5%	95.0%	83.3%
Health Share	100%	100%	80.0%	90.0%
IHN	100%	81.3%	55.0%	50.0%
JCC	100%	93.8%	60.0%	91.7%
PCS-CO	100%	100%	100%	100%
PCS-CG	100%	100%	100%	100%
PCS-Lane	100%	100%	100%	100%
PCS-MP	100%	100%	100%	100%
TCHP-North	100%	87.5%	100%	58.3%
TCHP-South	100%	87.5%	100%	58.3%
UHA	100%	93.8%	95.0%	100%
YCCO	100%	56.3%	75.0%	100%
Average CCO Compliance Rate	**98.5%**	**88.7%**	**82.8%**	**85.5%**

Network Capacity and Adequacy Assessment

Network Capacity

To address provider network capacity, HSAG conducted a review of the CCOs' provider network data files and synthesized the results to understand the provider network infrastructure in place to provide health care services to members. Using CCO data captured in OHA's quarterly *DSN Provider Capacity Reports,* HSAG aggregated the data and reported two core metrics for PCPs, PCDs, MH providers, and

SUD providers[4-2]—i.e., provider counts and network stability and provider-to-member ratios. These provider types were selected as key measures of network capacity due to their role in providing front-line medical services, which serve the widest array of needs and act as intake points. The results are unweighted, and percentages were calculated based on the number of unique, individual practitioners within each category. For comprehensive individual- and facility-based network capacity results, see the CCO-specific results contained in the appendices.

Provider Counts

Table 4-12 shows the total number of PCPs contracted with each CCO and the percentage of PCPs providing care to adults and children. The table also indicates, for each CCO, whether the change from Q2 2022 to Q1 2023 resulted in a substantial increase (i.e., ↑, or 10 percent) or decrease (i.e., ↓, or 10 percent) in the total number of PCPs. Due to how providers were grouped depending on population served, percentages may not total 100 percent.

Table 4-12—Number and Percentage of PCPs by Quarter

CCO	Q2 2022			Q1 2023			Difference PCP-All	
	PCP-All (N)	PCP-Adult (%)	PCP-Child (%)	PCP-All (N)	PCP-Adult (%)	PCP-Child (%)	#	% Change
AH	91	91.2%	67.0%	83	90.4%	74.7%	-8	-8.8%
AllCare	253	87.4%	100%	344	95.6%	61.3%	91	36.0% ↑
CHA	92	88.0%	21.7%	83	86.7%	24.1%	-9	-9.8%
CPCCO	3,614	89.2%	95.3%	1,527	84.2%	98.2%	-2,087	-57.7% ↓
OCCO	3,525	72.2%	28.5%	1,718	54.3%	46.3%	-1,807	-51.3% ↓
Health Share	3,751	88.1%	86.3%	1,915	83.7%	81.3%	-1,836	-48.9% ↓
IHN	265	86.4%	83.4%	273	86.8%	14.3%	88	3.0%
JCC	3,625	89.1%	95.3%	1,556	84.2%	98.3%	-2,069	-57.1% ↓
PCS-CG	62	95.2%	79.0%	76	89.5%	80.3%	14	22.6% ↑
PCS-CO	241	82.2%	85.9%	232	81.9%	86.2%	-9	-3.7%
PCS-Lane	389	86.6%	86.1%	383	87.2%	86.9%	-6	-1.5%
PCS-MP	359	87.2%	79.9%	326	86.2%	85.0%	-33	-9.2%
TCHP-North	1,311	91.9%	99.6%	574	99.0%	100%	-737	-56.2% ↓

[4-2] This used data from Q2 2022 and Q1 2023, representing a calendar difference of approximately nine months to one year. Provider data used to generate Q2 2022 network capacity counts and provider-to-member ratios used different data elements to classify PCPs, PCDs, MH providers, and SUD providers. Although a comparative review of the distribution of providers showed significant differences in some cases, caution should be used when interpreting network stability due to differences in reporting across calendar years.

CCO	Q2 2022			Q1 2023			Difference PCP-All	
	PCP-All (N)	PCP-Adult (%)	PCP-Child (%)	PCP-All (N)	PCP-Adult (%)	PCP-Child (%)	#	% Change
TCHP-South	775	93.7%	99.7%	477	99.8%	100%	-298	-38.5% ↓
UHA	114	93.0%	89.5%	147	92.5%	97.3%	33	28.9% ↑
YCCO	937	78.3%	22.6%	782	76.7%	72.8%	-155	-16.5% ↓

Table 4-13 shows the total number of PCDs contracted with each CCO and the percentage of PCDs providing care to adults and children. The table also indicates, for each CCO, whether the change from Q2 2022 to Q1 2023 resulted in a substantial increase (i.e., ↑, or 10 percent) or decrease (i.e., ↓, or 10 percent) in the total number of PCDs. Due to how providers were grouped depending on population served, percentages may not total 100 percent.

Table 4-13—Number and Percentage of PCDs by Quarter

CCO	Q2 2022			Q1 2023			Difference	
	PCD-All (N)	PCD-Adult (%)	PCD-Child (%)	PCD-All (N)	PCD-Adult (%)	PCD-Child (%)	#	% Change
AH	26	96.2%	100%	26	84.6%	100%	0	0.0%
AllCare	1	100%	100%	45	86.7%	62.2%	44	4400.0% ↑
CHA	26	76.9%	100%	30	66.7%	100%	4	15.4% ↑
CPCCO	270	85.9%	100%	200	79.5%	100%	-70	-25.9% ↓
EOCCO	174	87.9%	96.0%	164	85.4%	97.6%	-10	-5.7%
Health Share	598	89.8%	87.3%	551	88.9%	86.0%	-47	-7.9%
IHN	147	91.8%	100%	163	89.6%	100%	16	10.9% ↑
JCC	93	91.4%	100%	87	86.2%	100%	-6	-6.5%
PCS-CG	344	84.6%	99.7%	356	84.0%	99.2%	12	3.5%
PCS-CO	344	84.6%	99.7%	356	84.0%	99.2%	12	3.5%
PCS-Lane	344	84.6%	99.7%	356	84.0%	99.2%	12	3.5%
PCS-MP	344	84.6%	99.7%	356	84.0%	99.2%	12	3.5%
TCHP-North	426	87.6%	100%	399	87.0%	99.2%	-27	-6.3%
TCHP-South	147	84.4%	100%	137	85.4%	100%	-10	-6.8%
UHA	43	95.3%	97.7%	36	91.7%	100%	-7	-16.3% ↓
YCCO	57	84.2%	98.2%	60	80.0%	98.3%	3	5.3%

Table 4-14 shows the total number of MH providers contracted with each CCO and the percentage of MH providers providing care to adults and children. The table also indicates, for each CCO, whether the change from Q2 2022 to Q1 2023 resulted in a substantial increase (i.e., ↑, or 10 percent) or decrease (i.e., ↓, or 10 percent) in the total number of MH providers.

Table 4-14—Number and Percentage of MH Providers by Quarter

CCO	Q2 2022			Q1 2023			Difference	
	MH-All (N)	MH-Adult (%)	MH-Child (%)	MH-All (N)	MH-Adult (%)	MH-Child (%)	#	% Change
AH	159	93.7%	81.8%	202	97.5%	99.0%	43	27.0% ↑
AllCare	118	98.3%	99.2%	526	99.6%	48.9%	408	345.8% ↑
CHA	148	88.5%	40.5%	141	90.1%	56.0%	-7	-4.7%
CPCCO	2,255	97.1%	100%	2,409	97.3%	100%	154	6.8%
EOCCO	1,373	98.5%	3.8%	1,358	98.6%	2.1%	-15	-1.1%
Health Share	1,902	94.1%	99.3%	2,503	95.9%	99.8%	601	31.6% ↑
IHN	1,271	99.9%	99.9%	1,608	99.9%	99.8%	337	26.5% ↑
JCC	2,258	97.9%	100%	2,528	97.5%	100%	270	12.0% ↑
PCS-CG	3,607	100%	99.9%	4,250	100%	100%	643	17.8% ↑
PCS-CO	3,608	100%	99.9%	4,251	100%	100%	643	17.8% ↑
PCS-Lane	3,610	100%	99.9%	4,250	100%	100%	640	17.7% ↑
PCS-MP	3,612	100%	99.9%	4,253	100%	100%	641	17.7% ↑
TCHP-North	1,971	98.0%	99.7%	1,993	100%	100%	22	1.1%
TCHP-South	1,598	99.1%	100%	1,814	100%	100%	216	13.5% ↑
UHA	147	89.1%	69.4%	177	88.7%	93.2%	30	20.4% ↑
YCCO	1,868	99.5%	42.6%	2,382	98.7%	97.9%	514	27.5% ↑

Table 4-15 shows the total number of SUD providers contracted with each CCO and the percentage of SUD providers providing care to adults and children. The table also indicates, for each CCO, whether the change from Q2 2022 to Q1 2023 resulted in a substantial increase (i.e., ↑, or 10 percent) or decrease (i.e., ↓, or 10 percent) in the total number of SUD providers. Due to how providers were grouped depending on population served, percentages may not total 100 percent.

Table 4-15—Number and Percentage of SUD Providers by Quarter

CCO	Q2 2022			Q1 2023			Difference	
	SUD-All (N)	SUD-Adult (%)	SUD-Child (%)	SUD-All (N)	SUD-Adult (%)	SUD-Child (%)	#	% Change
AH	33	87.9%	24.2%	56	100%	92.9%	23	69.7% ↑
AllCare	38	94.7%	100%	144	98.6%	18.1%	106	278.9% ↑
CHA	66	97.0%	13.6%	69	95.7%	14.5%	3	4.5%
CPCCO	486	100%	100%	528	99.8%	100%	42	8.6%
EOCCO	337	100%	29.7%	292	100%	2.1%	-45	-13.4% ↓
Health Share	522	100%	100%	582	99.8%	100%	60	11.5% ↑
IHN	334	100%	99.7%	412	100%	99.3%	78	23.4% ↑
JCC	486	100%	100%	534	99.8%	100%	48	9.9%
PCS-CG	505	100%	100%	551	100%	100%	46	9.1%
PCS-CO	505	100%	100%	551	100%	100%	46	9.1%
PCS-Lane	505	100%	100%	551	100%	100%	46	9.1%
PCS-MP	505	100%	100%	551	100%	100%	46	9.1%
TCHP-North	293	100%	100%	293	100%	100%	0	0.0%
TCHP-South	357	100%	100%	415	100%	100%	58	16.2% ↑
UHA	82	96.3%	7.3%	100	96.0%	99.0%	18	22.0% ↑
YCCO	304	100%	97.7%	417	100%	98.3%	113	37.2% ↑

Provider-to-Member Ratios

HSAG calculated CCO-specific provider-to-member ratios for all provider types[4-3] in order to standardize the reporting of provider capacity. The provider-to-member ratio was calculated by dividing the total number of members enrolled in each CCO by the total number of providers within the CCO's network. The number of members enrolled in each CCO was determined by extracting members from the OHA enrollment and eligibility files who were active with the CCO as of March 31, 2023. HSAG applied member restrictions when calculating the provider-to-member ratios for MH and SUD providers based on the number of members with at least one IP or OP claim with an MH or SUD diagnosis during CY 2022.[4-4] This metric serves as a way to standardize estimations of a CCO's provider network as it accounts for service area and membership size. Since OHA does not currently have specific provider-to-member ratio standards for any provider type, the results below are presented for informational purposes.

Table 4-16 shows the provider-to-member ratios for PCPs stratified by the adult, pediatric, and total member populations.

Table 4-16—Provider-to-Member Ratios for PCPs by Member Population

CCO	PCP-All			PCP-Adult			PCP-Child		
	Members (N)	Providers (N)	Ratio	Members (N)	Providers (N)	Ratio	Members (N)	Providers (N)	Ratio
AH	28,967	83	1:349	20,196	75	1:270	8,771	62	1:142
AllCare	65,667	344	1:191	46,488	329	1:142	19,179	211	1:91
CHA	27,299	83	1:329	17,403	72	1:242	9,896	20	1:495
CPCCO	37,501	1,527	1:25	24,637	1,286	1:20	12,864	1,500	1:9
EOCCO	76,146	1,718	1:45	44,542	933	1:48	31,604	795	1:40
Health Share	439,034	1,915	1:230	290,023	1,603	1:181	149,011	1,556	1:96
IHN	84,219	273	1:309	55,375	237	1:234	28,844	39	1:740
JCC	66,084	1,556	1:43	40,438	1,310	1:31	25,646	1,529	1:17
PCS-CG	17,247	76	1:227	10,398	68	1:153	6,849	61	1:113
PCS-CO	77,028	232	1:333	49,553	190	1:261	27,475	200	1:138
PCS-Lane	91,951	383	1:241	60,330	334	1:181	31,621	333	1:95
PCS-MP	148,087	326	1:455	85,242	281	1:304	62,845	277	1:227

4-3 Provider-to-member ratios were generated by HSAG based on Q1 2023 DSN Provider Capacity files submitted by the CCOs to OHA, and subsequently provided to HSAG. Numbers presented may be slightly different than reported by OHA due to differences in the aggregation and deduplication process used by HSAG to prepare the Time and Distance Analysis.

4-4 Relevant claims and member data were collected by HSAG from the CCOs as part of the 2023 Mental Health Parity Evaluation.

CCO	PCP-All			PCP-Adult			PCP-Child		
	Members (N)	Providers (N)	Ratio	Members (N)	Providers (N)	Ratio	Members (N)	Providers (N)	Ratio
TCHP-North	55,283	574	1:97	41,457	568	1:73	13,826	574	1:25
TCHP-South	38,090	477	1:80	29,415	476	1:62	8,675	477	1:19
UHA	40,040	147	1:273	26,601	136	1:196	13,439	143	1:94
YCCO	37,208	782	1:48	22,751	600	1:38	14,457	569	1:26

Table 4-17 shows an example of the provider-to-member ratios for PCDs stratified by the adult, pediatric, and total member populations.

Table 4-17—Provider-to-Member Ratios for PCDs by Member Population

CCO	PCD-All			PCD-Adult			PCD-Child		
	Members (N)	Providers (N)	Ratio	Members (N)	Providers (N)	Ratio	Members (N)	Providers (N)	Ratio
AH	28,967	26	1:1,115	20,196	22	1:918	8,771	26	1:338
AllCare	65,667	45	1:1,460	46,488	39	1:1,192	19,179	28	1:685
CHA	27,299	30	1:910	17,403	20	1:871	9,896	30	1:330
CPCCO	37,501	200	1:188	24,637	159	1:155	12,864	200	1:65
EOCCO	76,146	164	1:465	44,542	140	1:319	31,604	160	1:198
Health Share	439,034	551	1:797	290,023	490	1:592	149,011	474	1:315
IHN	84,219	163	1:517	55,375	146	1:380	28,844	163	1:177
JCC	66,084	87	1:760	40,438	75	1:540	25,646	87	1:295
PCS-CG	17,247	356	1:49	10,398	299	1:35	6,849	353	1:20
PCS-CO	77,028	356	1:217	49,553	299	1:166	27,475	353	1:78
PCS-Lane	91,951	356	1:259	60,330	299	1:202	31,621	353	1:90
PCS-MP	148,087	356	1:416	85,242	299	1:286	62,845	353	1:179
TCHP-North	55,283	399	1:139	41,457	347	1:120	13,826	396	1:35
TCHP-South	38,090	137	1:279	29,415	117	1:252	8,675	137	1:64
UHA	40,040	36	1:1,113	26,601	33	1:807	13,439	36	1:374
YCCO	37,208	60	1:621	22,751	48	1:474	14,457	59	1:246

Table 4-18 shows an example of the provider-to-member ratios for MH providers stratified by the adult, pediatric, and total member populations.

Table 4-18—Provider-to-Member Ratios for MH Providers by Member Population

CCO	MH-All			MH-Adult			MH-Child		
	Members (N)	Providers (N)	Ratio	Members (N)	Providers (N)	Ratio	Members (N)	Providers (N)	Ratio
AH	28,967	202	1:144	20,196	197	1:103	8,771	200	1:44
AllCare	65,667	526	1:125	46,488	524	1:89	19,179	257	1:75
CHA	27,299	141	1:194	17,403	127	1:138	9,896	79	1:126
CPCCO	37,501	2,409	1:16	24,637	2,343	1:11	12,864	2,409	1:6
EOCCO	76,146	1,358	1:57	44,542	1,339	1:34	31,604	28	1:1,129
Health Share	439,034	2,503	1:176	290,023	2,400	1:121	149,011	2,498	1:60
IHN	84,219	1,608	1:53	55,375	1,606	1:35	28,844	1,605	1:18
JCC	66,084	2,528	1:27	40,438	2,465	1:17	25,646	2,528	1:11
PCS-CG	17,247	4,250	1:5	10,398	4,250	1:3	6,849	4,248	1:2
PCS-CO	77,028	4,251	1:19	49,553	4,251	1:12	27,475	4,249	1:7
PCS-Lane	91,951	4,250	1:22	60,330	4,250	1:15	31,621	4,248	1:8
PCS-MP	148,087	4,253	1:35	85,242	4,253	1:21	62,845	4,251	1:15
TCHP-North	55,283	1,993	1:28	41,457	1,993	1:21	13,826	1,993	1:7
TCHP-South	38,090	1,814	1:21	29,415	1,814	1:17	8,675	1,814	1:5
UHA	40,040	177	1:227	26,601	157	1:170	13,439	165	1:82
YCCO	37,208	2,382	1:16	22,751	2,350	1:10	14,457	2,333	1:7

Table 4-19 shows an example of the provider-to-member ratios for SUD providers stratified by the adult, pediatric, and total member populations.

Table 4-19—Provider-to-Member Ratios for SUD Providers by Member Population

CCO	SUD Provider-All			SUD Provider-Adult			SUD Provider-Child		
	Members (N)	Providers (N)	Ratio	Members (N)	Providers (N)	Ratio	Members (N)	Providers (N)	Ratio
AH	28,967	56	1:518	20,196	56	1:361	8,771	52	1:169
AllCare	65,667	144	1:457	46,488	142	1:328	19,179	26	1:738
CHA	27,299	69	1:396	17,403	66	1:264	9,896	10	1:990
CPCCO	37,501	528	1:72	24,637	527	1:47	12,864	528	1:25
EOCCO	76,146	292	1:261	44,542	292	1:153	31,604	6	1:5,268
Health Share	439,034	582	1:755	290,023	581	1:500	149,011	582	1:257

CCO	SUD Provider-All			SUD Provider-Adult			SUD Provider-Child		
	Members (N)	Providers (N)	Ratio	Members (N)	Providers (N)	Ratio	Members (N)	Providers (N)	Ratio
IHN	84,219	412	1:205	55,375	412	1:135	28,844	409	1:71
JCC	66,084	534	1:124	40,438	533	1:76	25,646	534	1:49
PCS-CG	17,247	551	1:32	10,398	551	1:19	6,849	551	1:13
PCS-CO	77,028	551	1:140	49,553	551	1:90	27,475	551	1:50
PCS-Lane	91,951	551	1:167	60,330	551	1:110	31,621	551	1:58
PCS-MP	148,087	551	1:269	85,242	551	1:155	62,845	551	1:115
TCHP-North	55,283	293	1:189	41,457	293	1:142	13,826	293	1:48
TCHP-South	38,090	415	1:92	29,415	415	1:71	8,675	415	1:21
UHA	40,040	100	1:401	26,601	96	1:278	13,439	99	1:136
YCCO	37,208	417	1:90	22,751	417	1:55	14,457	410	1:36

Time and Distance Analysis

This section highlights the CCOs' compliance with OHA time and distance standards (i.e., 95 percent of members within 30 miles or 30 minutes of a provider in urban settings, and 95 percent of members within 60 miles or 60 minutes of a provider in rural settings). The findings in this section are limited to a subset of core providers[4-5] that represent and perform fundamental health services covered by the CCOs. These provider types were selected due to their role in providing front-line medical services, which serve the widest array of needs and act as critical intake points. Table 4-20 and Table 4-21 show the percentages of CCO members with access to core service categories by urban and rural geographic classifications, respectively. Results showing less than 95 percent of members meeting the state-defined time and distance access standards are shaded red.

Table 4-20—Time and Distance Results by Provider Type—Urban

CCO	PCP	PCD	MH	SUD	OB/ GYN	OPT	DME	HOSP	Rx	SNF
AllCare	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
CPCCO	100%	100%	100%	92.3%	92.5%	92.3%	100%	100%	100%	92.7%
EOCCO	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Health Share	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
IHN	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
JCC	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
PCS-CO	100%	100%	100%	100%	100%	100%	100%	95.4%	100%	98.8%
PCS-Lane	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

[4-5] For detailed time and distance CCO findings for all provider specialties and oral health service providers, see the CCO-specific appendices.

CCO	PCP	PCD	MH	SUD	OB/ GYN	OPT	DME	HOSP	Rx	SNF
PCS-MP	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TCHP-North	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TCHP-South	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
YCCO	100%	100%	100%	100%	100%	100%	99.6%	100%	100%	100%

Note: Results shown in red font indicate that less than 95 percent of members had access to the provider type within the time and distance standard.

Table 4-21—Time and Distance Results by Provider Type—Rural

CCO	PCP	PCD	MH	SUD	OB/ GYN	OPT	DME	HOSP	Rx	SNF
AH	100%	100%	100%	100%	100%	100%	90.8%	100%	94.3%	94.5%
AllCare	100%	98.5%	100%	100%	100%	100%	92.9%	100%	100%	81.3%
CHA	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
CPCCO	100%	100%	100%	100%	100%	100%	100%	100%	100%	93.9%
EOCCO	99.8%	99.6%	99.5%	98.5%	96.5%	98.6%	89.5%	98.5%	99.5%	75.0%
Health Share	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
IHN	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
JCC	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
PCS-CG	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
PCS-CO	99.9%	99.9%	100%	>99.9%	>99.9%	100%	99.9%	98.7%	100%	99.2%
PCS-Lane	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
PCS-MP	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TCHP-North	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TCHP-South	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
UHA	100%	100%	100%	>99.9%	>99.9%	>99.9%	>99.9%	>99.9%	99.8%	>99.9%
YCCO	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Note: Results shown in red font indicate that less than 95 percent of members had access to the provider type within the time and distance standard.

DSN Provider Capacity Report Findings

DSN Provider Capacity Reporting results are based on the Q1 2023 Quarterly DSN Provider Capacity Analysis conducted and reported by OHA. This section highlights key findings from OHA's analyses; a summary of CCO-specific results is available in the appendices.

Quality of Provider Network Data

The ability of the CCOs to collect, integrate, and report high quality provider data is critical to the ongoing monitoring and assessment of network adequacy. The completeness, accuracy, and timeliness of CCO provider data is also important in determining the utility of the CCOs' provider directories.

Drawing upon the quarterly *DSN Provider Capacity Reports* submitted by the CCOs, OHA evaluated incoming provider data files based on the percentage of data entry fields that demonstrated whether:

1. A data value was present.
2. If present, the data were populated according to the requirements of that field.
3. If complete, the data were submitted in the required format.

Table 4-22 displays the percentage of provider directory-focused data elements present in provider capacity data files by CCO. Results showing less than 95 percent of data values present are shaded red, and results showing less than 99 percent but more than 95 percent are shaded yellow.

Table 4-22—Percentage of Key Provider Directory Data Elements Present in CCO Individual Practitioner Data

CCO	Practitioner Name	Business Name	Address	Phone Number	Taxonomy	New Patient Indicator	PCP Indicator
AH	100%	100%	NA	100%	100%	100%	100%
AllCare	100%	100%	NA	100%	100%	100%	100%
CHA	100%	100%	NA	100%	100%	100%	100%
CPCCO	100%	100%	NA	100%	100%	98.2%	100%
EOCCO	100%	100%	NA	100%	100%	100%	100%
Health Share	100%	99.9%	NA	100%	100%	100%	100%
IHN	100%	98.7%	NA	100%	100%	99.8%	100%
JCC	100%	100%	NA	100%	100%	99.0%	100%
PCS-CO	100%	98.7%	NA	100%	100%	100%	100%
PCS-CG	100%	98.7%	NA	100%	100%	100%	100%
PCS-Lane	100%	98.7%	NA	100%	100%	100%	100%
PCS-MP	100%	98.8%	NA	100%	100%	100%	100%
TCHP-North	100%	100%	NA	100%	100%	100%	100%
TCHP-South	100%	100%	NA	100%	100%	100%	100%
UHA	100%	100%	NA	100%	100%	100%	100%
YCCO	100%	100%	NA	99.4%	100%	100%	100%

Note: Results given as "NA" indicate that OHA did not assess the data quality of the "Address" data element.

Table 4-23 displays the percentage of network adequacy-focused data elements present in provider capacity data files by CCO, not reported in Table 4-22, per CCO. Results showing less than 95 percent of data values present are shaded red, while results showing less than 99 percent but more than 95 percent are shaded yellow.

Table 4-23—Percentage of Key Network Adequacy Data Elements Present in CCO Individual Practitioner Data

CCO	NPI	DMAP ID	Service Area	Participation Status	PCP Capacity	PCP Assignment
AH	100%	100%	100%	100%	100%	100%
AllCare	100%	100%	100%	100%	100%	100%
CHA	100%	100%	100%	100%	100%	100%
CPCCO	100%	100%	100%	100%	100%	100%
EOCCO	100%	100%	100%	100%	100%	100%
Health Share	100%	99.8%	100%	100%	100%	100%
IHN	100%	96.4%	100%	100%	100%	100%
JCC	100%	100%	100%	100%	100%	100%
PCS-CO	100%	99.4%	100%	100%	100%	100%
PCS-CG	100%	99.4%	100%	100%	100%	100%
PCS-Lane	100%	99.4%	100%	100%	100%	100%
PCS-MP	100%	99.4%	100%	100%	100%	100%
TCHP-North	100%	98.4%	100%	100%	100%	100%
TCHP-South	100%	99.2%	100%	100%	100%	100%
UHA	100%	100%	100%	100%	100%	100%
YCCO	99.1%	95.6%	100%	100%	100%	100%

Table 4-24 displays the overall level of confidence in the quality of each CCO's provider network data by file and data element type. A *High* level of confidence reflects CCO performance where all data quality metric results (i.e., percent present, percent complete, and percent reported in valid formats) were 99 percent or higher. A *Moderate* level of confidence reflects CCO performance with at least one quality metric less than 99 percent, but all results greater than or equal to 95 percent, and are shaded yellow. A *Low* level of confidence was assigned if one or more data quality metric fell below 95 percent, and are shaded red.

Table 4-24—Overall Level of Confidence in Key Data Elements by File and Data Element Type by CCO

CCO	Data Quality Confidence Level			
	Individual		Facility	
	Directory	Network Adequacy	Directory	Network Adequacy
AH	High	High	High	High
AllCare	High	High	High	High
CHA	High	High	High	High
CPCCO	Moderate	Moderate	High	High
EOCCO	High	High	High	High
Health Share	High	Low	High	Low
IHN	Moderate	Moderate	High	Low
JCC	High	Low	High	High
PCS-CG	Moderate	Moderate	High	Moderate
PCS-CO	Moderate	Moderate	High	Moderate
PCS-Lane	Moderate	Moderate	High	Moderate
PCS-MP	Moderate	Moderate	High	Moderate
TCHP-North	High	Moderate	High	Moderate
TCHP-South	High	High	High	Moderate
UHA	High	High	Moderate	Low
YCCO	High	Moderate	High	Moderate

Provider Availability and Accessibility

OHA assessed the availability of the CCOs' network providers by assessing the percentage of PCPs, PCDs, MH providers, and SUD providers who were active, accepting new patients, and located within a CCO's service areas. These service categories were selected as key measures of the adequacy of accessibility to front-line medical services, which serve the widest array of needs and act as intake points and facilitators to more specialized care. Additionally, for PCPs, OHA also evaluated the percentage of a PCP's total capacity available for assignment as of Q1 2023. Table 4-25 through Table 4-28 display the overall percentage of providers who speak a prevalent non-English language in Oregon. While the CCOs are required to provide QHCI services (typically via subcontractor), assessing the

number of providers within a network who speak a non-English language contributes to an understanding of how each CCO evaluates and adjusts its ability to provide services in a linguistically accessible and culturally responsive manner.

Table 4-25 shows the unweighted results for PCPs stratified by CCO.

Table 4-25—Availability and Accessibility of PCPs by CCO

CCO	Count	Availability				Accessibility
		Active (%)	Within Service Area (%)	Accepting New Patients (%)	PCP Capacity (%)	Prevalent Non-English Speaking (%)
AH	89	96.6%	100%	100%	53.9%	5.6%
AllCare	353	96.9%	98.9%	39.4%	90.9%	9.9%
CHA	92	98.9%	100%	75.0%	100%	21.7%
CPCCO	1,703	98.4%	7.6%	60.5%	98.0%	16.7%
EOCCO	1,475	95.7%	18.3%	80.6%	47.0%	1.2%
Health Share	2,096	97.9%	84.3%	71.0%	81.1%	11.8%
IHN	290	99.0%	78.6%	97.9%	0.0%	3.4%
JCC	1,733	98.4%	10.9%	63.8%	92.8%	17.0%
PCS-CO	248	100%	97.2%	75.8%	80.7%	12.9%
PCS-CG	90	98.9%	93.3%	90.0%	86.7%	26.7%
PCS-Lane	402	98.5%	98.5%	51.5%	77.4%	14.9%
PCS-MP	342	99.4%	98.5%	62.9%	76.3%	14.9%
TCHP-North	619	93.1%	91.9%	100%	98.1%	14.5%
TCHP-South	500	96.2%	55.2%	100%	99.0%	12.2%
UHA	150	96.7%	54.0%	35.3%	56.7%	12.0%
YCCO	785	98.9%	100%	63.7%	83.2%	8.7%

Table 4-26 shows the unweighted results for PCDs stratified by CCO.

Table 4-26—Availability and Acceptability of PCDs by CCO

CCO	Count	Availability			Accessibility
		Active (%)	Within Service Area (%)	Accepting New Patients (%)	Prevalent Non-English Speaking (%)
AH	23	95.7%	82.6%	100%	NA
AllCare	36	100%	100%	100%	30.6%
CHA	28	92.9%	64.3%	78.6%	10.7%
CPCCO	181	98.9%	13.3%	0.0%	19.3%
EOCCO	145	95.2%	78.6%	85.5%	13.1%
Health Share	504	95.0%	95.6%	73.2%	26.8%
IHN	139	81.3%	77.7%	90.6%	15.1%
JCC	76	98.7%	69.7%	0.0%	26.3%
PCS-CO	296	97.0%	23.6%	72.0%	19.9%
PCS-CG	296	97.0%	6.8%	72.0%	19.9%
PCS-Lane	296	97.0%	27.7%	72.0%	19.9%
PCS-MP	296	97.0%	36.5%	72.0%	19.9%
TCHP-North	365	92.9%	97.5%	62.7%	39.5%
TCHP-South	116	97.4%	67.2%	70.7%	26.7%
UHA	29	100%	96.6%	96.6%	NA
YCCO	54	100%	40.7%	94.4%	20.4%

Note: Results given as "NA" indicate that no contracted PCDs were reported by the CCO as speaking a prevalent non-English language.

Table 4-27 shows the unweighted results for MH providers stratified by CCO.

Table 4-27—Availability and Accessibility of MH Providers by CCO

CCO	Count	Availability			Accessibility
		Active (%)	Within Service Area (%)	Accepting New Patients (%)	Prevalent Non-English Speaking (%)
AH	179	89.4%	73.7%	100%	2.2%
AllCare	458	91.3%	96.9%	96.9%	2.8%
CHA	122	93.4%	91.0%	100%	9.0%
CPCCO	1,760	87.1%	10.2%	0.1%	3.5%
EOCCO	1,025	77.8%	40.6%	0.0%	0.1%
Health Share	1,735	90.8%	77.9%	11.0%	4.2%
IHN	1,038	79.7%	39.5%	98.5%	0.2%
JCC	1,920	87.7%	18.5%	0.1%	2.8%
PCS-CO	3,374	92.3%	18.8%	89.4%	4.1%
PCS-CG	3,373	92.3%	32.7%	89.4%	4.1%
PCS-Lane	3,373	92.3%	34.2%	89.4%	4.1%
PCS-MP	3,376	92.3%	16.9%	89.4%	4.1%
TCHP-North	1,625	83.1%	94.3%	100%	2.7%
TCHP-South	1,583	80.3%	70.3%	100%	2.8%
UHA	128	90.6%	89.8%	93.0%	1.6%
YCCO	1,381	86.1%	100%	98.3%	1.7%

Table 4-28 shows the unweighted results for SUD providers stratified by CCO.

Table 4-28—Availability and Accessibility of SUD Providers by CCO

CCO	Count	Availability			Accessibility
		Active (%)	Within Service Area (%)	Accepting New Patients (%)	Prevalent Non-English Speaking (%)
AH	56	91.1%	48.2%	100%	NA
AllCare	144	88.2%	86.8%	97.2%	1.4%
CHA	69	84.1%	52.2%	100%	2.9%
CPCCO	528	85.0%	9.3%	0.4%	3.4%
EOCCO	292	78.4%	43.2%	0.0%	NA
Health Share	583	87.8%	71.5%	3.4%	4.5%
IHN	411	78.3%	36.0%	99.3%	NA
JCC	536	88.4%	20.7%	0.4%	3.2%
PCS-CO	552	85.9%	14.9%	97.3%	3.4%
PCS-CG	552	85.9%	1.1%	97.3%	3.4%
PCS-Lane	552	85.9%	38.8%	97.3%	3.4%
PCS-MP	552	85.9%	25.9%	97.3%	3.4%
TCHP-North	293	74.1%	91.8%	100%	2.4%
TCHP-South	414	71.3%	52.4%	100%	0.2%
UHA	96	55.2%	42.7%	100%	NA
YCCO	336	89.0%	100%	100%	0.3%

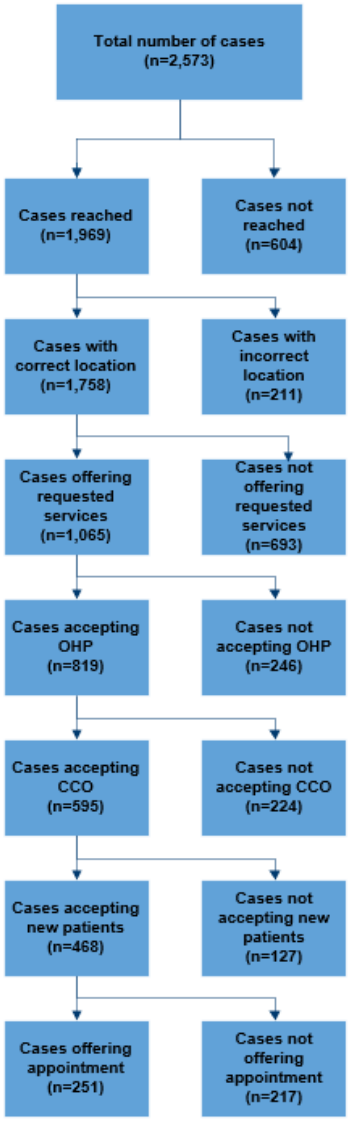
Note: Results given as "NA" indicate that no contracted SUD providers were reported by the CCO as speaking a prevalent non-English language.

Secret Shopper Survey Results

This section presents the secret shopper survey results in aggregate and by CCO for study indicators related to provider data accuracy and appointment availability. The survey results include in a series of bar charts and tables displaying CCO performance relative to other CCOs and overall CCO aggregate performance. Across each measure and specialty category, the CCOs are ranked based on performance from the highest to lowest rate.

Figure 4-2 illustrates the flow of data collection during the survey calls, as well as the total number of cases with each potential survey outcome.

Figure 4-2—Secret Shopper Survey Data Collection Process and Case Outcomes



Response Rates

Survey callers attempted to contact each survey case up to two times during standard business hours at different times on different days; a case that could not be contacted was considered nonresponsive. Figure 4-3 through Figure 4-5 illustrate the survey response rates by specialty category and CCO and the PCP and PCD combined total response rates by CCO. "N" represents the number of cases resulting in successful contact (cases reached), or the numerator, for the measure.

Figure 4-3—PCP Response Rates

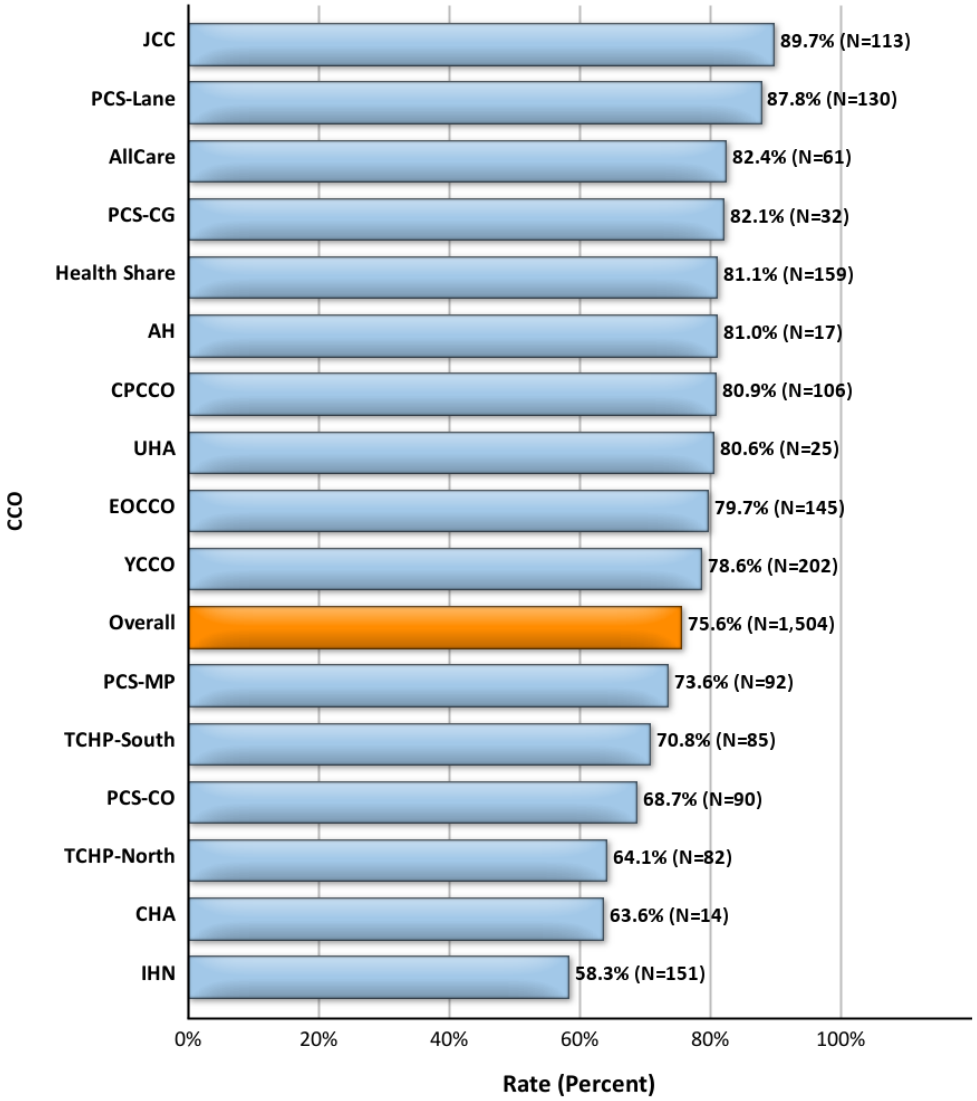


Figure 4-4—PCD Response Rates

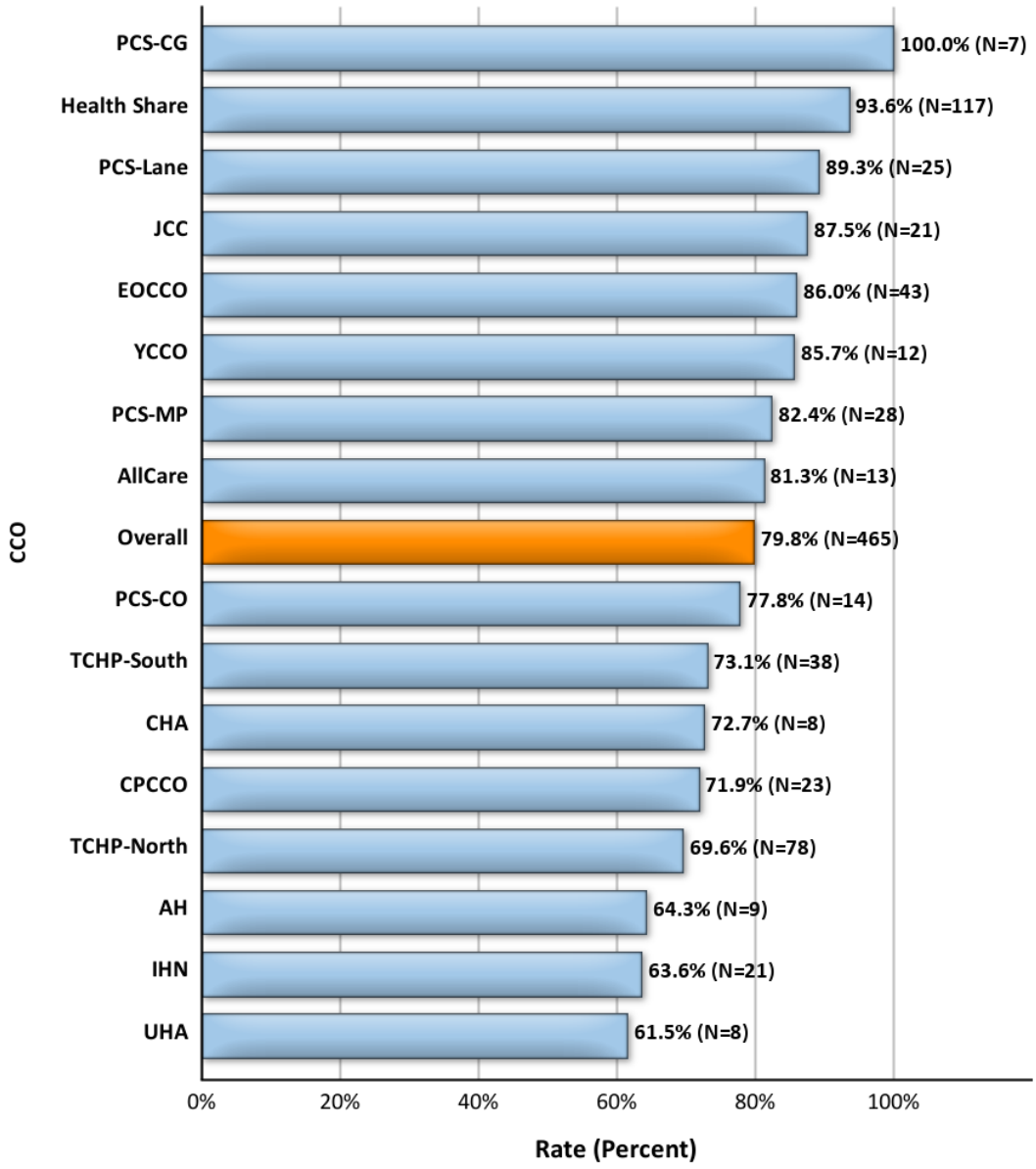
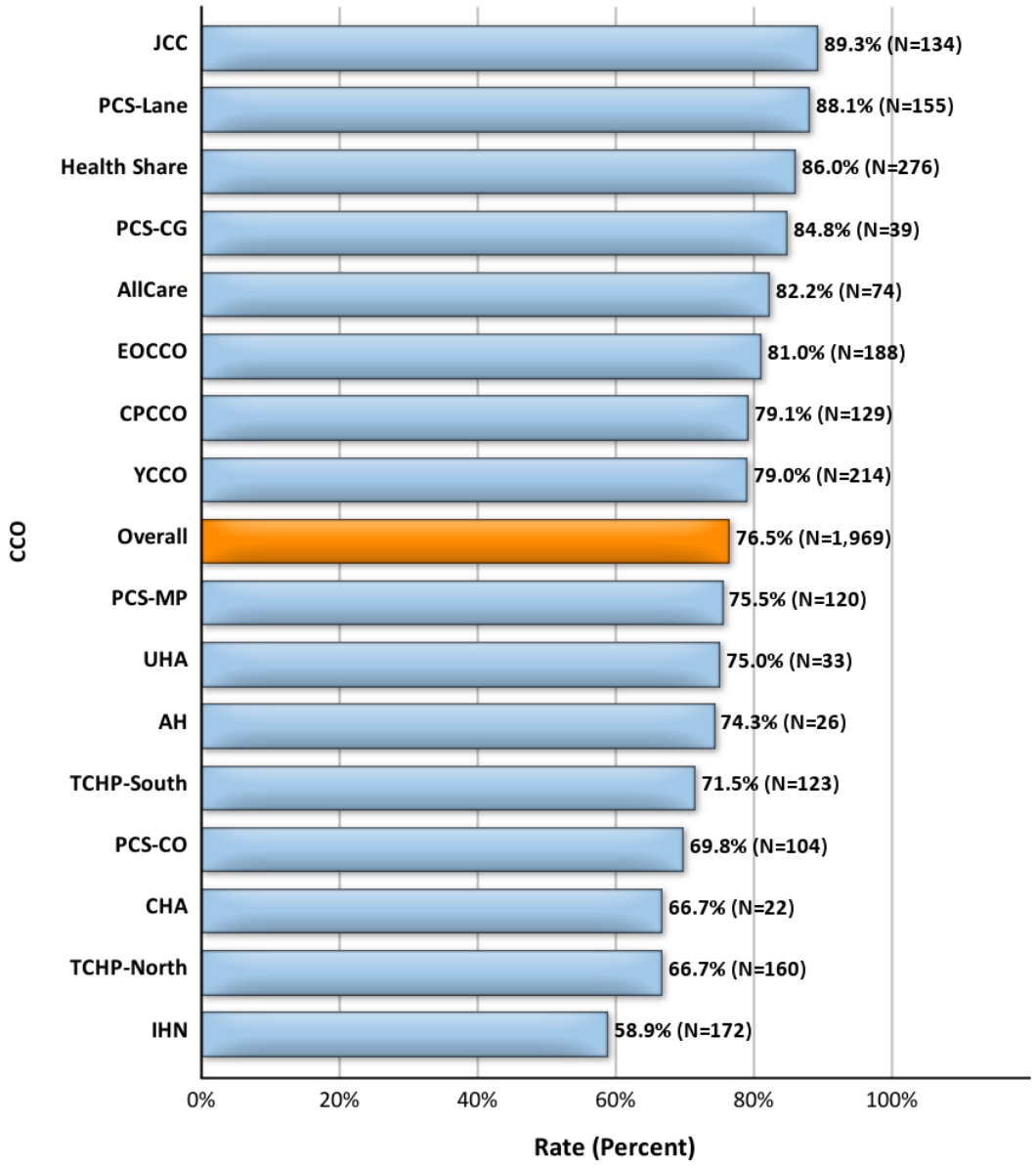


Figure 4-5—Response Rates—Total



Nonresponsive calls were classified into one of two types—i.e., bad phone number or unable to reach. *Bad phone numbers* included nonresponse reasons related to reaching a disconnected number, a fax number, or a nonmedical facility. Survey callers who were connected to a voicemail, received a busy signal or continuous ringing, or were put on hold for an extended hold time (i.e., more than five minutes) resulted in an *unable to reach* nonresponse reason. Overall, the most prevalent nonresponse reasons were associated with reaching a voicemail, disconnected number, or nonmedical facility. Table 4-29 displays the overall survey dispositions and response rates by CCO.

Table 4-29—Survey Dispositions and Response Rates by CCO: Total Outreach Calls

CCO	Sampled Cases	Respondents	Bad Phone Number	Unable to Reach	Response Rate
Overall	**2,573**	**1,969**	**241**	**363**	**76.5%**
AH	35	26	2	7	74.3%
AllCare	90	74	9	7	82.2%
CHA	33	22	6	5	66.7%
CPCCO	163	129	1	33	79.1%
EOCCO	232	188	24	20	81.0%
Health Share	321	276	26	19	86.0%
IHN	292	172	45	75	58.9%
JCC	150	134	3	13	89.3%
PCS-CO	149	104	22	23	69.8%
PCS-CG	46	39	3	4	84.8%
PCS-Lane	176	155	15	6	88.1%
PCS-MP	159	120	12	27	75.5%
TCHP-North	240	160	25	55	66.7%
TCHP-South	172	123	24	25	71.5%
UHA	44	33	0	11	75.0%
YCCO	271	214	24	33	79.0%

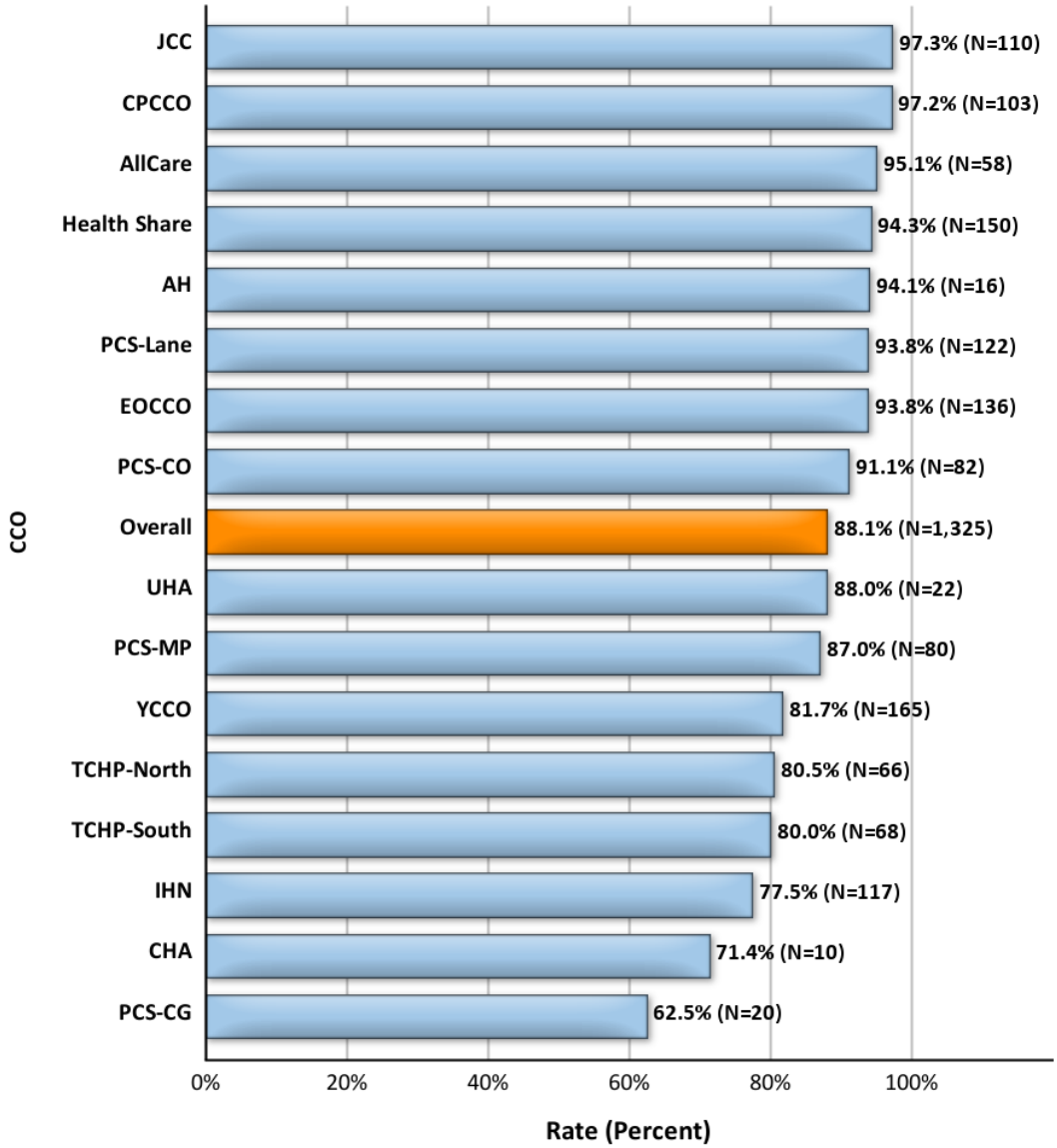
Provider Data Accuracy

The following charts reflect the accuracy of key data elements along the survey process and display the percentage of cases for which provider data were validated.

Correct Location

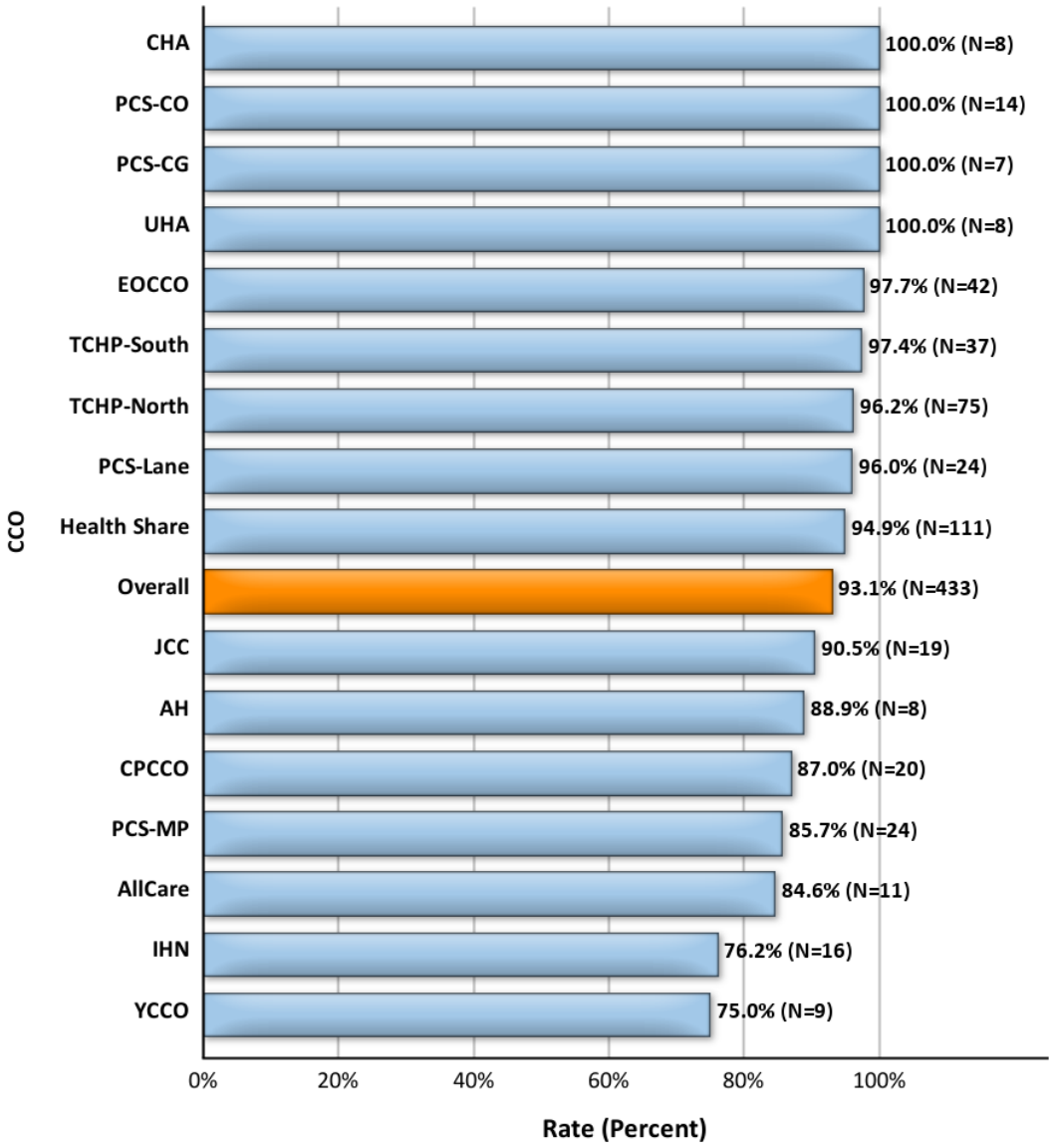
Figure 4-6 through Figure 4-8 illustrate, by specialty category and CCO, the number and percentage of survey respondents who reported that the CCOs' provider data reflected the correct location out of all cases reached.

Figure 4-6—PCP Respondents With the Correct Location



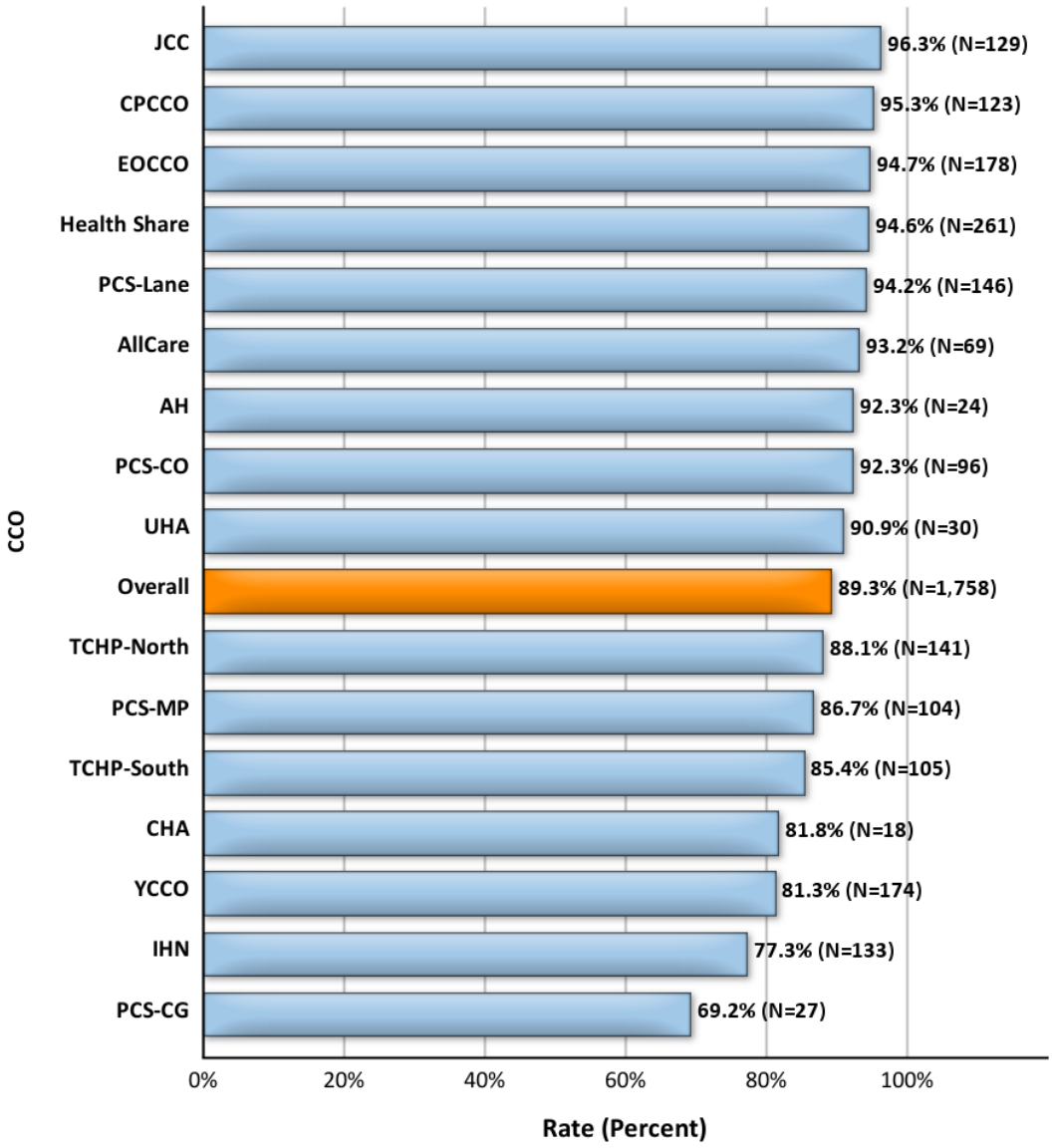
Note: "N" represents the numerator for the measure.

Figure 4-7—PCD Respondents With the Correct Location



Note: "N" represents the numerator for the measure.

Figure 4-8—Respondents With the Correct Location—Total

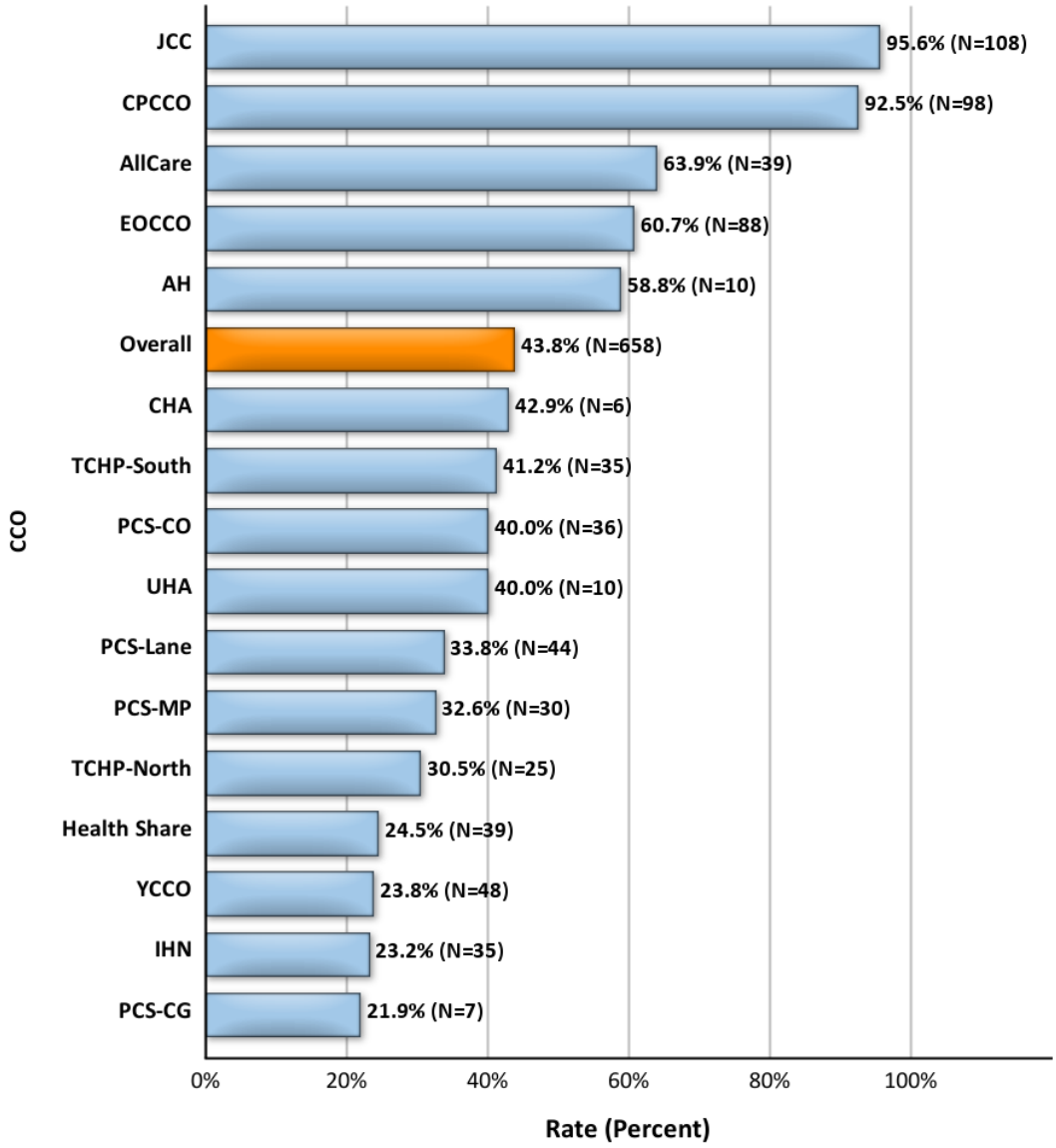


Note: "N" represents the numerator for the measure.

Offering Requested Services

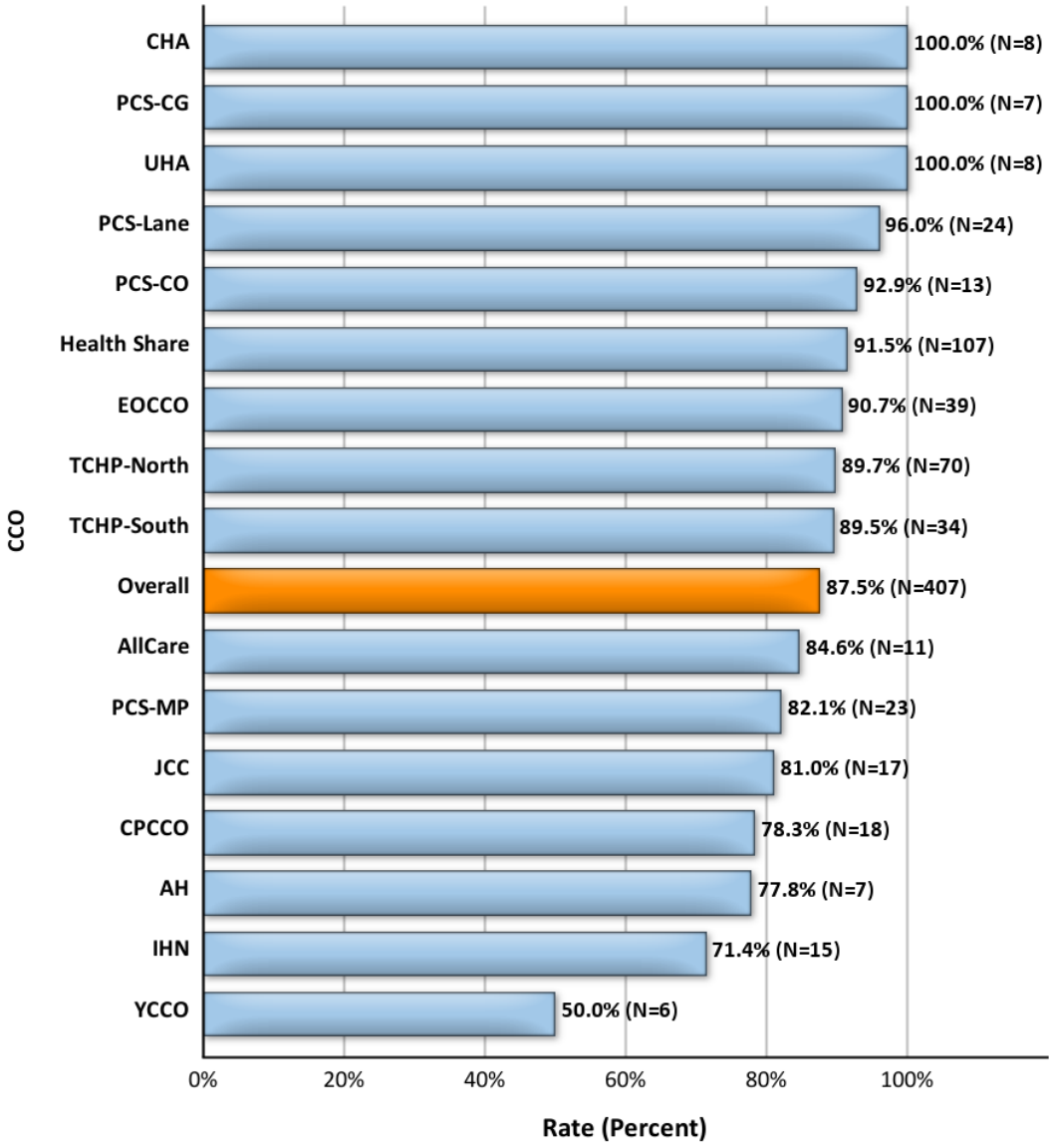
Figure 4-9 through Figure 4-11 display, by specialty category and CCO, the number and percentage of survey respondents with a verified location that offered the requested services out of all cases reached.

Figure 4-9—Verified PCP Locations That Offered the Requested Services



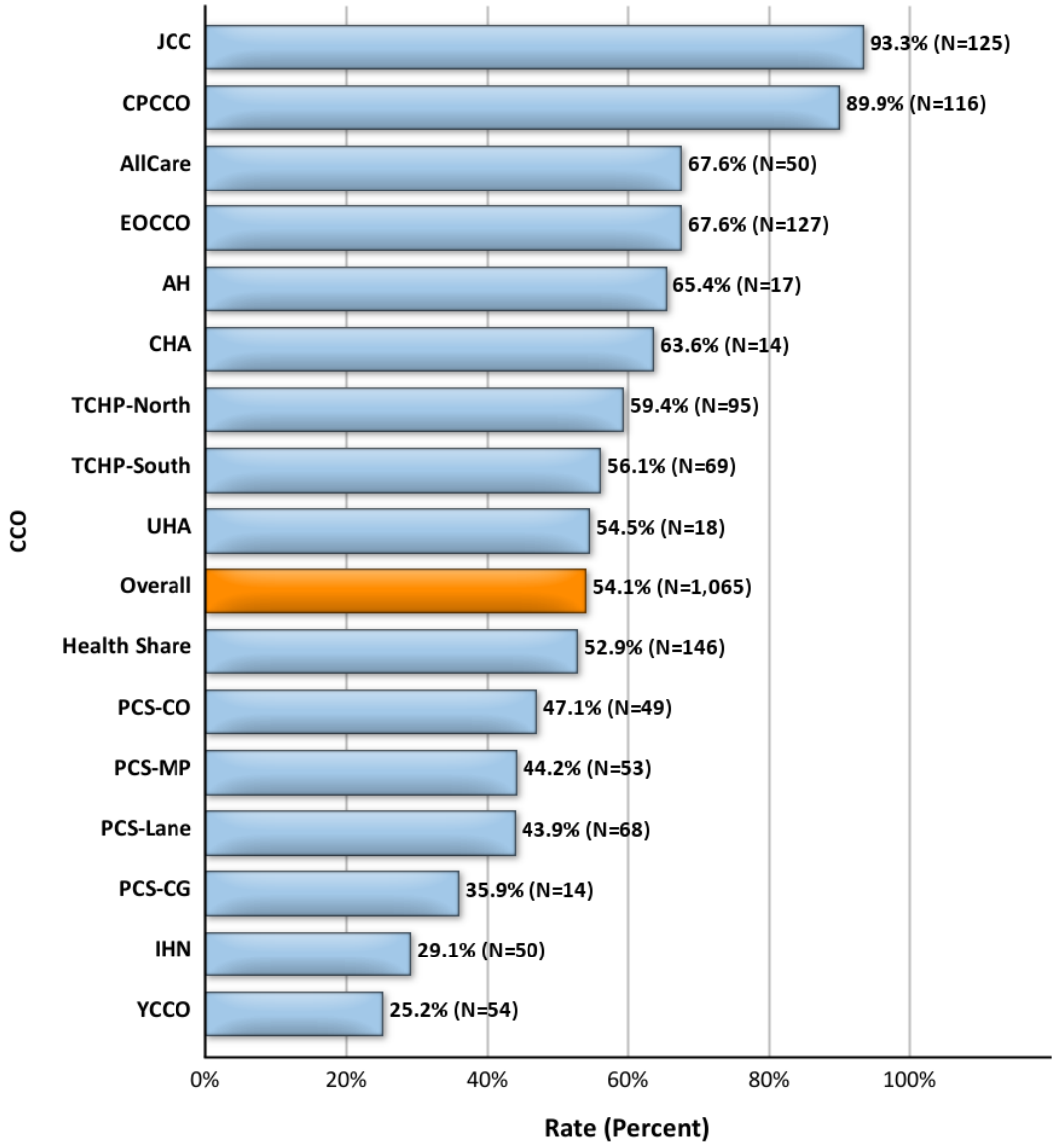
Note: "N" represents the numerator for the measure.

Figure 4-10—Verified PCD Locations That Offered the Requested Services



Note: "N" represents the numerator for the measure.

Figure 4-11—Verified Locations That Offered the Requested Services—Total

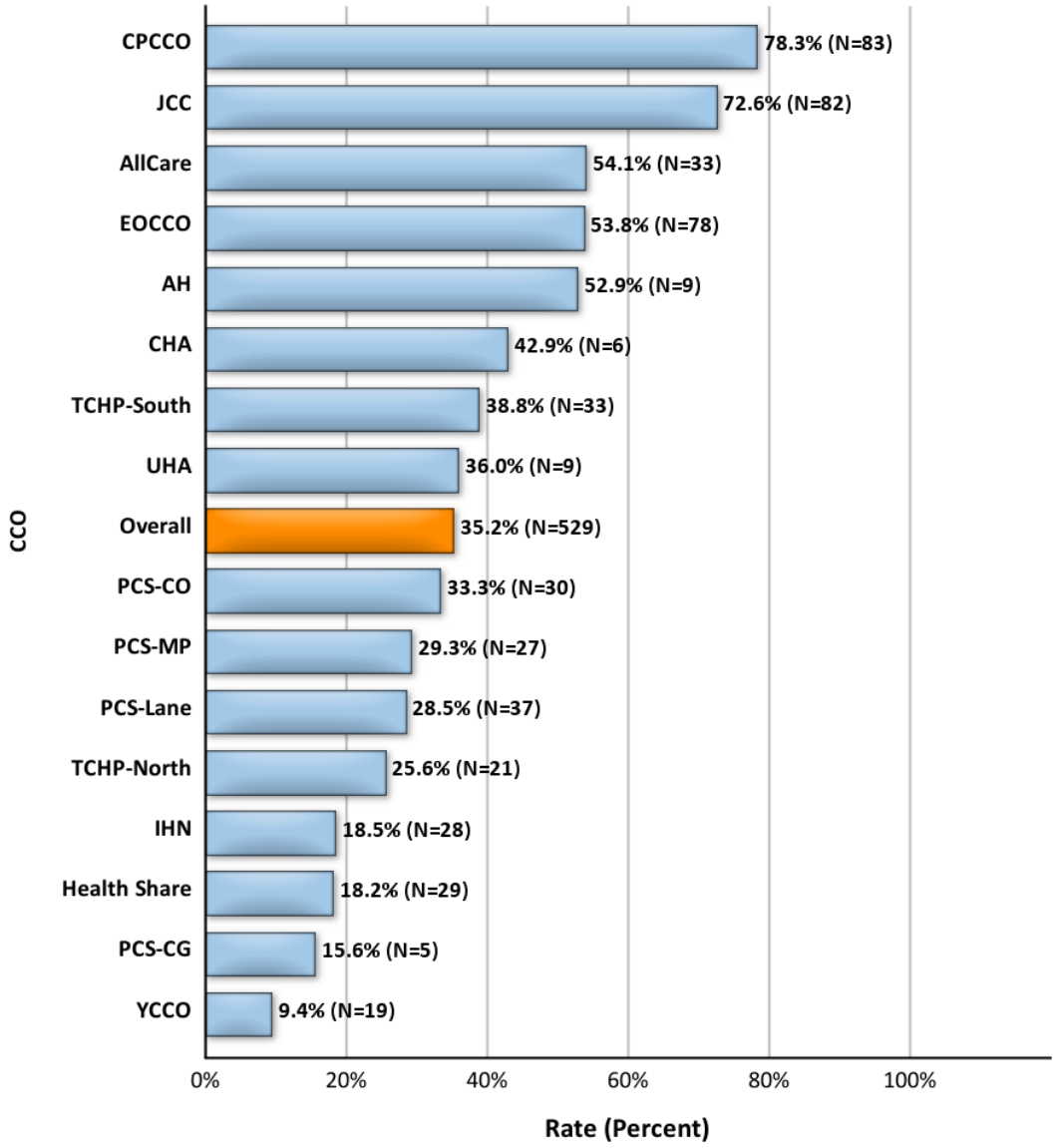


Note: "N" represents the numerator for the measure.

OHP Acceptance

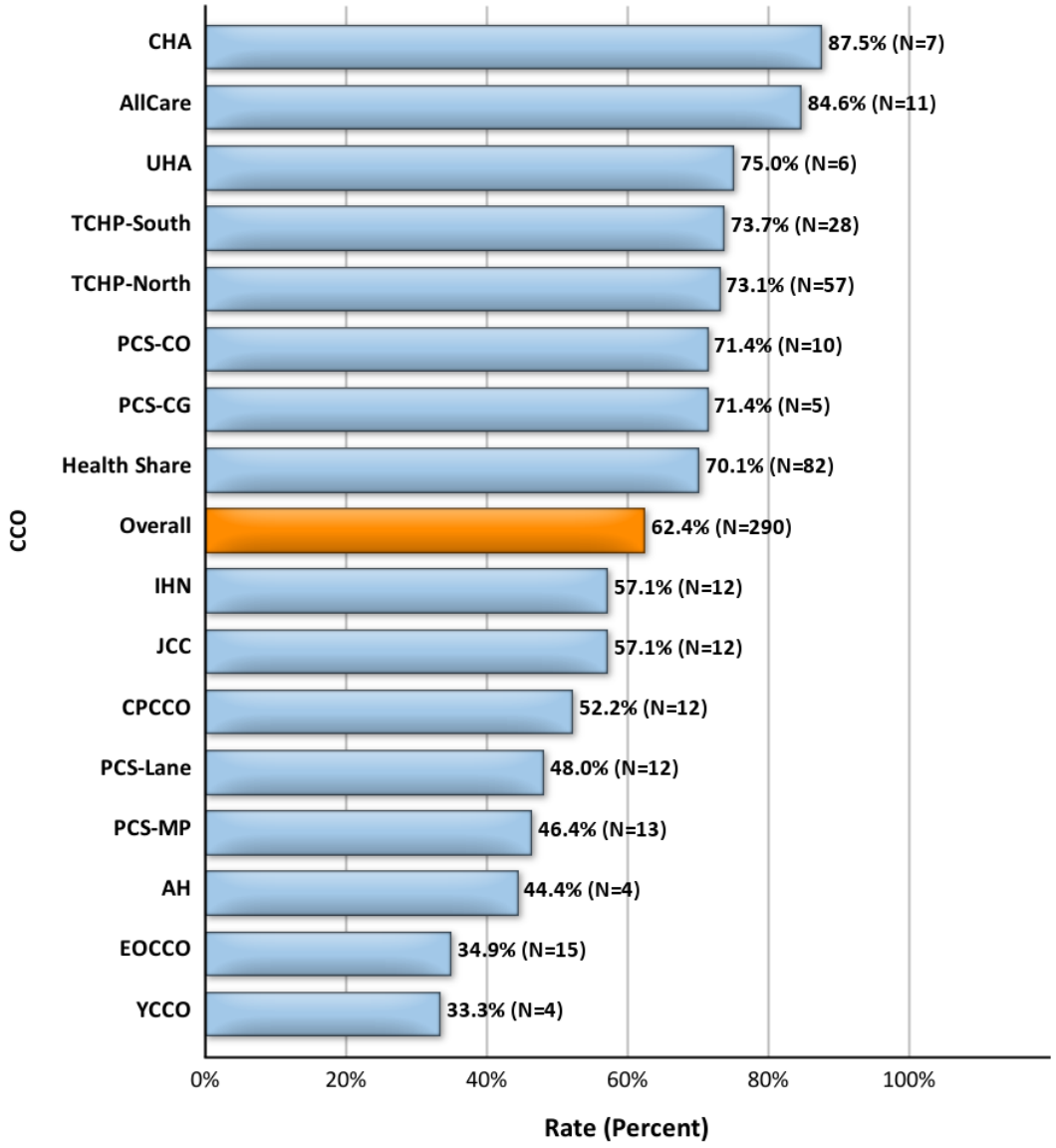
Figure 4-12 through Figure 4-14 display, by specialty category and CCO, the number and percentage of survey respondents with a verified location offering the requested services that accepted OHP out of all cases reached.

Figure 4-12—Verified PCP Locations That Offered Requested Services and Accepted OHP



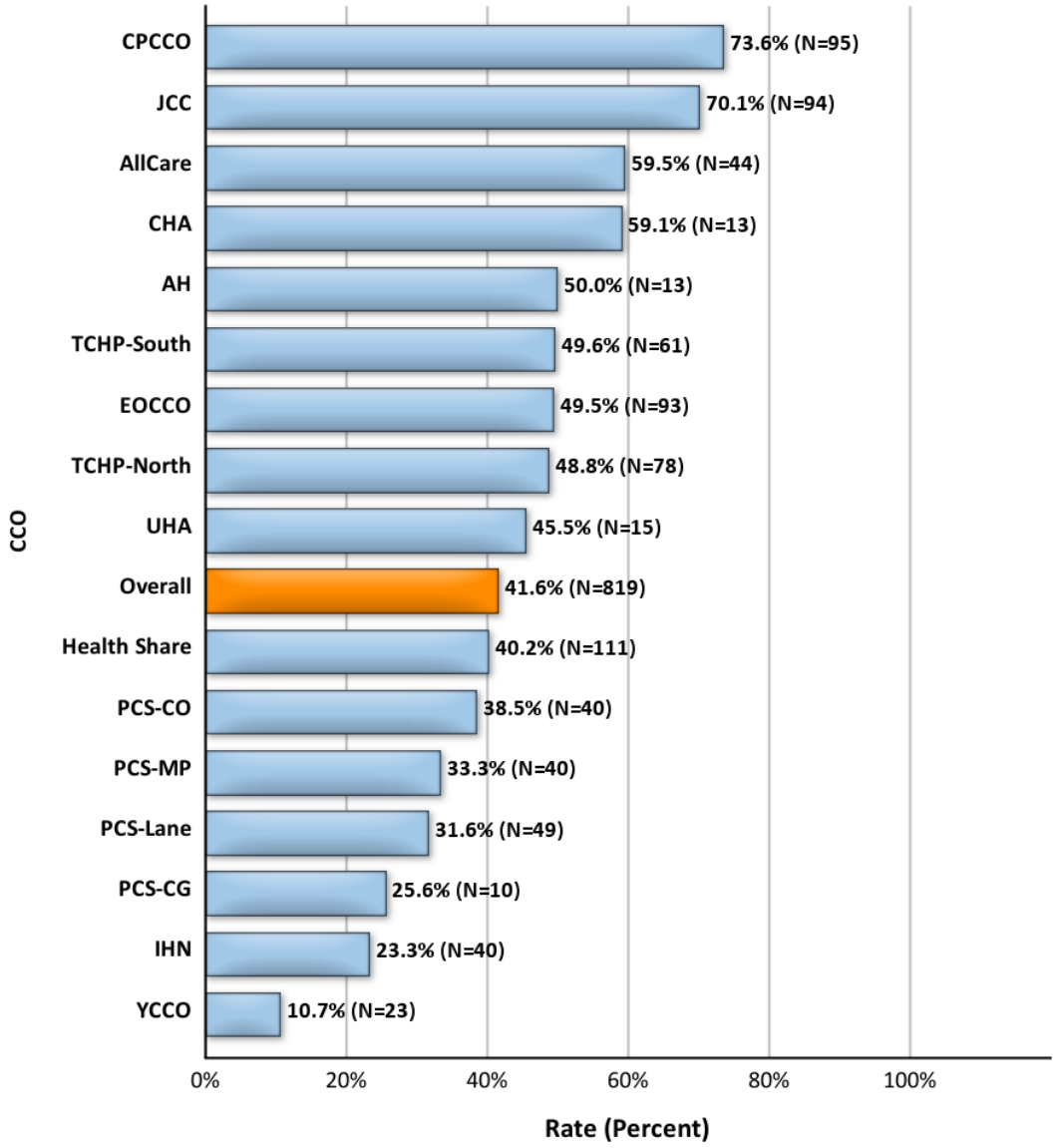
Note: "N" represents the numerator for the measure.

Figure 4-13—Verified PCD Locations That Offered Requested Services and Accepted OHP



Note: "N" represents the numerator for the measure.

Figure 4-14—Verified Locations That Offered Requested Services and Accepted OHP—Total

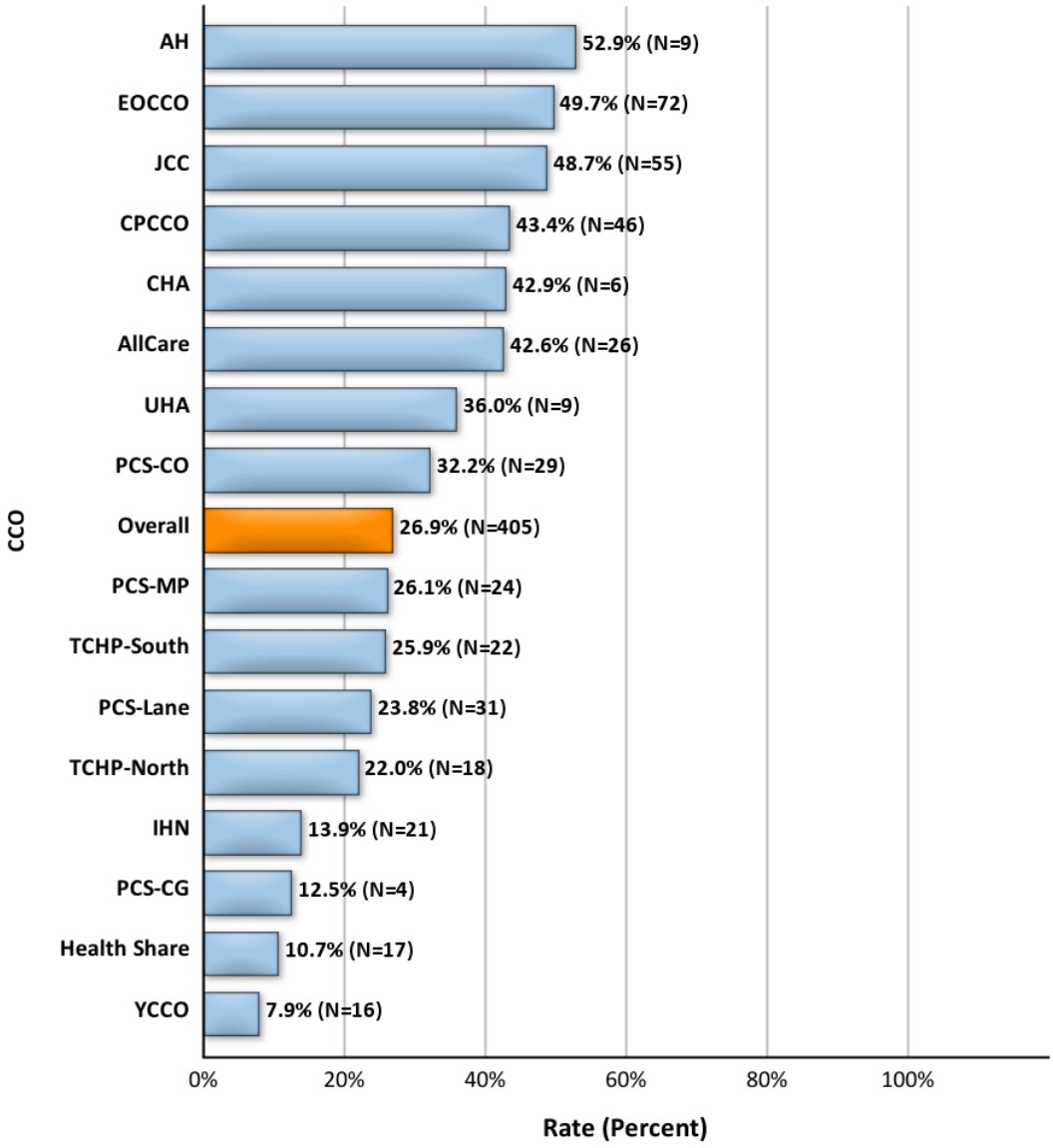


Note: "N" represents the numerator for the measure.

CCO Acceptance

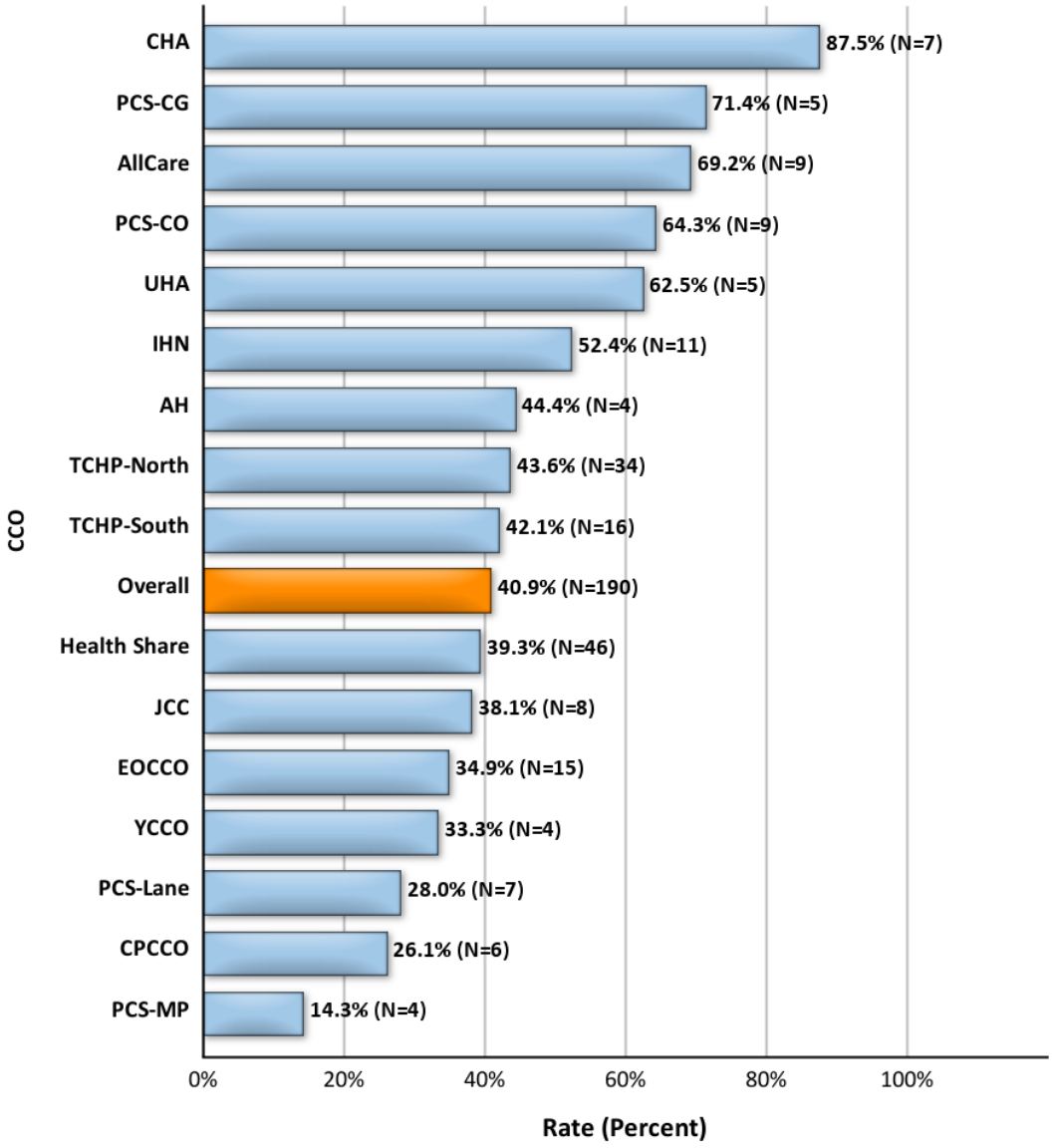
Figure 4-15 through Figure 4-17 display, by specialty category and CCO, the number and percentage of survey respondents with a verified location offering the requested services that accepted OHP and the CCO out of all cases reached.

Figure 4-15—Verified PCP Locations That Offered Requested Services and Accepted OHP and the CCO



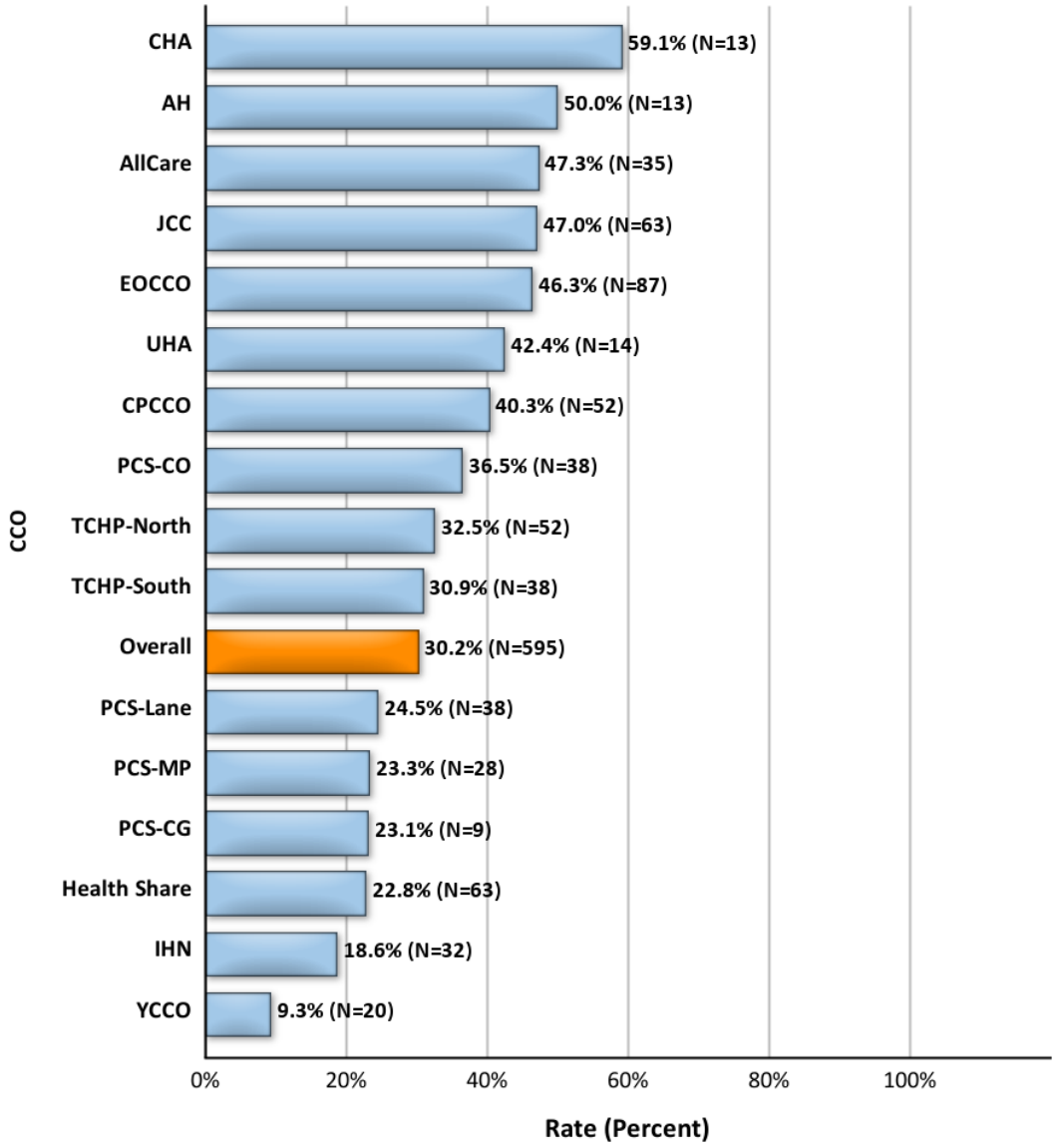
Note: "N" represents the numerator for the measure.

Figure 4-16—Verified PCD Locations That Offered Requested Services and Accepted OHP and the CCO



Note: "N" represents the numerator for the measure.

Figure 4-17—Verified Locations That Offered Requested Services and Accepted OHP and the CCO—Total



Note: "N" represents the numerator for the measure.

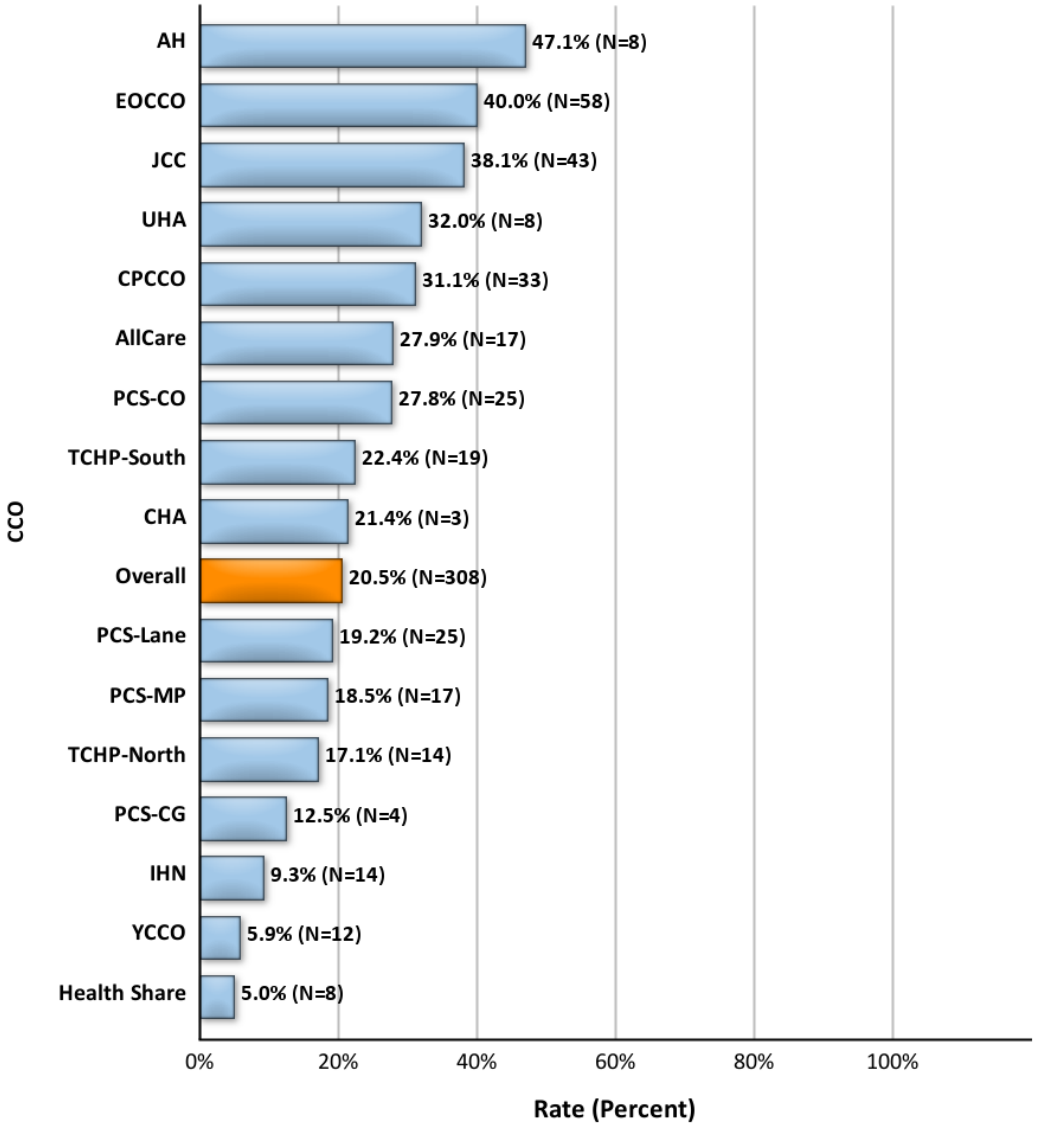
Access and Availability

The following charts reflect members' access to services and display the percentage of cases that resulted in obtaining appointment availability among providers accepting new patients.

New Patient Acceptance

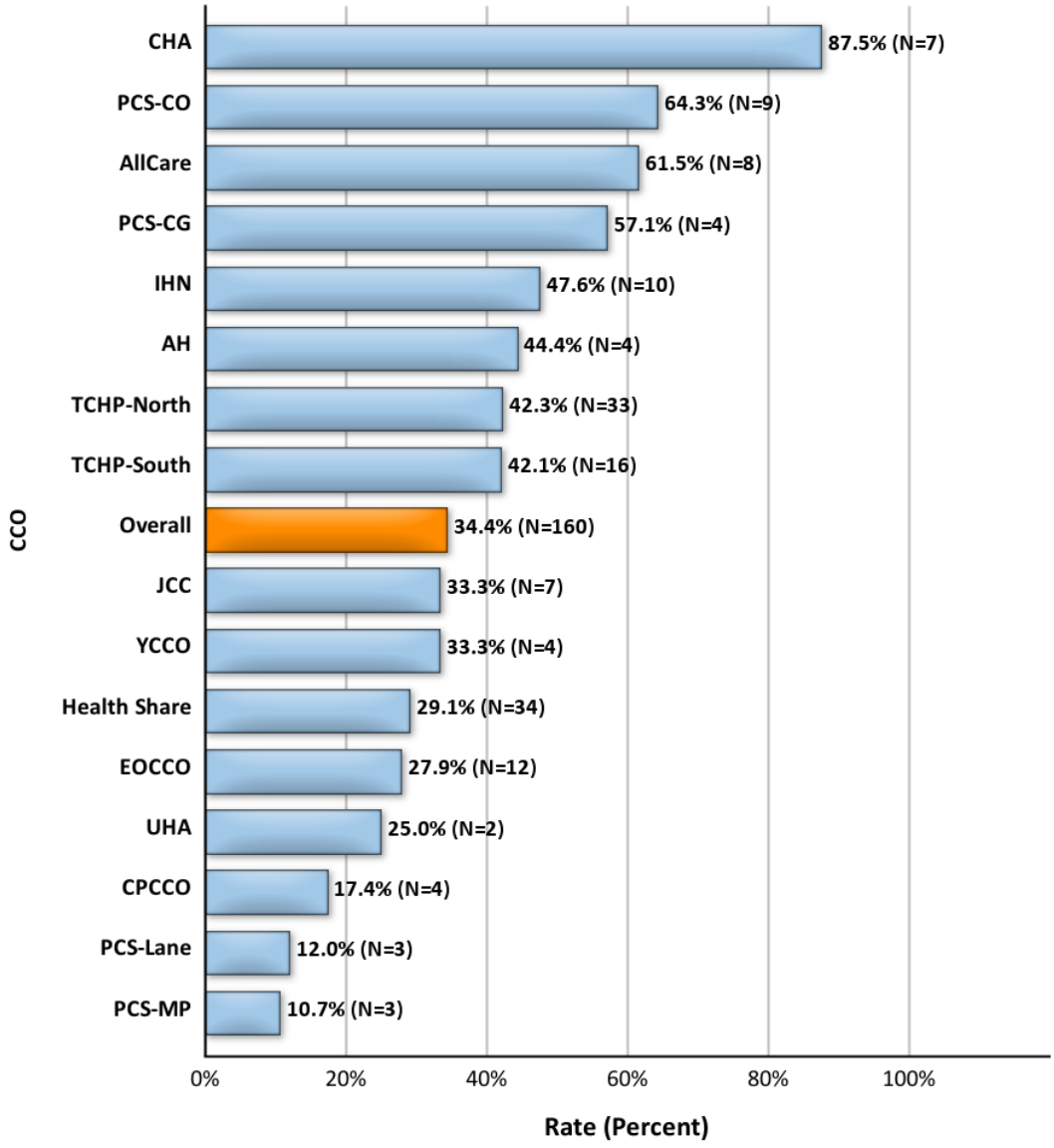
Figure 4-18 through Figure 4-20 display, by specialty category and CCO, the number and percentage of survey respondents with a verified location offering the requested services that accepted OHP and the CCO, and accepted new patients out of all cases reached.

Figure 4-18—Verified PCP Locations That Offered Requested Services, Accepted OHP and the CCO, and Accepted New Patients



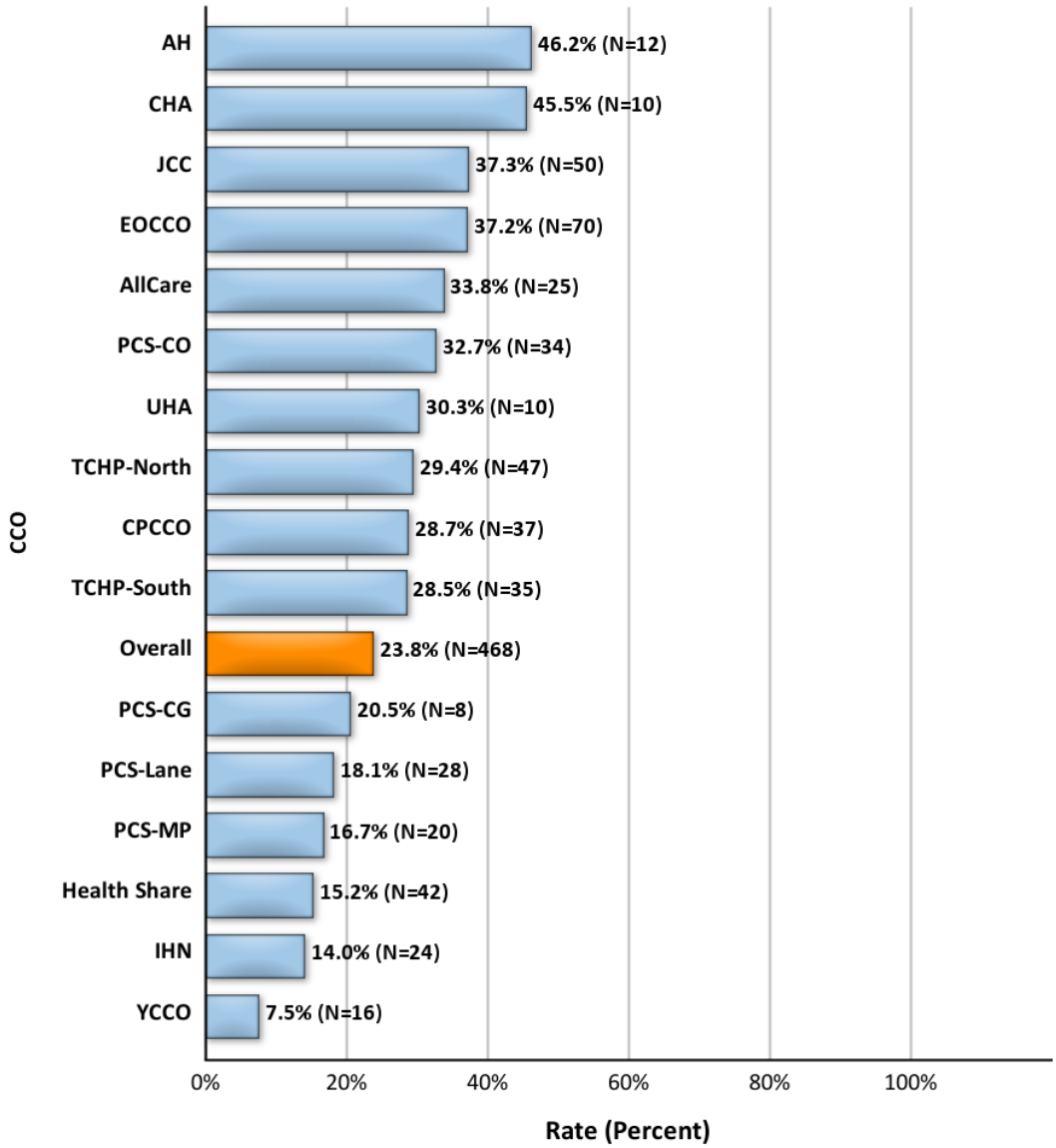
Note: "N" represents the numerator for the measure.

Figure 4-19—Verified PCD Locations That Offered Requested Services, Accepted OHP and the CCO, and Accepted New Patients



Note: "N" represents the numerator for the measure.

Figure 4-20—Verified Locations That Offered Requested Services, Accepted OHP and the CCO, and Accepted New Patients—Total

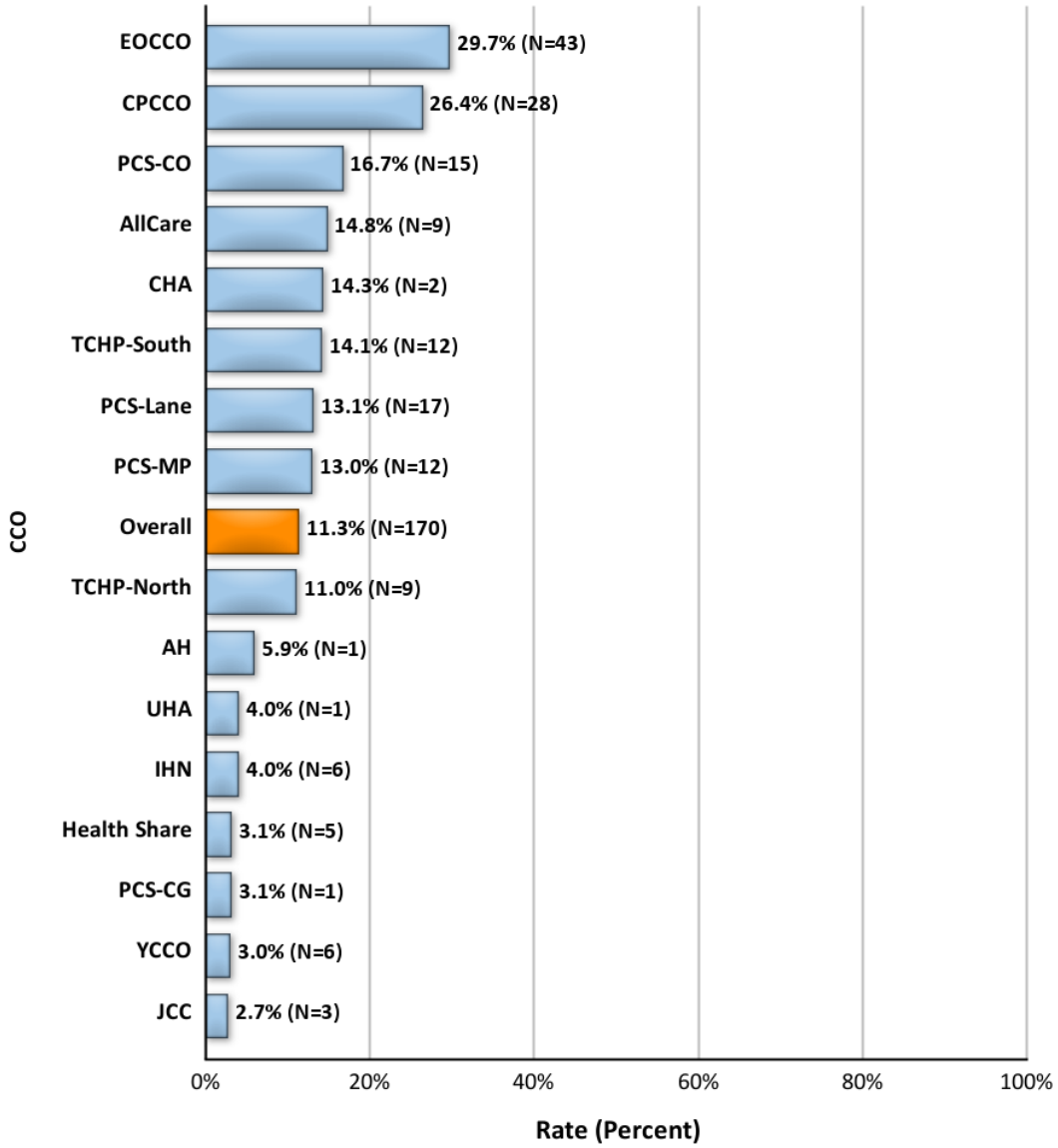


Note: "N" represents the numerator for the measure.

New Patient Appointment Availability

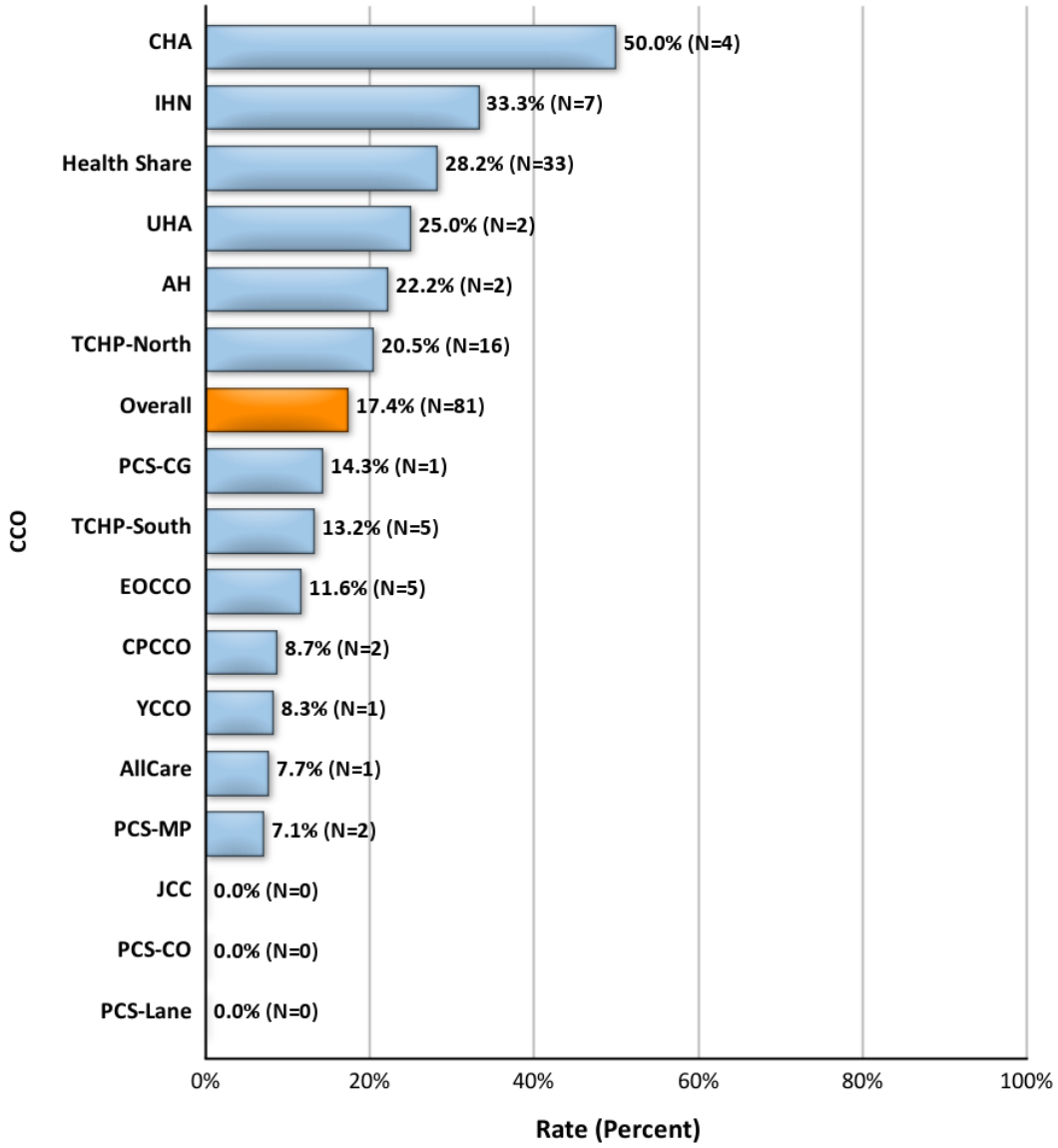
Figure 4-21 through Figure 4-23 display, by specialty category and CCO, the number and percentage of survey respondents with a verified location offering the requested services that accepted OHP and the CCO, accepted new patients, and offered an appointment out of all cases reached.

Figure 4-21—New Patient Appointment Availability for Verified PCP Locations That Offered Requested Services, and Accepted OHP and the CCO



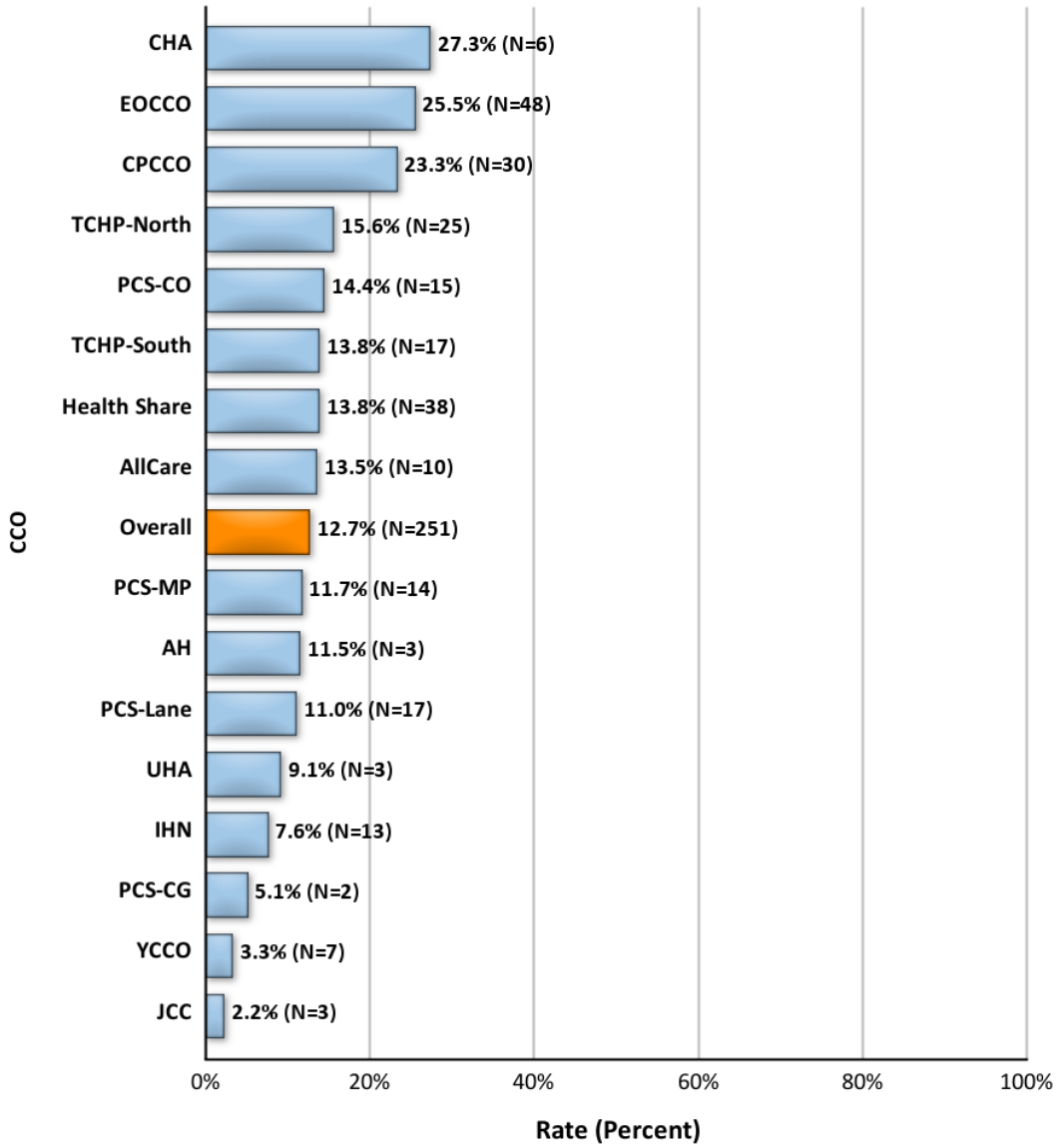
Note: "N" represents the numerator for the measure.

Figure 4-22—New Patient Appointment Availability for Verified PCD Locations That Offered Requested Services, and Accepted OHP and the CCO



Note: "N" represents the numerator for the measure.

Figure 4-23—New Patient Appointment Availability for Verified Locations That Offered Requested Services, and Accepted OHP and the CCO—Total



Note: "N" represents the numerator for the measure.

While callers did not specifically ask survey respondents about factors limiting the ability to schedule appointments, any additional information captured by the callers was categorized and presented below. In some cases, these limitations, or conditions, must be met to schedule an appointment but did not prevent the caller from documenting the first available appointment. Conditional factors limiting the scheduling of appointments included, but were not limited to, the following:

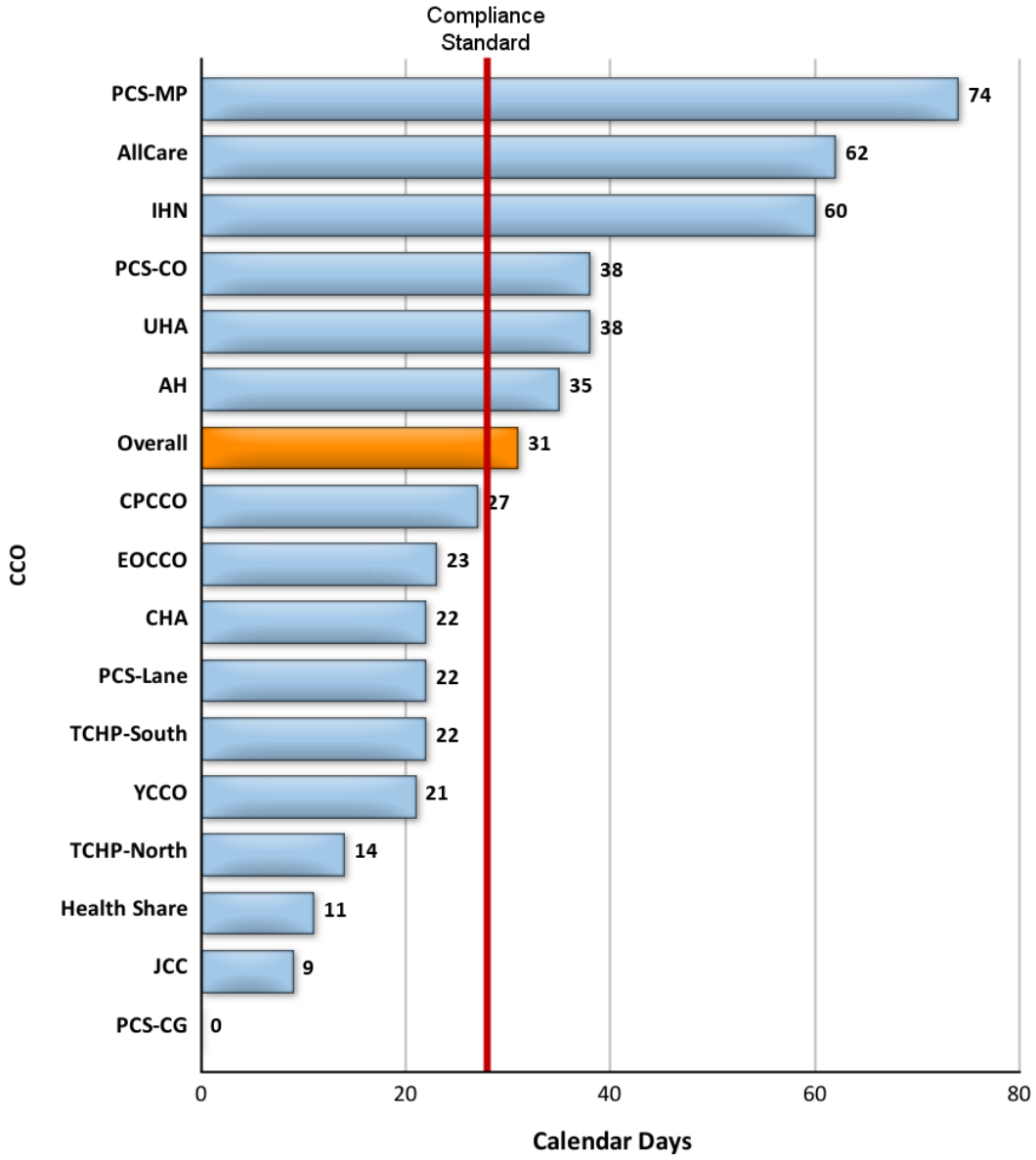
- Pre-registration requirements or providing personal information.
- Medicaid eligibility verification.
- Completion of questionnaire/interview.
- Requiring a review of member's medical record or initial evaluation.
- The unavailability of office location schedule or calendar.
- Requiring patients to live in a particular area.
- Limiting appointments to specific age groups.

Office locations may have applied multiple requirements and limitations that affected members' access to care, including the ability to obtain appointment availability. The most prevalent factors reported by survey respondents were requiring members to pre-register or provide personal information (154 office locations), the scheduling calendar being unavailable (44 office locations), and completion of a questionnaire or interview (28 office locations).

Appointment Wait Times

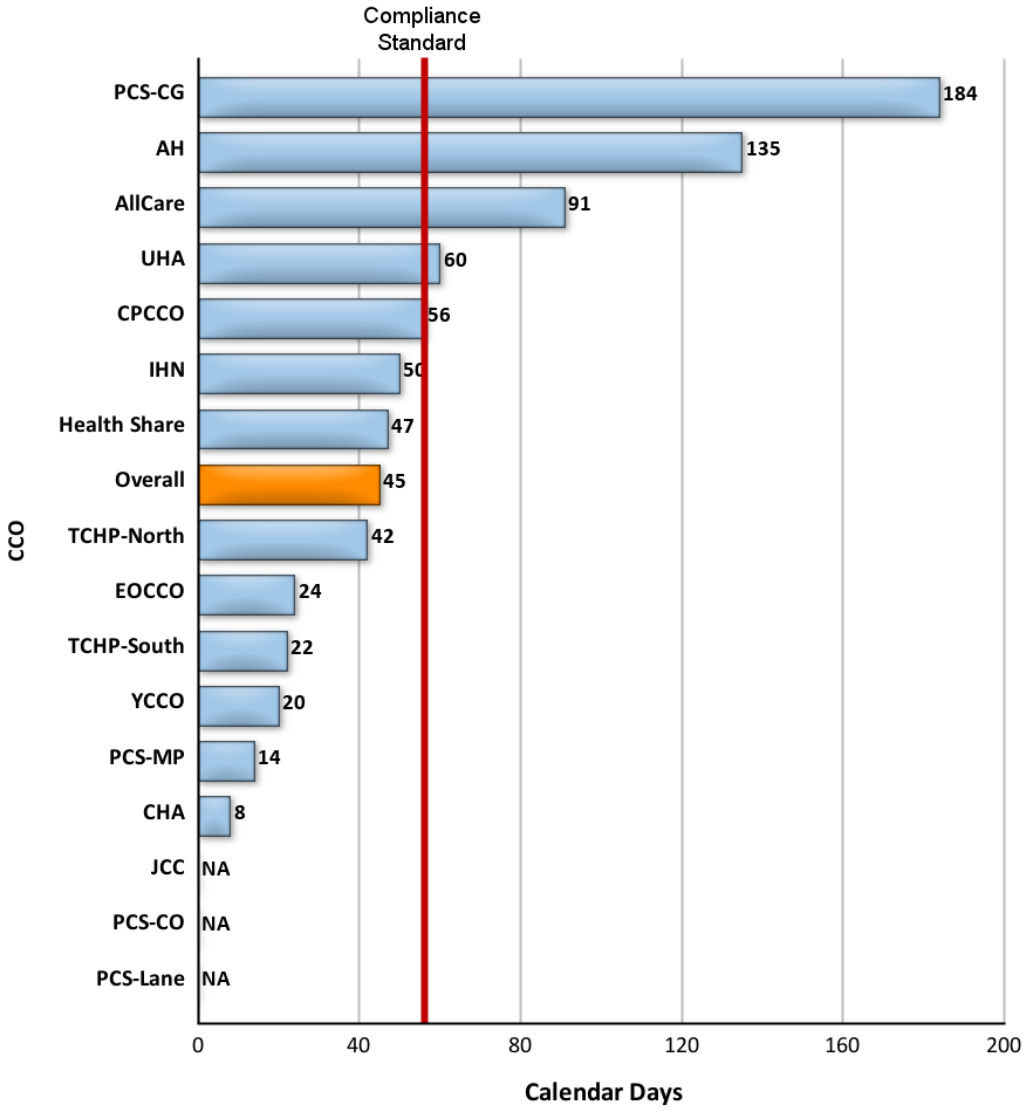
The CCOs must have policies and procedures in place to ensure the scheduling of appointments is reasonable. For PCPs, members should be treated, or referred, within four weeks (or 28 calendar days) for well-care visits. Figure 4-24 displays the average wait times, in calendar days, for verified locations offering the requested services that accepted OHP and the CCO, and offered an appointment to new patients for a nonurgent or routine PCP visit.

Figure 4-24—Average Wait Times to First Available Appointment—PCP Visits



For PCDs, members should be treated, or referred, within eight weeks (or 56 calendar days) for routine dental visits, unless there is a documented clinical reason that makes a period of longer than eight weeks appropriate. Figure 4-25 displays the average wait times, in calendar days, for verified locations offering the requested services that accepted OHP and the CCO, and offered an appointment to new patients for a nonurgent or routine PCD visit.

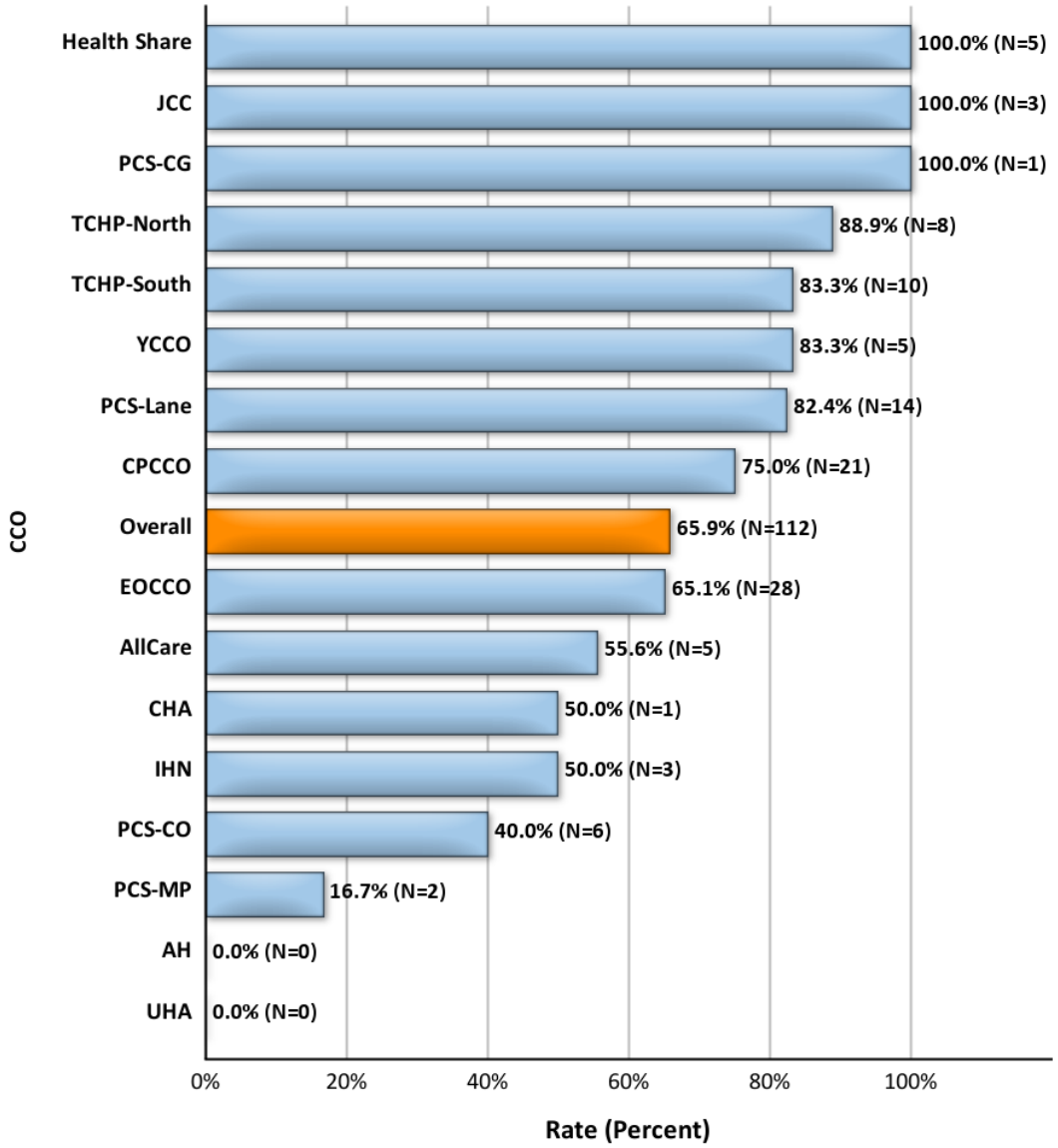
Figure 4-25—Average Wait Times to First Available Appointment—PCD Visits



Note: "NA" indicates that none of the CCO's survey respondents offered an appointment.

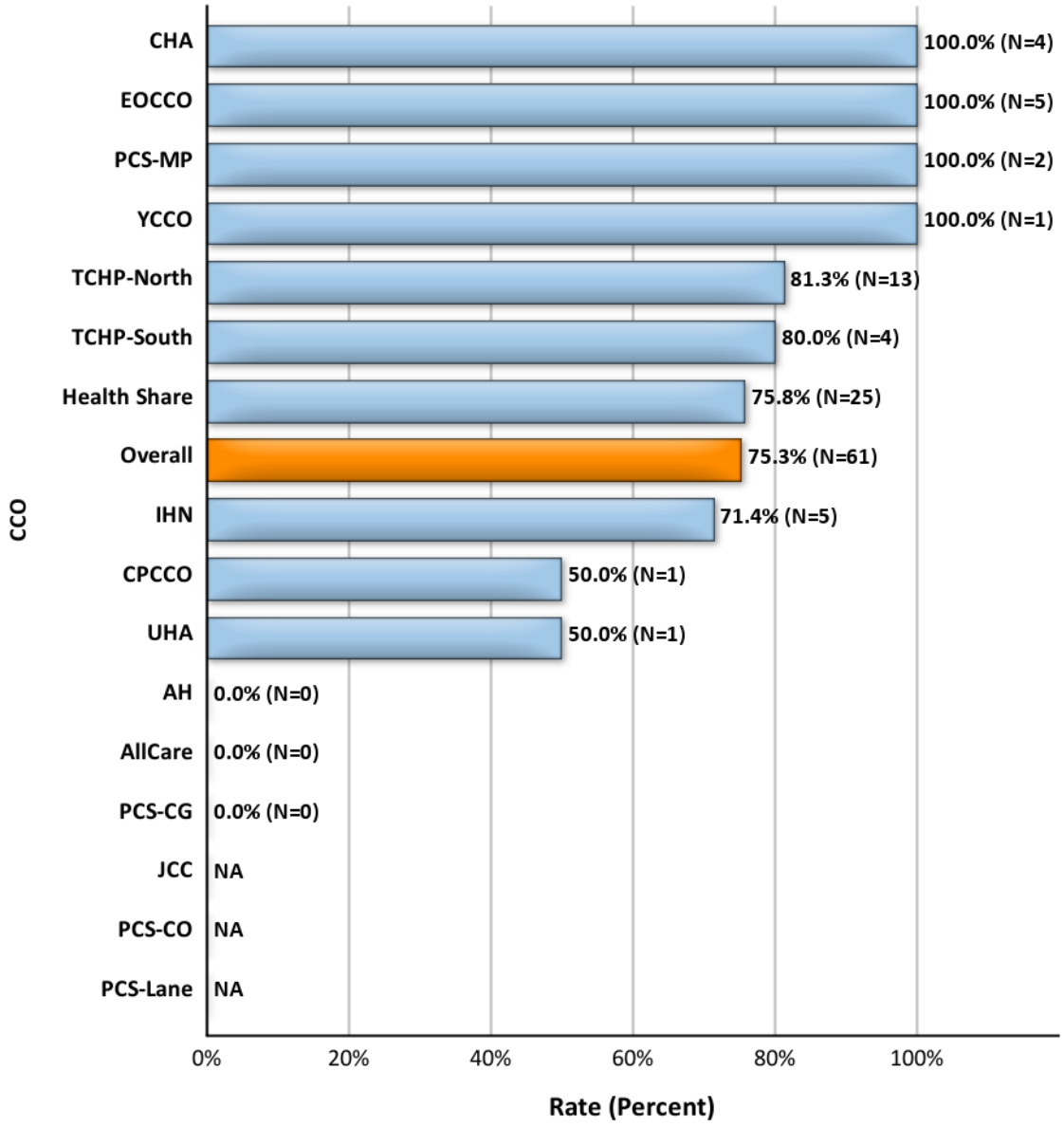
Figure 4-26 and Figure 4-27 display the percentage of appointments in compliance with the appointment availability compliance standards for routine primary care visits to PCPs (i.e., four weeks or 28 calendar days) and for routine dental visits to PCDs (i.e., eight weeks or 56 calendar days), respectively. The denominator was based on survey respondents with a verified location offering the requested services that accepted OHP and the CCO, accepted new patients, and offered an appointment.

Figure 4-26—Percentage of PCP Appointments Meeting Appointment Availability Standards



Note: "N" represents the numerator for the measure.

Figure 4-27—Percentage of PCD Appointments Meeting Appointment Availability Standards



Notes:

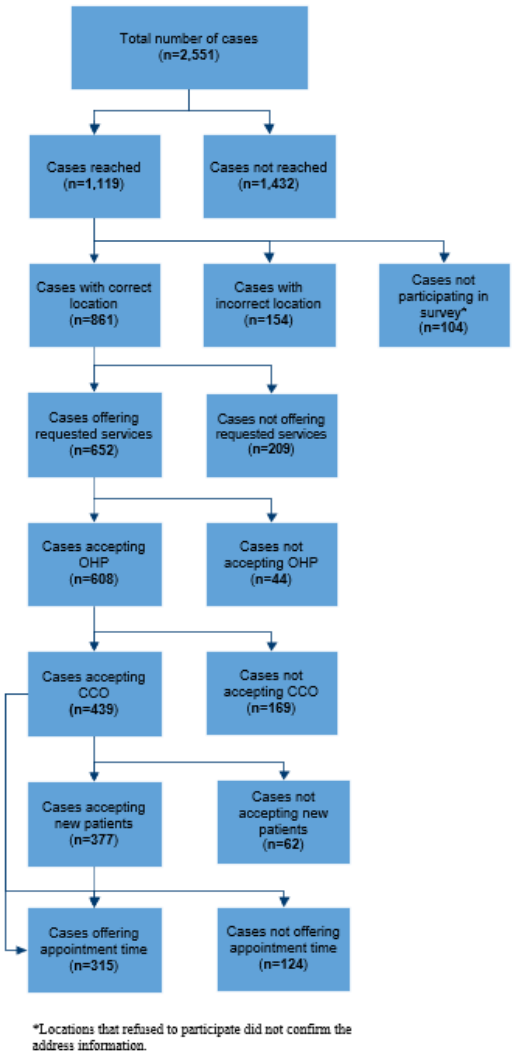
- "N" represents the numerator for the measure.
- "NA" indicates that none of the CCO's survey respondents offered an appointment.

Revealed Telephone Survey Results

This section presents the revealed telephone survey results in aggregate and by CCO for study indicators related to provider data accuracy and appointment availability. The survey results include in a series of bar charts and tables displaying CCO performance relative to other CCOs and overall CCO aggregate performance. Across each measure, the CCOs are ranked based on performance from the highest to lowest rate.

Figure 4-28 illustrates the flow of data collection during the survey calls, as well as the total number of cases with each potential survey outcome.

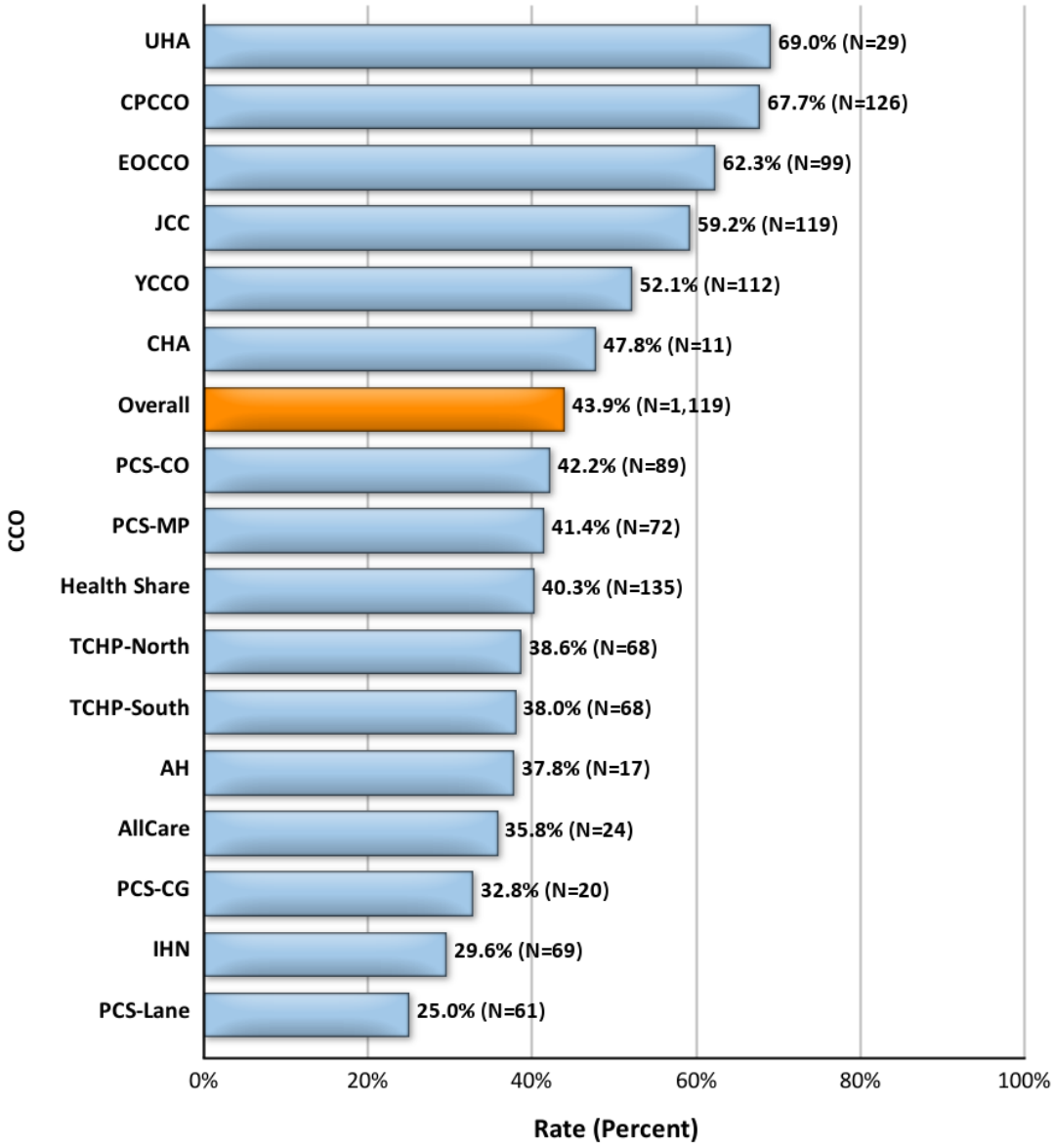
Figure 4-28—Revealed Telephone Survey Data Collection Process and Case Outcomes



Response Rates

Survey callers attempted to contact each survey case up to two times during standard business hours on different days and times of day; a case that could not be contacted was considered nonresponsive. Figure 4-29 illustrates the survey response rates by CCO. "N" represents the number of cases resulting in successful contact (cases reached), or the numerator, for the measure. The denominator includes all cases sampled.

Figure 4-29—Response Rates



Nonresponsive calls were classified into one of three types—i.e., bad phone number, unable to reach, or refusals. *Bad phone number* included nonresponse reasons related to reaching a disconnected number, a

fax number, or a nonmedical facility. Survey callers who were connected to a voicemail, received a busy signal or continuous ringing, or were put on hold for an extended time (i.e., more than five minutes) resulted in an *unable to reach* nonresponse reason. Sampled cases contacted, but who refused to participate in the survey, were categorized as *refusals* but were included as respondents in the response rate. Overall, the most prevalent non-response reasons were reaching a voicemail, disconnected number, and nonmedical facility. Table 4-30 displays the detailed survey dispositions and response rates by CCO.

Table 4-30—Survey Dispositions and Response Rates by CCO

CCO	Sampled Cases	Respondents	Refusals	Bad Phone Number	Unable to Reach	Response Rate
Overall	**2,551**	**1,119**	**104**	**298**	**1,134**	**43.9%**
AH	45	17	0	2	26	37.8%
AllCare	67	24	3	5	38	35.8%
CHA	23	11	0	2	10	47.8%
CPCCO	186	126	3	3	57	67.7%
EOCCO	159	99	13	28	32	62.3%
Health Share	335	135	9	20	180	40.3%
IHN	233	69	0	23	141	29.6%
JCC	201	119	7	7	75	59.2%
PCS-CG	61	20	7	16	25	32.8%
PCS-CO	211	89	22	37	85	42.2%
PCS-Lane	244	61	15	67	116	25.0%
PCS-MP	174	72	1	14	88	41.4%
TCHP-North	176	68	11	15	93	38.6%
TCHP-South	179	68	6	22	89	38.0%
UHA	42	29	1	0	13	69.0%
YCCO	215	112	6	37	66	52.1%

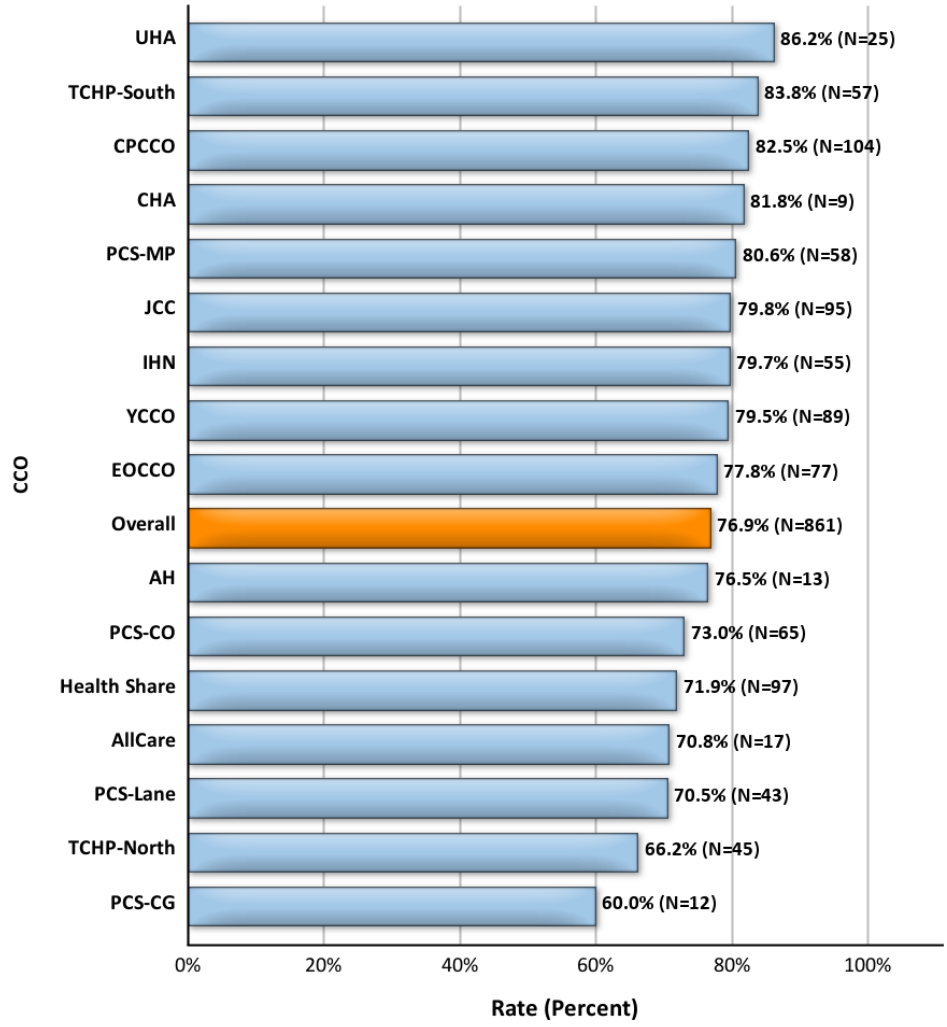
Provider Data Accuracy

The following charts reflect the accuracy of key data elements along the survey process and display the percentage of cases for which provider data were validated.

Correct Location

Figure 4-30 illustrates the number and percentage of survey respondents who reported that the CCO's provider data reflected the correct location out of all respondents, including providers who refused to participate in the survey.

Figure 4-30—Respondents With the Correct Location

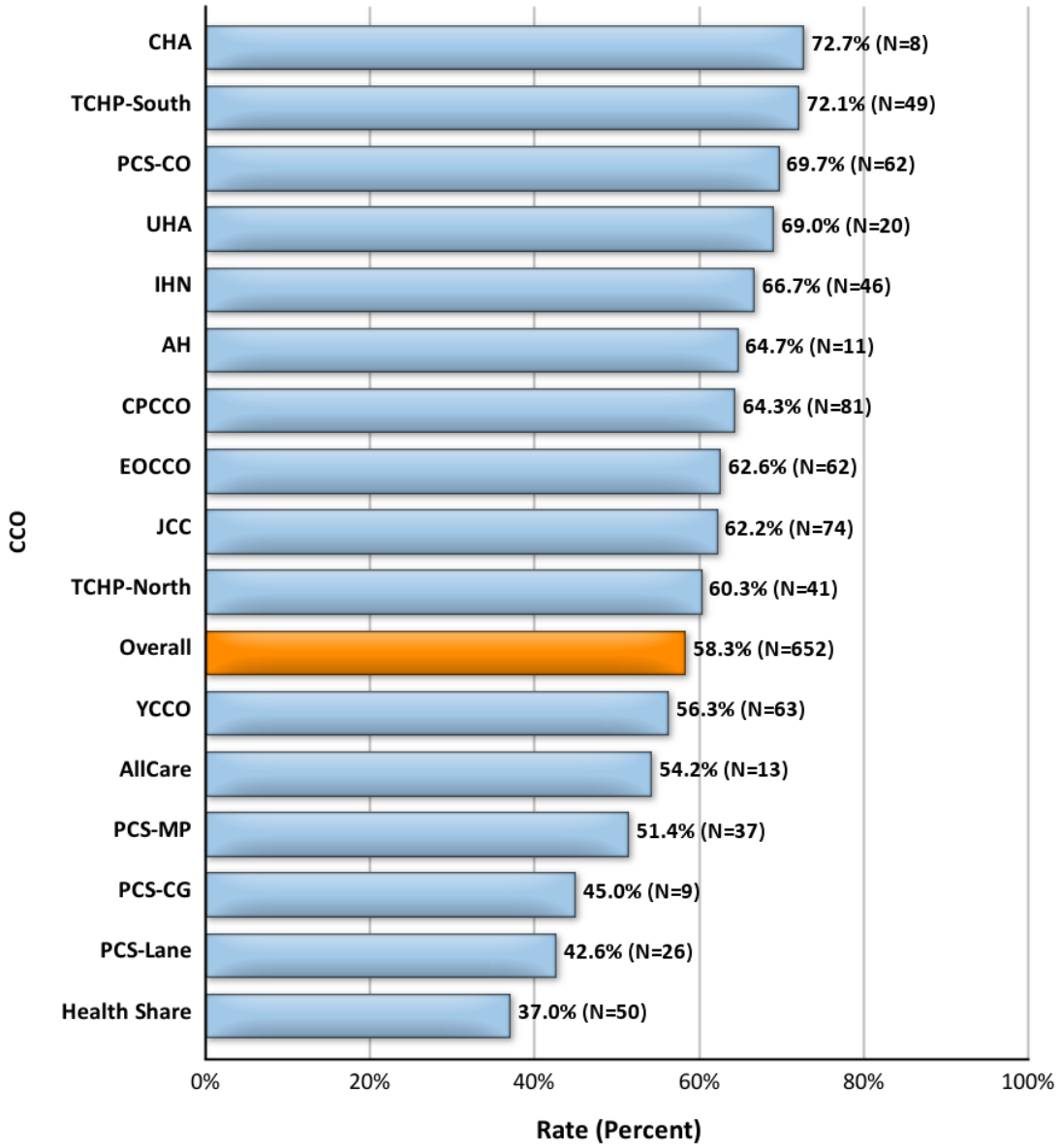


Note: "N" represents the numerator for the measure.

Offering Requested Services

Figure 4-31 displays the number and percentage of survey respondents with a verified location that offered BH or counseling services out of all respondents, including providers who refused to participate in the survey.

Figure 4-31—Verified Locations That Offered the Requested Services

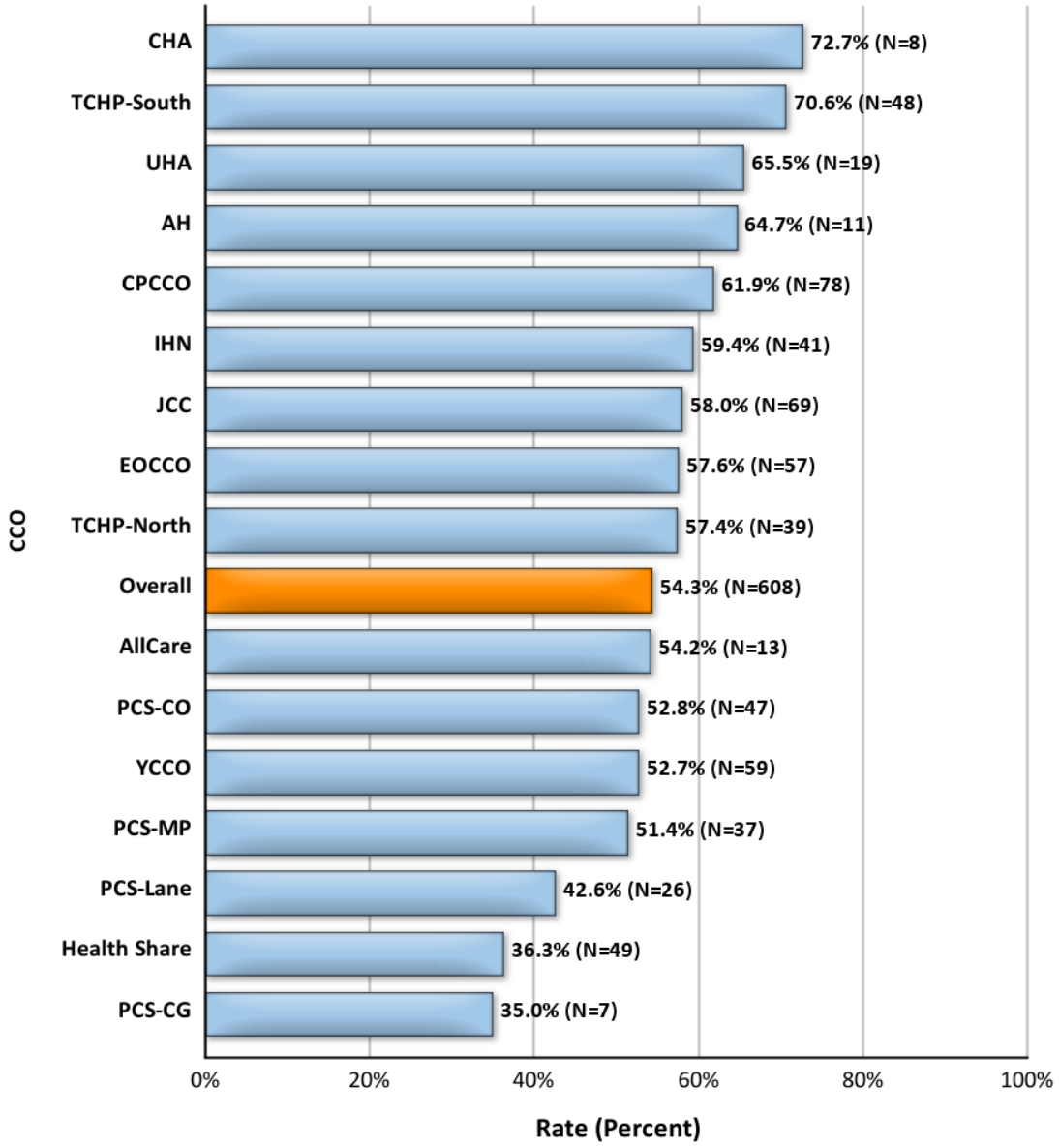


Note: "N" represents the numerator for the measure.

OHP Acceptance

Figure 4-32 displays the number and percentage of survey respondents with a verified location offering the requested services that accepted OHP out of all respondents, including providers who refused to participate in the survey.

Figure 4-32—Verified Locations That Offered Requested Services and Accepted OHP

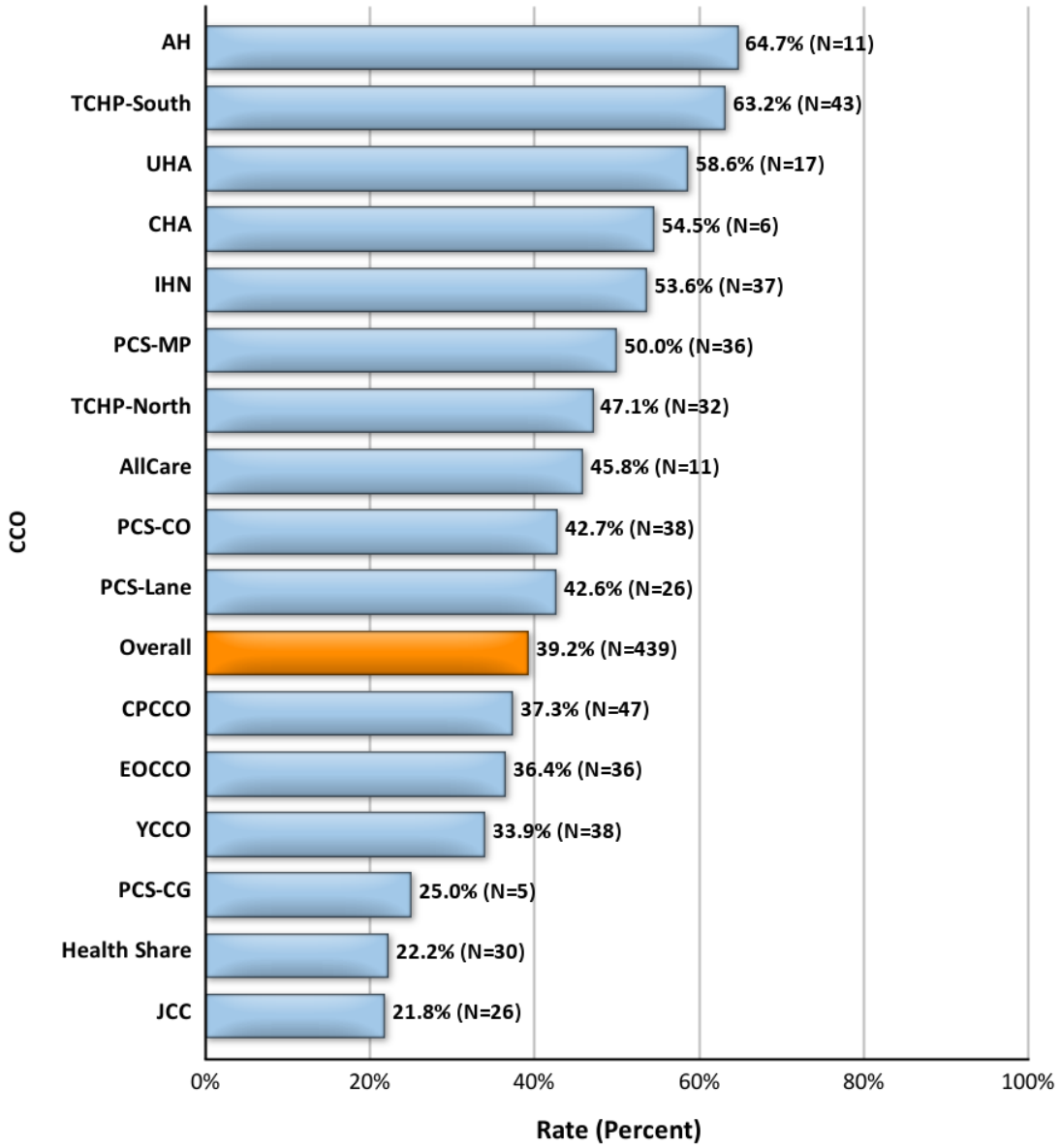


Note: "N" represents the numerator for the measure.

CCO Acceptance

Figure 4-33 displays the number and percentage of survey respondents with a verified location offering the requested services that accepted OHP and the requested CCO out of all respondents, including providers who refused to participate in the survey.

Figure 4-33—Verified Locations That Offered Requested Services and Accepted OHP and the CCO



Note: "N" represents the numerator for the measure.

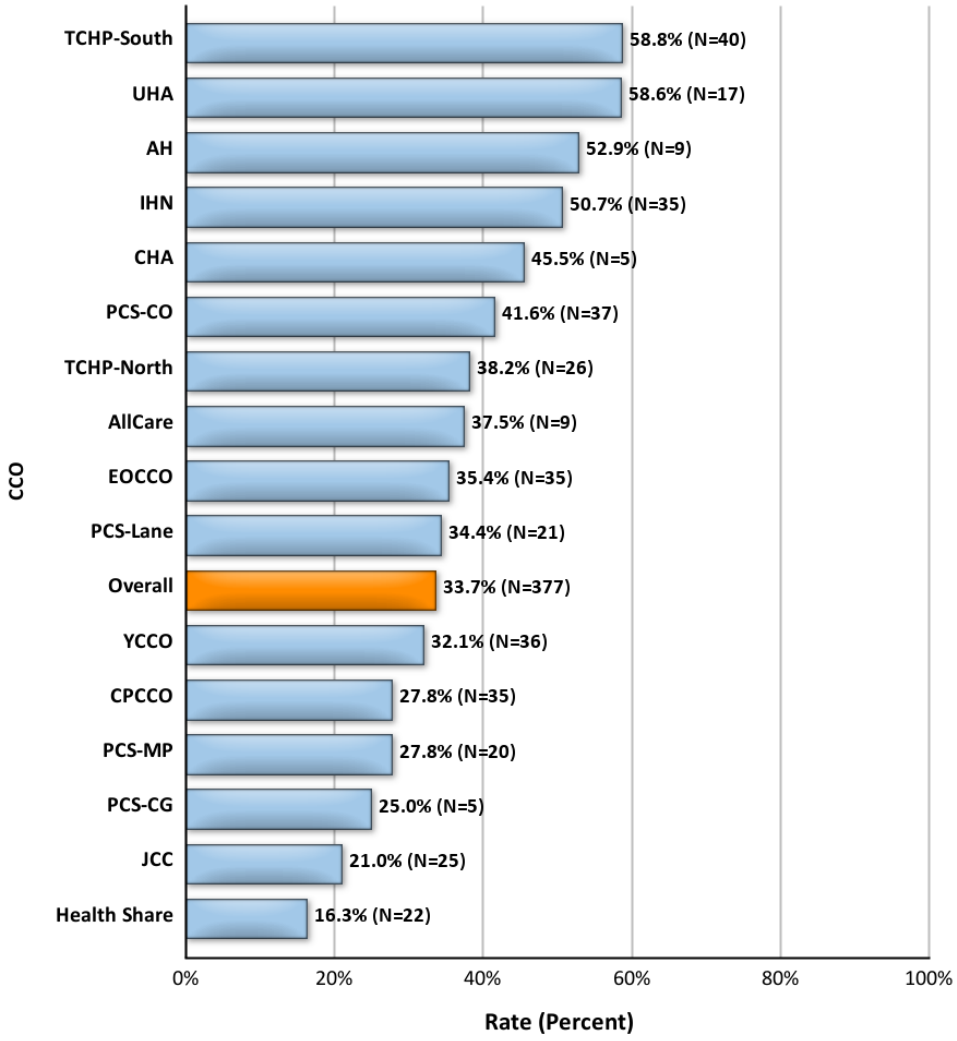
Access and Availability

The following charts reflect members' access to services and display the percentage of cases that resulted in obtaining appointment availability among providers accepting new patients, as well as the prevalence and type of interpreter services available at provider offices.

New Patient Acceptance

Figure 4-34 displays the number and percentage of survey respondents with a verified location offering the requested services that accepted OHP and the CCO, and accepted new patients out of all respondents, including providers who refused to participate in the survey.

Figure 4-34—Verified Locations That Offered Requested Services, Accepted OHP and the CCO, and Accepted New Patients

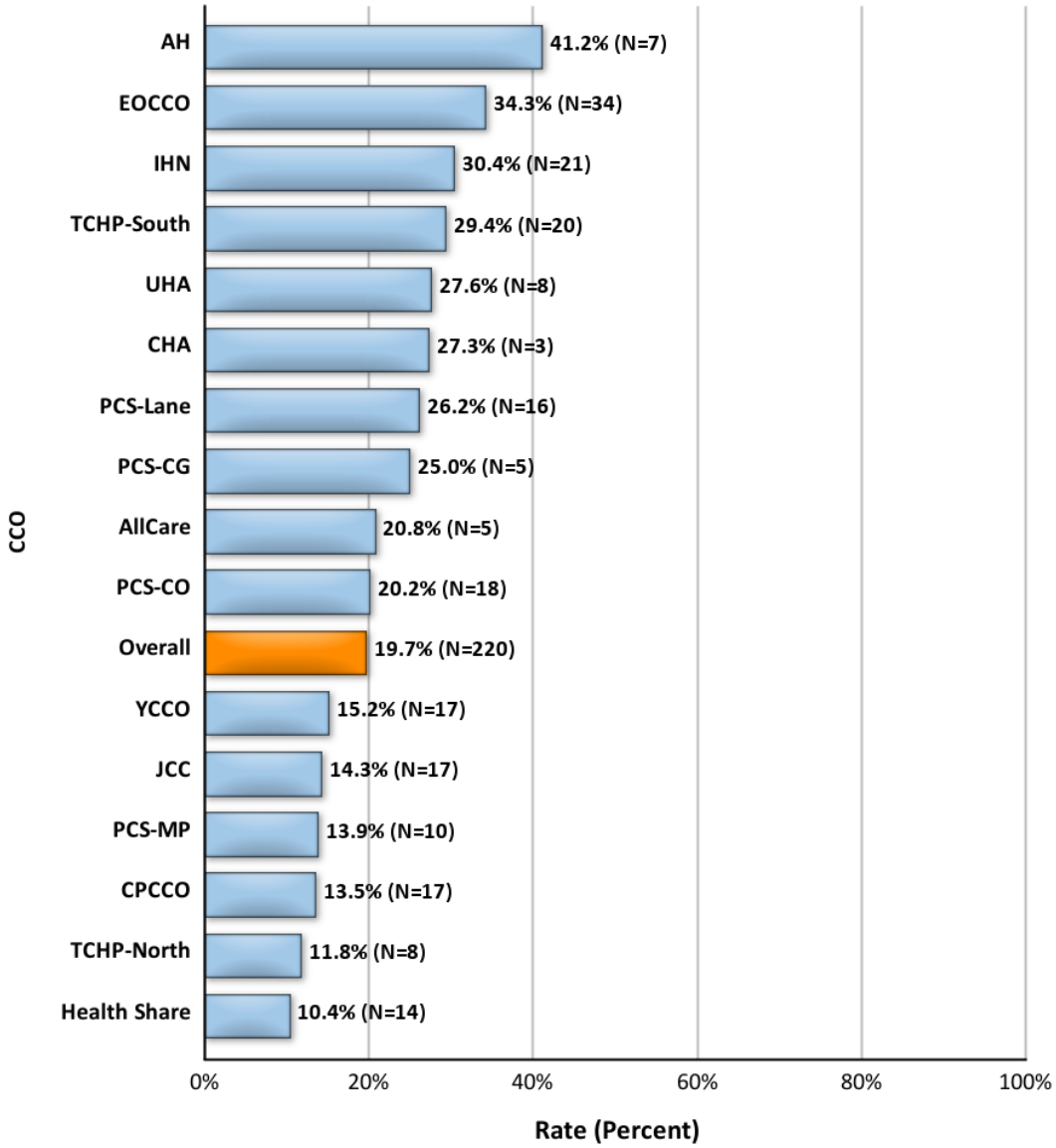


Note: "N" represents the numerator for the measure.

Appointment Availability

Figure 4-35 displays the number and percentage of survey respondents with a verified location offering the requested services that accepted OHP and the CCO, accepted new patients, and offered a new patient appointment out of all respondents, including providers who refused to participate in the survey.

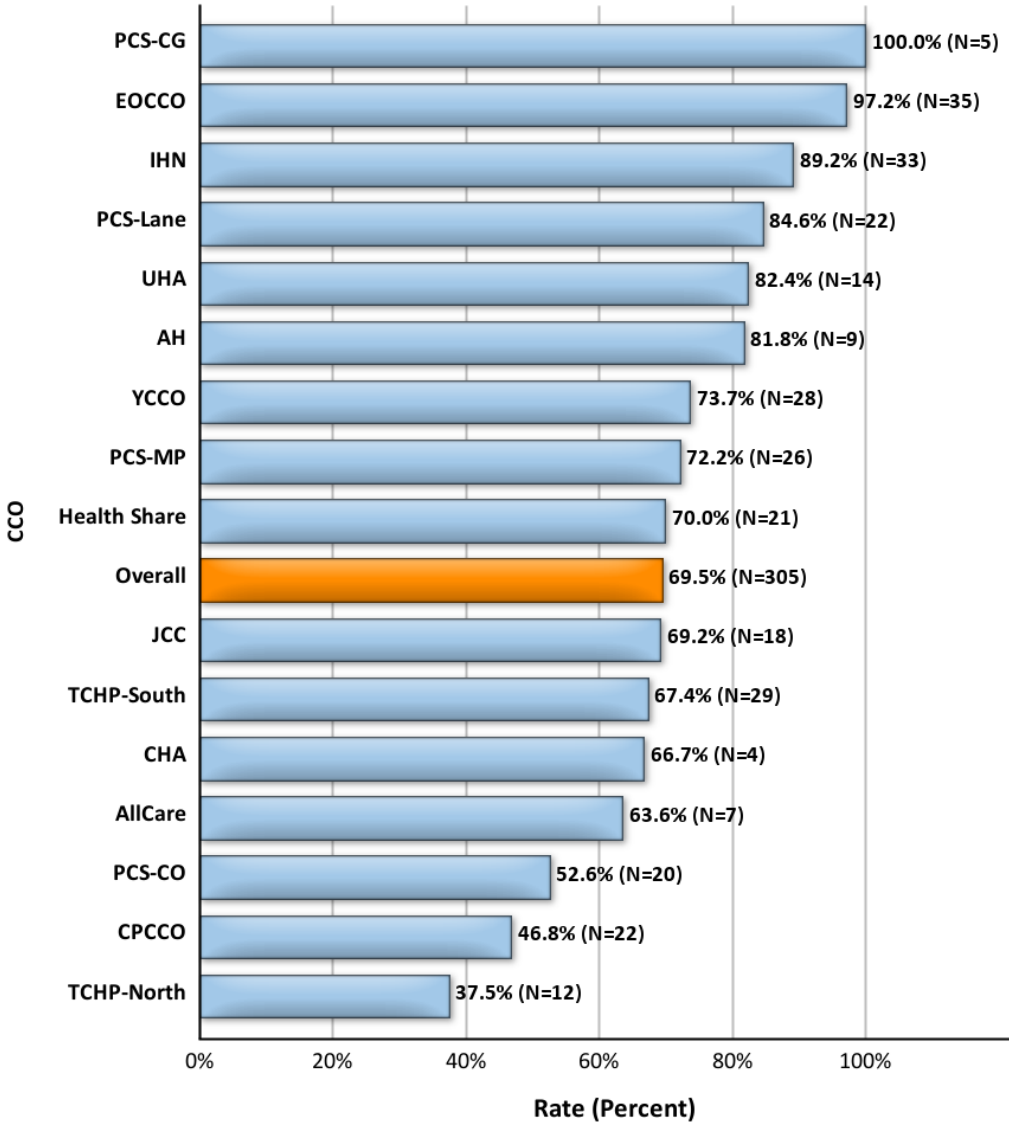
Figure 4-35—New Patient Appointment Availability for Verified Locations That Offered Requested Services, and Accepted OHP and the CCO



Note: "N" represents the numerator for the measure.

Figure 4-36 displays the number and percentage of survey respondents with a verified location offering the requested services that accepted OHP and the CCO, and offered an existing patient appointment out of all respondents, including providers who refused to participate in the survey.

Figure 4-36—Existing Patient Appointment Availability for Verified Locations That Offered Requested Services, and Accepted OHP and the CCO



While callers did not specifically ask survey respondents about factors limiting the ability to schedule appointments, any additional information captured by the callers was categorized and presented in Table 4-31. Table 4-31 displays the overall count and percentage of survey respondents for which limitations (e.g., preconditions to scheduling) were noted by provider locations that impact appointment availability. In some

cases, these limitations, or conditions, must be met to schedule an appointment but did not prevent the caller from documenting the first available appointment.

Table 4-31—Limitations to Scheduling Appointments

Limitation	Number[1]	Rate[2] (%)
No Limitations		
No limitations noted	148	33.7%
Limitations Noted		
Requires pre-registration or personal information to schedule	102	23.2%
Requires eligibility (Medicaid ID) verification	12	2.7%
Requires medical record review	16	3.6%
Initial evaluation required	47	10.7%
Must fill out questionnaire/conduct interview first	7	1.6%
Schedule/calendar not available	119	27.1%
Must live in a particular area	2	0.5%
Unique age restriction	12	2.7%
Special clinical condition only	11	2.5%
Other limitations	90	20.5%

[1] Callers were able to identify all applicable limitations for a survey case, and cases may be counted for one or more limitation.
[2] The denominator includes cases reached that accept OHP and the CCO.

Office locations may have applied multiple requirements and limitations that affected members' access to care, including the ability to obtain appointment availability. The most prevalent factors reported by survey respondents were the scheduling calendar being unavailable (119 office locations, or 27.1 percent) and requiring members to pre-register or provide personal information (102 office locations, or 23.2 percent).

Appointment Wait Times

The CCOs must have policies and procedures in place to ensure the scheduling of BH appointments is reasonable. For routine BH services for non-priority populations, assessments should be scheduled and performed within seven calendar days of the request, with a second appointment occurring as clinically appropriate. Figure 4-37 and Figure 4-38 display the average wait times, in calendar days, for verified locations offering the requested services that accepted OHP and the CCO, and offered an appointment to new and existing patients for a nonurgent or routine BH visit.

Figure 4-37—Average Wait Time to First Available Appointment—Routine BH Visits for New Patients

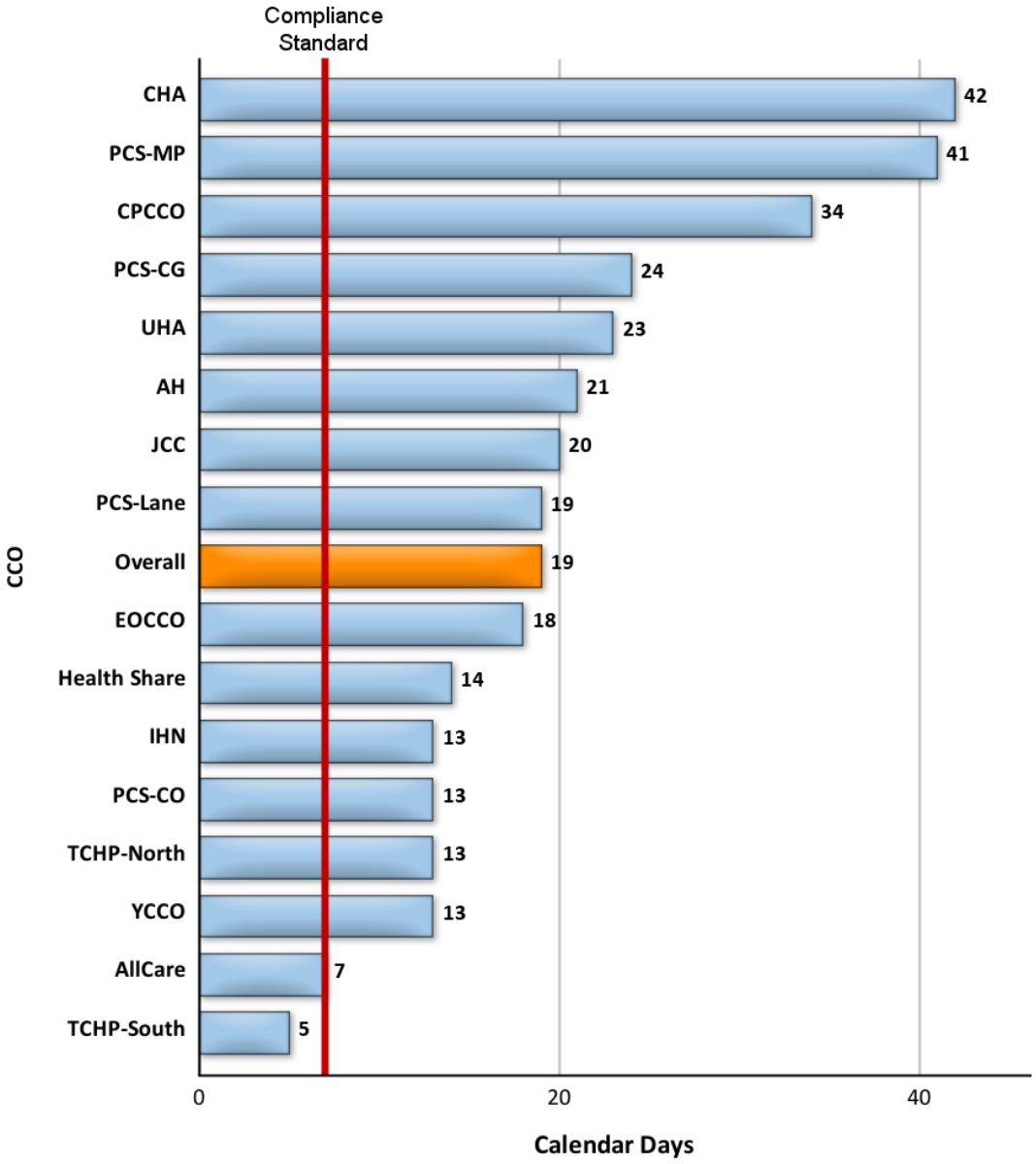
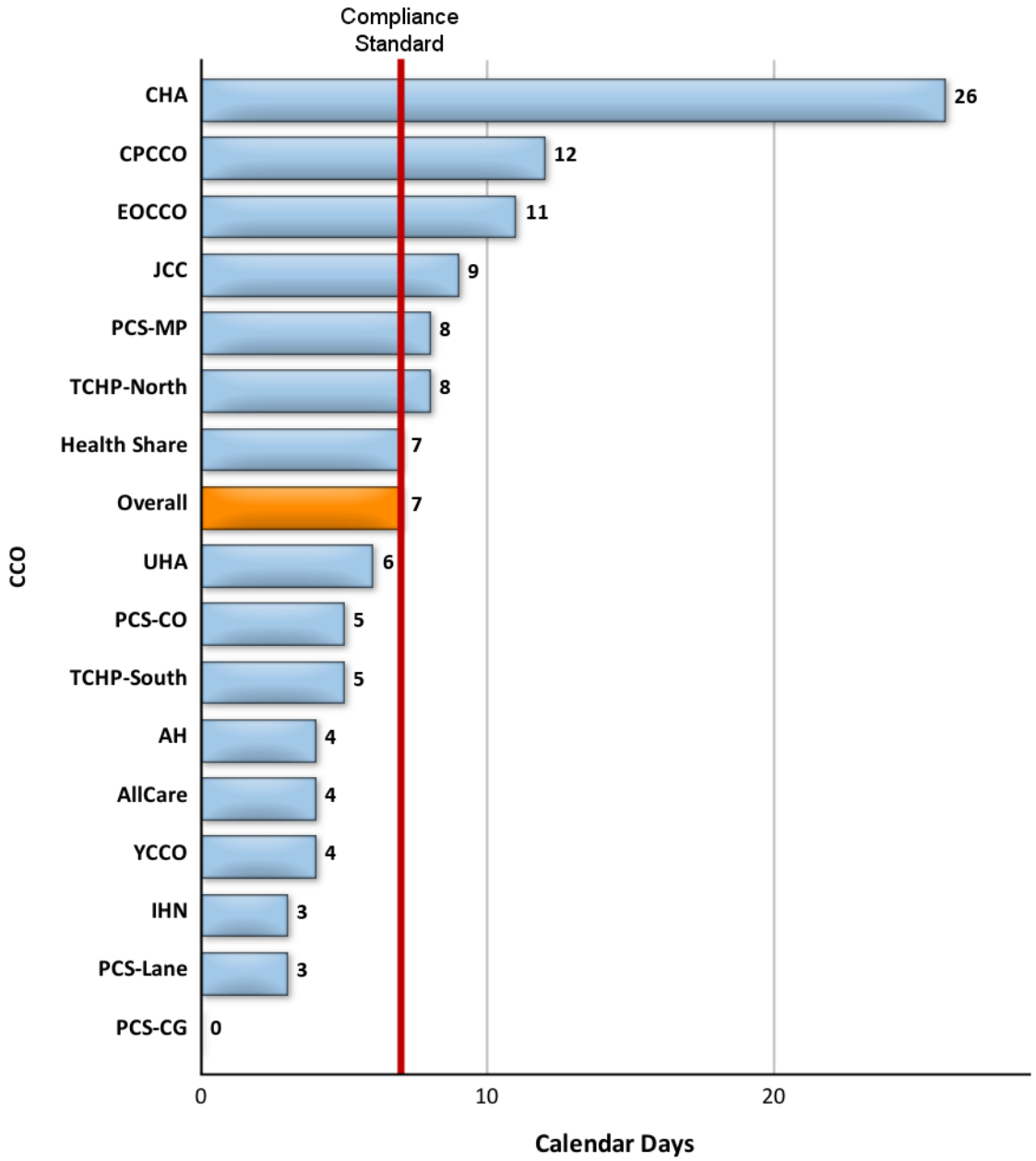


Figure 4-38—Average Wait Time to First Available Appointment—Routine BH Visits for Existing Patients



Note: Average wait time to the first available appointment for PCS-CG was less than one calendar day.

In addition to routine BH visits, the CCOs must have policies and procedures in place to ensure the scheduling of urgent BH appointments for all populations within 24 hours (or one calendar day) of the request. Figure 4-39 and Figure 4-40 display the average wait times, in calendar days, for new and existing patients for an urgent BH visit.

Figure 4-39—Average Wait Time to First Available Appointment—Urgent BH Visits for New Patients

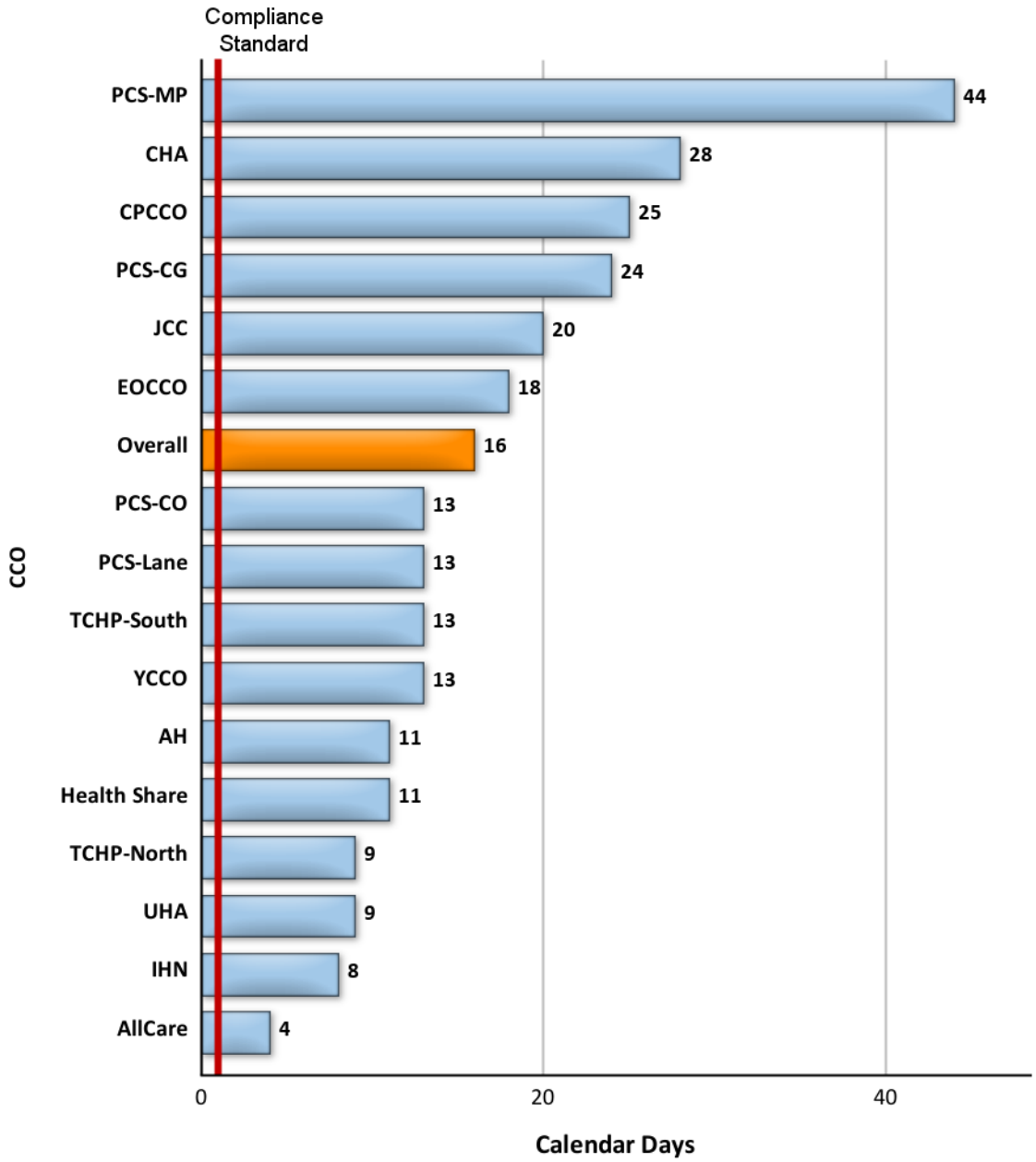


Figure 4-40—Average Wait Time to First Available Appointment—Urgent BH Visits for Existing Patients

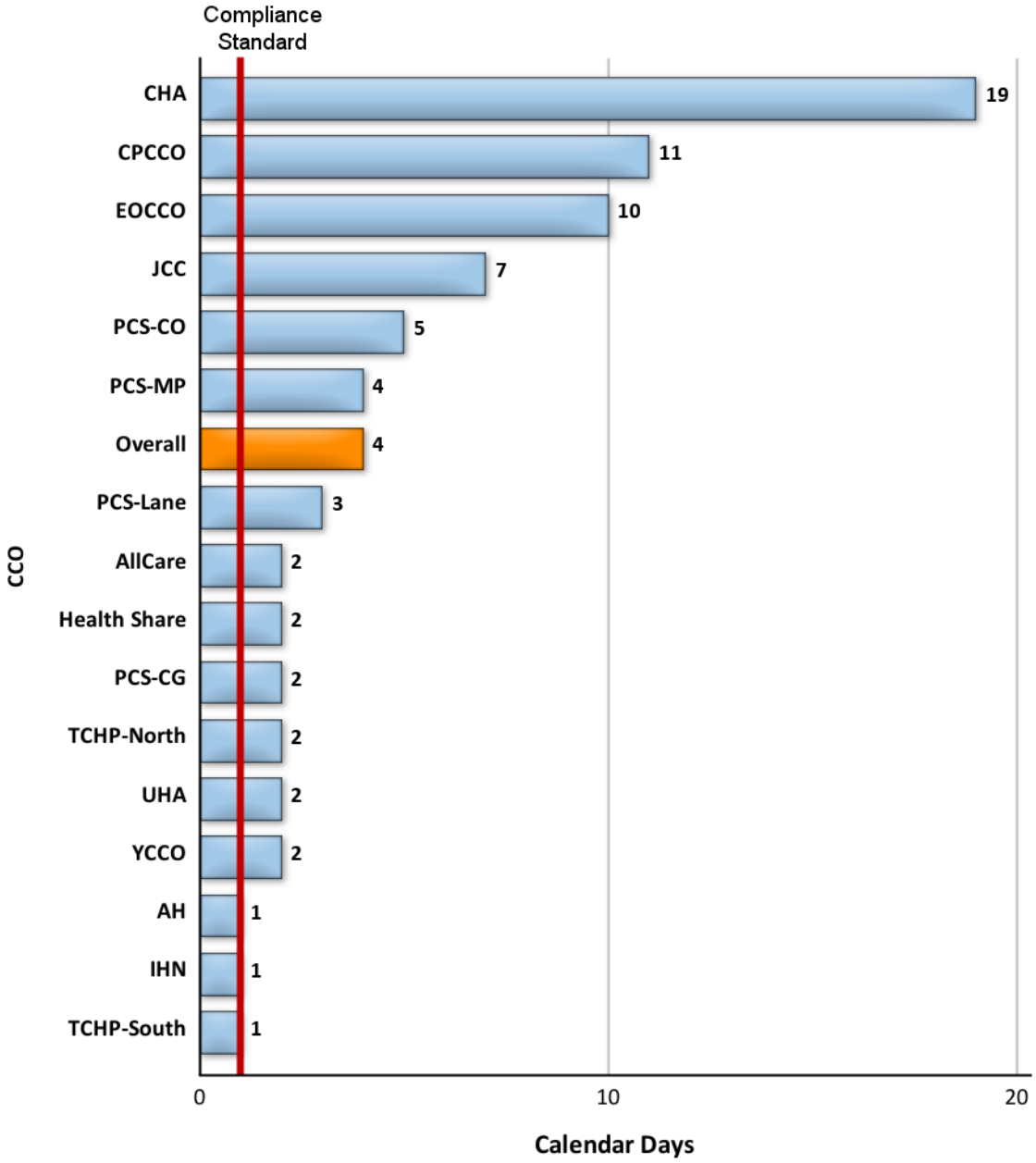


Figure 4-41 and Figure 4-42 display the percentage of appointments in compliance with the appointment availability compliance standards for routine BH visits (i.e., seven calendar days) and for urgent BH visits (i.e., 24 hours, or one calendar day) for new and existing patients.

Figure 4-41—Percentage of Routine BH Appointments Meeting Appointment Availability Standards by New and Existing Patients

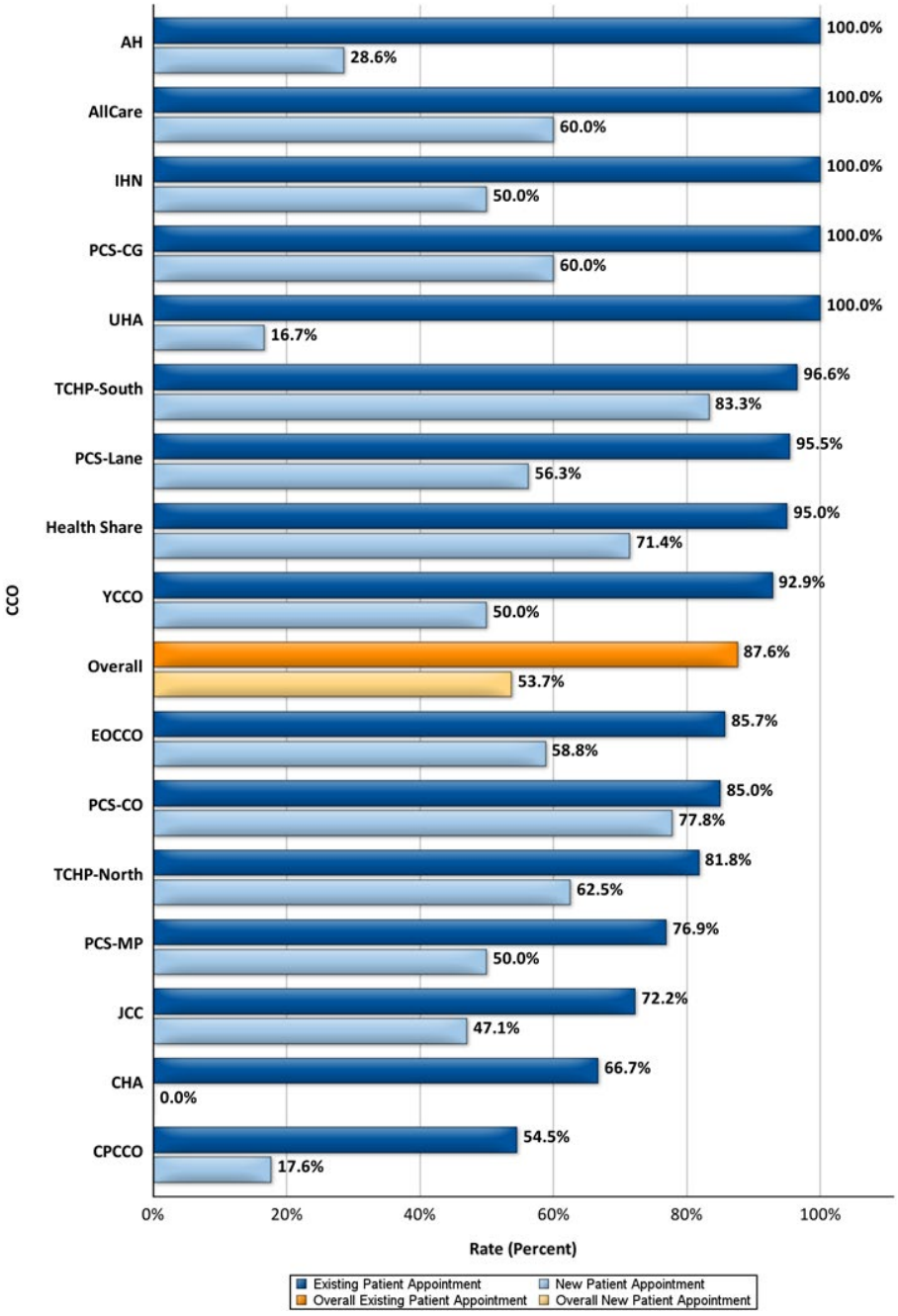


Figure 4-42—Percentage of Urgent BH Appointments Meeting Appointment Availability Standards by New and Existing Patients

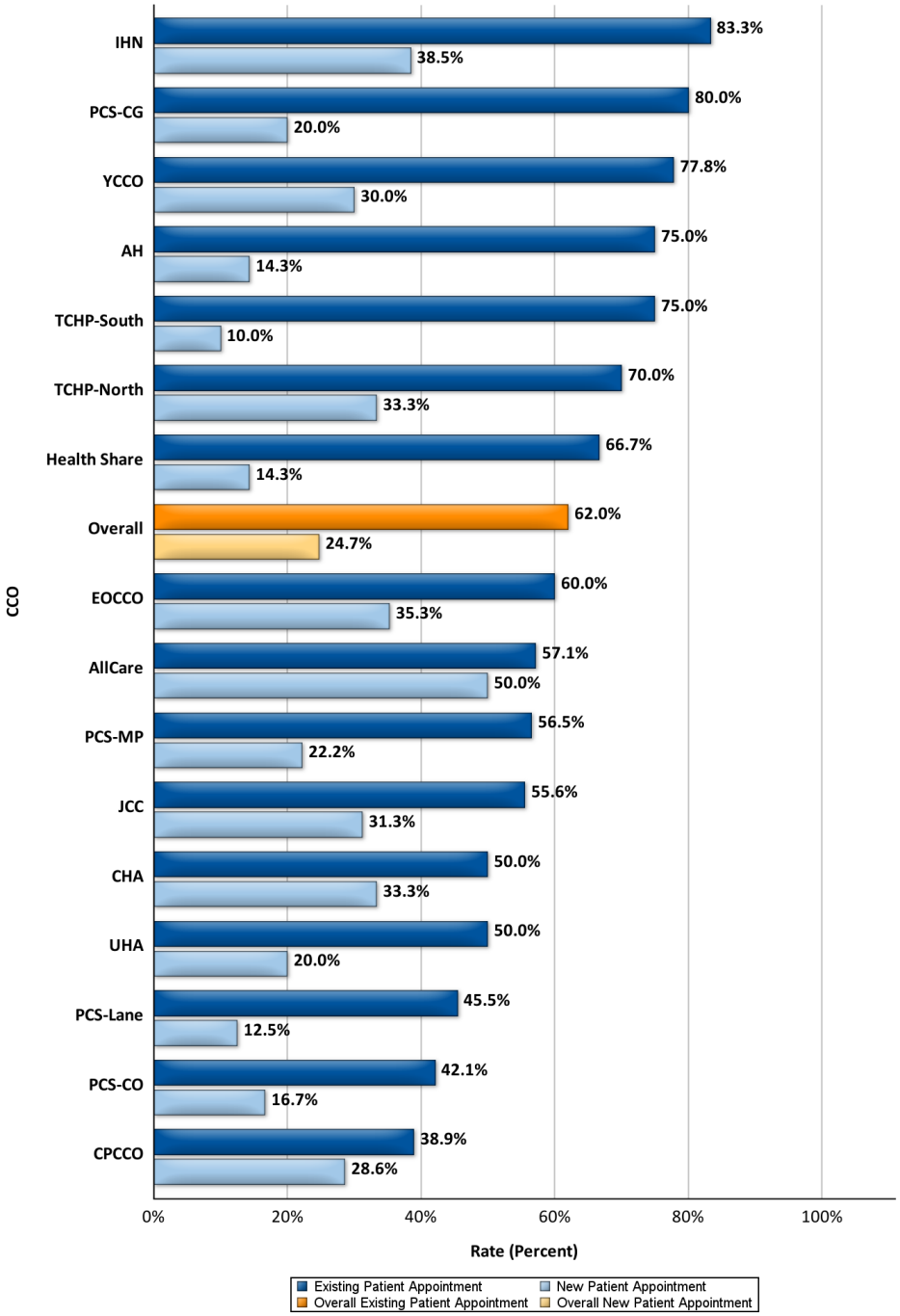
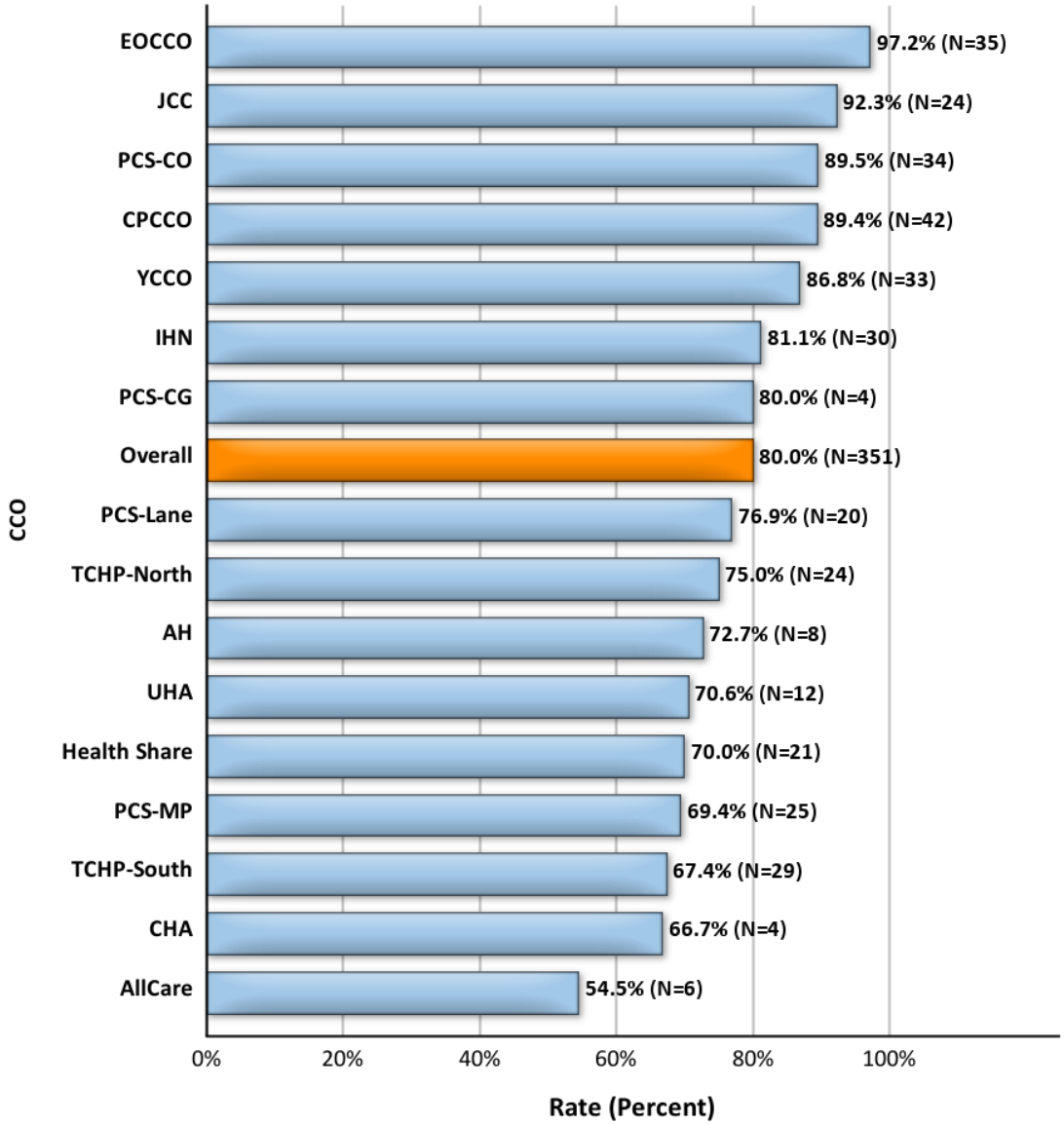


Figure 4-43 displays the number and percentage of survey respondents with a verified location offering the requested services that accepted OHP and the CCO, and offered translation or interpreter services out of all cases reached.

Figure 4-43—Verified Locations That Offered Requested Services, Accepted OHP and the CCO, and Offered Translation or Interpreter Services



Note: "N" represents the numerator for the measure.

Table 4-32 displays the documented translation or interpreter service methods identified by survey respondents by CCO.

Table 4-32—Reported Translation or Interpreter Service Methods by CCO

CCO	Verbal (In Person)	Verbal (Electronic)	Sign Language (In Person)	Sign Language (Electronic)	Cued Language Transliterating/ Visual Interpretation (In Person)	Cued Language Transliterating/ Visual Interpretation (Electronic)	Other
AH	27.3%	45.5%	18.2%	27.3%	0.0%	9.1%	45.5%
AllCare	18.2%	36.4%	18.2%	36.4%	18.2%	18.2%	18.2%
CHA	16.7%	66.7%	0.0%	0.0%	0.0%	0.0%	0.0%
CPCCO	83.0%	66.0%	70.2%	61.7%	59.6%	57.4%	17.0%
EOCCO	94.4%	97.2%	55.6%	52.8%	8.3%	8.3%	0.0%
Health Share	46.7%	60.0%	33.3%	30.0%	0.0%	0.0%	10.0%
IHN	43.2%	45.9%	24.3%	21.6%	10.8%	5.4%	43.2%
JCC	53.8%	80.8%	34.6%	69.2%	26.9%	38.5%	3.8%
PCS-CG	80.0%	80.0%	80.0%	80.0%	0.0%	0.0%	0.0%
PCS-CO	86.8%	68.4%	42.1%	21.1%	0.0%	5.3%	0.0%
PCS-Lane	69.2%	69.2%	42.3%	50.0%	15.4%	19.2%	3.8%
PCS-MP	52.8%	52.8%	38.9%	50.0%	25.0%	19.4%	2.8%
TCHP-North	68.8%	53.1%	50.0%	28.1%	0.0%	0.0%	6.3%
TCHP-South	48.8%	32.6%	23.3%	9.3%	0.0%	0.0%	18.6%
UHA	17.6%	58.8%	23.5%	41.2%	0.0%	0.0%	17.6%
YCCO	36.8%	28.9%	26.3%	18.4%	0.0%	0.0%	50.0%
Overall	**58.5%**	**57.9%**	**38.7%**	**36.4%**	**13.0%**	**13.4%**	**15.7%**

Note: Percentages may not total 100 percent due to respondents reporting multiple translation or interpreter service methods.

Statewide Conclusions, Opportunities for Improvement, and Recommendations Related to Validation of Network Adequacy

For the CCOs statewide, the following conclusions were made:

Delivery System Network Evaluation

- Based on HSAG's review of the DSN Provider Narrative submissions, the CCOs' level of compliance with the State requirements varied by the CCOs' monitoring and reporting of the adequacy of their provider networks. Statewide, the CCOs exhibited compliance with 86.5 percent of elements across the four provider narrative domains with individual category compliance ranging from 82.8 percent (*DSN Monitoring and Analysis*) to 98.5 percent (*DSN Governance Structure*).
- Overall, nearly two-thirds of the CCOs showed substantial changes in PCP counts between 2022 and 2023. However, caution should be used when interpreting these results due to changes made by OHA in its data collection and the CCOs' reporting of provider capacity data. Since 2022, OHA worked extensively with the CCOs to improve the quality of their data, including the use of the National Uniform Claim Committee health care provider taxonomy code to define areas of specialty and reliance on the PCP indicator (PCP_Ind) data field to define PCPs. As such, changes in PCP counts likely reflect improved data quality and methodology updates rather than an actual increase or decrease in contracted PCPs within the CCOs' networks.
- The dental provider network reported by the CCOs in 2023 remained stable with a few exceptions (i.e., AllCare, CHA, CPCCO, IHN, and UHA). AllCare showed a substantial increase in PCDs from one to 45 providers in 2023; however, this change was likely due to improvement in the accuracy and completeness of provider data rather than an actual change in its network, as AllCare did not provide sufficient PCD data for the CY 2022 DSN Evaluation. CHA and UHA showed substantial changes, but these changes were due to relatively small provider pools (i.e., differences of four and seven PCDs, respectively). IHN showed a substantial increase in PCDs that was likely due to additional contracting. Conversely, CPCCO showed a substantial decrease in PCDs (i.e., 70 PCDs, or a quarter of its 2022 network). Within its DSN Provider Narrative Template, CPCCO noted a workforce shortage for PCDs within its service areas and stated it was offering incentive programs and working with national recruiters to improve access to oral health care services. However, dental workforce shortages have been observed statewide, and it was unclear from the results why CPCCO demonstrated a larger decrease compared to other CCOs with greater membership (e.g., Health Share) and/or equally rural service areas (e.g., PCS).
- Between 2022 and 2023, the CCOs showed substantial increases in MH provider counts across the board with few decreases. Several factors likely contributed to these increases, including efforts by the CCOs to increase enrollment and contracting with MH providers in response to members' needs as well as improvements to the quality of provider data and changes in study protocols (e.g., provider categorization). However, caution should be used when interpreting the results, as some CCOs report provider network capacity data at an enterprise level, which may increase the overall number of providers regardless of location and/or availability to Medicaid members. This situation is often identified with CCOs managing multiple service areas or with extensive delegated services (e.g., PCS, TCHP, and Health Share). Additionally, PCS reported a somewhat higher percentage of

its provider workforce as MH providers in comparison to other CCOs (i.e., approximately 30 percent for PCS compared to approximately 20 percent to 25 percent overall), which may also indicate a data issue.

- Between 2022 and 2023, demand for SUD services greatly increased in Oregon. Most CCOs responded with some level of increase in SUD provider networks, with seven CCOs (i.e., AH, AllCare, Health Share, IHN, TCHP-S, UHA, and YCCO) showing substantial increases in the number of contracted SUD providers. The reported increase in providers was likely due to efforts by the CCOs to increase enrollment of SUD providers, as well as general improvement in the completeness and quality of the CCOs' provider data. One CCO, EOCCO, exhibited a substantial decrease (13.4 percent, or 45 providers). Further analysis of the CCO's data showed that the decrease was driven by losses in SUD providers serving pediatric members. However, this finding likely reflected a data quality issue as EOCCO reported nearly all its providers as exclusively serving either adult or pediatric populations, with few providers documented as serving both adults and children. Additionally, several CCOs reported a comparatively small numbers of providers (i.e., AH and CHA), which may also impact reported changes in rates. As such, caution should be used when interpreting these results.
- Overall, provider-to-member ratios for both MH and SUD providers were low, indicating the CCOs had a large number of providers contracted to perform MH and SUD services relative to members with an MH or SUD diagnosis. However, this does not mean that members had greater access to MH and SUD providers compared to other provider types (e.g., PCPs, specialty providers). While provider-to-member ratios are not indicative of network adequacy in and of themselves, and Oregon has not adopted minimum provider-to-member ratio standards, they serve as useful general trend indicators that often help to identify potential network outliers and data issues.
- Overall, the results showed substantial compliance with time and distance standards among core PCPs, facility-based providers, and most specialty care practitioners. Eight CCOs exhibited full compliance with both urban and rural time and distance standards across all provider types.
- Nearly all CCOs demonstrated full compliance with time and distance standards for PCPs. While CPCCO was noncompliant with urban time and distance standards for SUD providers and OB/GYN and OPT specialty providers, at least 90 percent of the CCO's members had access to a SUD provider. Geographic areas impacting CPCCO's noncompliance, while classified as urban, were predominantly rural and would have been compliant with rural time and distance standards. As such, overall OHP members had access within time and distance standards to PCPs statewide. Results for key facilities were also high but not at full compliance for four CCOs in rural or frontier settings (i.e., AH, AllCare, CPCCO, and EOCCO). While caution should be used when evaluating the CCOs' compliance with time and distance standards, the results suggest that the CCOs' distribution of providers was in alignment with their member population centers, resulting in a high degree of compliance with access standards for key PCPs and facilities.
- Overall, the CCOs demonstrated some improvement in the quality and completeness of provider capacity data reporting, though opportunities for improvement continue to exist. Quantitative assessment of the quality of quarterly provider capacity data showed that the CCOs generally demonstrated greater compliance with the reporting requirements and file integrity with higher levels

of confidence in the quality of provider directory data elements for facilities and individual practitioners than for network adequacy data elements.

Secret Shopper Survey

Survey findings identified several opportunities to improve the quality of the CCOs' provider capacity data and address the availability of new patient appointments for OHP members.

The following are the conclusions from the study:

- In total, 2,322 provider offices (90.2 percent) were unable to be reached, did not offer the requested services, were not at the sampled location, did not accept the requested CCO, did not accept OHP, were not accepting new patients, or were unable to offer an appointment date.
- The overall response rate was 76.5 percent (N=1,969). Of the 604 cases that could not be reached, 39.9 percent (N=241) of the cases were due to bad phone number information (i.e., disconnected number, fax number, or a nonmedical facility). Response rates for PCPs and PCDs were similar at 75.6 percent and 79.8 percent, respectively.
  - Individual CCO response rates ranged from 58.9 percent (IHN) to 89.3 percent (JCC).
  - IHN had the highest percentage of cases in which the service location was unable to be reached (25.7 percent) or had a bad number (15.4 percent).
- Once contact with a provider office was made, callers verified provider information prior to requesting the availability of appointments. Errors associated with provider data resulted in decreased opportunities to secure an appointment, representing substantial barriers to obtaining an appointment. In general, PCD offices exhibited fewer data quality issues than the PCP offices. Of the cases that were reached:
  - 10.7 percent of the survey respondents reported that the sampled address was incorrect, and a forwarding number was not available for the requested address.
  - 45.9 percent of the survey respondents did not offer the requested services. Moreover, 56.2 percent of the PCP locations and 12.5 percent of the PCD locations did not offer the requested services.
  - 58.4 percent of the survey respondents did not accept OHP.
  - 69.8 percent of the survey respondents did not accept the requested CCO.
  - 76.2 percent of the survey respondents reported not accepting new patients at the time of the outreach call. Comments captured from the provider offices included that they were only taking established patients associated with OHP and/or the CCO, not taking new patients due to provider retirement, and not taking new patients at the specific location surveyed.
- Of the survey respondents reached, only 12.7 percent resulted in an appointment date due to the quality of provider data and conditional requirements associated with scheduling appointments. In addition to barriers created through inaccurate provider data, common reasons for not scheduling an appointment included requiring pre-registration, personal information, completion of

questionnaire/interview, or MRR prior to scheduling the appointment, or that the schedule/calendar was unavailable.
  - Overall, JCC had the lowest rate of appointments offered (i.e., 2.2 percent). However, JCC had the highest rate of offices confirming the correct location (i.e., 96.3 percent) and offering the requested services (93.3 percent).
  - YCCO had the lowest rates of office locations that offered the requested services (25.2 percent), accepted OHP (10.7 percent), accepted the CCO (9.3 percent), and accepted new patients (7.5 percent).
  - PCS-CG had the lowest rate of office locations that verified the provider's location (69.2 percent).
- The overall average wait time was 31 calendar days (or 4.4 weeks) for a routine PCP visit and 45 calendar days (or 6.4 weeks) for a routine PCD visit.
- For cases that were offered a routine PCP appointment, 65.9 percent were compliant with the appointment availability standard of four weeks (or 28 calendar days), while 75.3 percent of the appointment wait times for routine PCD appointments were compliant with the appointment availability standard of eight weeks (or 56 calendar days).

Revealed Telephone Survey

- In total, 2,112 cases (82.8 percent) were unable to be contacted, refused to participate, did not offer the requested services at the verified location, or did not accept the requested OHP or CCO.
- The overall response rate was 43.9 percent (N=1,119), of which 104 (or 9.3 percent) refused to participate in the survey. Of the 1,432 cases that could not be reached, 11.7 percent (N=298) of the cases were due to bad phone number information (i.e., disconnected number, fax number, or reaching a nonmedical facility). Of the total cases, 1,134 cases reached a voicemail, busy signal, continuous ringing, or extended hold time after two attempts.
- Once contact with a provider office was made, callers verified provider information prior to requesting the availability of appointments. Errors associated with provider data resulted in decreased opportunities to secure an appointment, representing substantial barriers to obtaining an appointment. Of the cases that were reached:
  - 23.1 percent of the survey respondents reported that the sampled address was incorrect, and a forwarding number was not available for the requested address. This includes respondents who refused to participate in the survey and did not confirm the address information.
  - 41.7 percent of the survey respondents did not offer the requested services.
  - 45.7 percent of the survey respondents did not accept OHP.
  - 60.8 percent of the survey respondents did not accept the requested CCO.
  - 66.3 percent of the survey respondents reported not accepting new patients at the time of the outreach call. Comments captured from the provider offices included that they were only accepting the CCO and/or OHP for established patients, not accepting new patients due to provider retirement, and not accepting new patients at the specific location surveyed.

- Due to the quality of provider data and conditional requirements associated with scheduling appointments, only 19.7 percent and 69.5 percent resulted in an appointment date for new and existing patients, respectively. In addition to barriers created through inaccurate provider data, common reasons for not scheduling an appointment included the schedule or calendar being unavailable (27.1 percent), requiring pre-registration or personal information to schedule (23.2 percent), or other limitations (20.5 percent).
  - Health Share (10.4 percent) and TCHP-North (37.5 percent) had the lowest rates of appointments offered for new and existing patients, respectively.
  - Health Share also exhibited the lowest percentages of verified locations offering the requested services (37.0 percent), accepting the CCO (22.2 percent), and accepting new patients (16.3 percent).
  - PCS-CG had the lowest percentage of office locations that verified the provider's location (60.0 percent) and that were accepting OHP (35.0 percent).
- The overall average wait times for nonurgent or routine BH visits were 19 calendar days for new patients and seven calendar days for existing patients. Of the cases reached for which a nonurgent or routine appointment was made, 53.7 percent and 87.6 percent of the appointments were compliant with appointment availability standards (i.e., seven calendar days) for new and established patients, respectively. The results suggest that while established patients are more likely to obtain an appointment within seven calendar days, just over half of new patients failed to get an appointment within seven calendar days.
- The overall average wait times for urgent BH visits was 16 calendar days for new patients and four calendar days for existing patients. Of the cases reached for which an urgent appointment was made, 24.7 percent and 62.0 percent of the appointments were compliant with appointment availability standards (i.e., 24 hours) for new and established patients, respectively. The results suggest that while established patients are more likely to obtain an appointment within 24 hours, nearly one-third do not.

For the CCOs statewide, the following opportunities for improvement were identified:

Delivery System Network Evaluation

- Based on HSAG's review of the DSN Provider Narrative submissions, compliance with the State and federal requirements for maintaining and monitoring the adequacy and assurance of the provider network demonstrated opportunities for improvement across all CCOs. Statewide, the CCOs exhibited compliance with 86.5 percent of the elements across all DSN Provider Narrative domains, with individual domain CCO aggregate compliance ranging from 82.8 percent (i.e., *DSN Monitoring and Analysis*) to 98.5 percent (i.e., *DSN Governance Structure*). Overall, these results suggest a high level of compliance with State reporting requirements but with room for improvement for the CCOs at the lower end of compliance rates.
- The CCOs showed a greater range of overall compliance scores than in previous DSN Evaluations, with CCO-specific compliance scores ranging from 63.5 percent (AllCare) to 100 percent (PCS-CG, PCS-CO, PCS-Lane, and PCS-MP). Of the 10 CCOs with compliance scores equal to or above the CCO aggregate, eight CCOs exhibited an overall high level of compliance (i.e., 90 percent or

greater). Of the six CCOs performing below the CCO aggregate score, four (YCCO, CHA, IHN, and AllCare) had substantially lower overall scores (i.e., greater than 10 percent difference).

- In general, some CCOs continued to struggle with describing their network monitoring programs, including the collection and use of provider, member, and network adequacy data to drive network adequacy monitoring and decision-making. Individual CCO approaches varied widely in methodology and the frequency at which network performance metrics are monitored and addressed. HSAG noted considerable variation in the technical specifications and protocols used to assess timely access to appointments, monitor member populations with disabilities and special health care needs (SHCN), calculate provider-to-member ratio data, and track telehealth utilization data.
- Several CCOs were not compliant with OHA provider monitoring and reporting standards related to monitoring by individual specialty type. Most CCOs expanded their approach to assessing wait time to appointment availability beyond the monitoring of member grievances, incorporating quarterly or annual provider surveys. While the adoption of more direct and robust monitoring by the CCOs demonstrated ongoing improvement since 2021, only two CCOs conducted secret shopper surveys and only five CCOs proactively surveyed members regarding their appointment availability experiences.
- Prior to 2023, State reporting and monitoring standards and guidance for specialty providers were very limited, combining all such providers into an aggregate "Specialty" category, making analysis of members' access less meaningful and noncompliant with the need to monitor and report the necessary range of specialty provider services adequate for the member population (i.e., 42 CFR §438.207[b]). With most CCOs reporting individual specialty provider types in 2023, the evaluation showed that many CCOs continued to experience gaps in access to care for multiple specialties, particularly for rural settings that had small numbers of contracted providers operating in a CCO's service area.
- In general, the CCOs demonstrated greater availability and accessibility among its PCPs and PCDs than its MH and SUD providers. However, the results associated with some data elements (e.g., provider capacity) also suggested ongoing data issues with data reporting across several CCOs. Findings also showed potential barriers to provider availability and accessibility for certain specialty provider types (i.e., END, NEPH, PUL, and SLP) within several CCOs and statewide. Two CCOs in particular (i.e., CPCCO and JCC) failed to address persistent issues in their provider availability and accessibility data as identified in prior years' DSN Evaluations. Additionally, PCP capacity and the percentage of PCPs accepting new patients for some CCOs were inconsistently reported and suggested illogical conclusions—i.e., PCP maximum capacity being much higher than population needs. For example, one CCO's (CHA's) data showed that 75 percent of PCPs were accepting new patients, yet PCP capacity was 100 percent (i.e., no members were assigned). Data for MH and SUD providers suggested a statewide language accessibility issue with all but one CCO (CHA) reporting that less than 5 percent of all MH and SUD providers spoke a prevalent non-English language.

Secret Shopper Survey

- Overall, HSAG was unable to contact 23.5 percent of the sampled locations, with 9.4 percent of the cases being unable to be reached due to bad phone number information (i.e., disconnected number, fax number, or a nonmedical facility). Since the secret shopper survey used the CCOs' quarterly

provider capacity data to select sample cases, the high percentage of unreachable provider offices suggests there are data quality issues with the CCOs' source data. These provider data files reflect the data used to support the production of the CCOs' provider directories; as such, inaccurate data represents a potential barrier for members accessing health care services. Additionally, 45.9 percent of the cases reached indicated that the verified provider locations did not offer the requested services (i.e., routine primary care or dental visits).

- Survey results indicated that only 41.6 percent of responsive cases had a verified location, offered the requested services, and accepted OHP, with YCCO exhibiting the lowest rate (10.7 percent). Further, only 30.2 percent of responsive cases had a verified location, offered the requested services, accepted OHP, and accepted the requested CCO. Again, YCCO exhibited the lowest rate (9.3 percent) of all the CCOs. These findings suggest a lack of understanding by provider office staff on the types of insurance accepted by the provider offices. Some respondents reported a lack of awareness or familiarity with OHP and/or the CCO. Additionally, survey respondents reported the office location required personal information and/or the member's Medicaid ID number to confirm their coverage and assigned CCO.
- Of the survey respondents reached, only 12.7 percent resulted in an appointment[4-6] date with an overall average wait time of 31 calendar days (4.4 weeks) and 45 calendar days (6.2 weeks) for PCP and PCD visits, respectively. Additionally, 65.9 percent of routine PCP appointments were compliant with the appointment availability standard of four weeks (or 28 calendar days), while 75.3 percent of the appointment wait times for routine PCD appointments were compliant with the appointment availability standard of eight weeks (or 56 calendar days).

Revealed Telephone Survey

- Overall, HSAG callers were unable to contact 56.1 percent of the sampled locations, with 11.7 percent due to bad phone number information (i.e., disconnected number, fax number, or a nonmedical facility) and 44.5 percent due to being unable to reach (i.e., reached a voicemail, received a busy signal or continuous ringing, or were put on hold for an extended hold time). Since the revealed telephone survey used the CCOs' quarterly provider capacity data to select sample cases, the high percentage of unreachable provider offices suggests there are data quality issues with the CCOs' source data. These provider data files reflect the data used to support the production of the CCOs' provider directories; as such, inaccurate data represents a potential barrier for members accessing health care services. Additionally, 41.7 percent of the survey respondents indicated the sampled location did not offer the requested services.
- Survey results indicated that only 54.3 percent of responsive cases had verified locations, offered the requested services, and accepted OHP, with PCS-CG exhibiting the lowest rate (35.0 percent). Further, only 39.2 percent of responsive cases had a verified location, offered the requested services, accepted OHP, and accepted the requested CCO. JCC had the lowest rate (21.8 percent) of all CCOs followed closely by Health Share (22.2 percent). These findings suggest a lack of understanding by provider office staff members on the types of insurance accepted by the provider offices. Some

[4-6] Appointment dates reflected survey respondents with verified locations that offered the requested services, accepted OHP and the CCO, and were accepting new patients.

respondents reported a lack of awareness or familiarity with OHP and/or the CCO. Additionally, survey respondents reported the office location required personal information and/or the member's Medicaid ID number to confirm their coverage and assigned CCO.

- Of the survey respondents reached, only 19.7 percent and 69.5 percent resulted in an appointment[4-7] date for new and existing patients, respectively, with an overall average of 19 calendar days (new patients) and four calendar days (existing patients) for a routine BH appointment, and 16 calendar days (new patients) and four calendar days (existing patients) for an urgent BH appointment. Additionally, with the exception of routine BH appointments for existing patients (87.6 percent), less than two-thirds of new or existing patients received an appointment date compliant with the appointment availability standard for routine (i.e., seven calendar days) or urgent (i.e., 24 hours) BH services (i.e., 53.7 percent, 24.7 percent, and 62.0 percent, respectively).

For the CCOs statewide, the following recommendations were identified to evaluate and address deficiencies in the statewide DSN reporting activity:

Delivery System Network Evaluation

- The CCOs should ensure that all DSN Provider Narrative Template responses provide sufficient information to demonstrate that collected data are used to inform network adequacy monitoring and decision-making, and should provide sufficient and relevant explanation for planned network interventions.
- The CCOs should ensure that all future reporting utilizes the state-established specialty provider taxonomies current to the review period, and should demonstrate how it collects and uses DSN data to inform network adequacy monitoring and decision-making.
- The CCOs should investigate all potential data issues and potential barriers to care identified and implement mechanisms to improve data quality. If needed, the CCOs should work collaboratively with and seek technical assistance from OHA to determine the nature of the data quality issues to ensure effective corrective action.
- OHA and the CCOs should work collaboratively to develop a standardized methodology for monitoring members' accessibility and utilization of interpreter services.
- The CCOs should seek technical assistance from OHA regarding the collecting, monitoring, and reporting of network monitoring requirements and how to use the information to support network management, including conducting assessments to understand the member populations and needs.

Secret Shopper Survey and Revealed Telephone Survey

- The CCOs should investigate each nonresponsive provider office, as well as the accuracy of provider locations and available provider specialties and services. Where necessary, the CCO should update its provider network data and directory to reflect accurate information.

[4-7] Appointment dates reflected survey respondents with verified locations that offered the requested services, accepted OHP and the CCO, and were accepting new patients.

- The CCOs should investigate the data deficiencies identified during the survey calls (e.g., accepting OHP and the requested CCO) and implement mechanisms to improve data quality.
- The CCOs should ensure they follow up with provider locations reported as being out of compliance with appointment availability standards and take corrective actions to ensure future compliance. Activities could include, though not be limited to, reviewing provider office procedures for ensuring appointment availability standards are being met, addressing questions or reeducating office staff on OHA standards, and incorporating appointment availability requirements into educational materials.
- The CCOs should evaluate current mechanisms and implement effective and meaningful processes to improve timely access to care for members, including network provider compliance with regulatory access standards.

Encounter Data Validation

Results for Targeted Assessment of Encounter Data Information Systems and Processes

Representatives from all 16 CCOs participated in the data collection process by completing an OHA-approved questionnaire provided by HSAG. Based on the initial questionnaire responses, HSAG identified additional follow-up questions specific to each CCO, and the CCOs provided responses to these tailored questions. To support their questionnaire responses, the CCOs submitted a diverse array of documents with varying formats and levels of detail.

Encounter Data Process Flow

This section of the report summarizes the description of the complete life cycle of dental encounter data processing including the following: extraction from claims adjudication system, preparation of dental encounter files, submission to OHA, reconciliation with OHA, and final storage/management of dental encounter data for internal reporting.

The CCOs were asked about the configuration of their data process flow for dental encounters across their entire network. Generally, their processes are similar with slight variations depending on their unique encounter processing systems. With the exception of CHA, all CCOs delegated claims processing and dental provider management to their dental subcontractor(s).

The dental encounter data submission process adheres to a complex set of rules designed to determine the readiness of claims for encounter. This readiness is contingent on claims being adjudicated, paid (if necessary), and finalized. Typically, a weekly job is executed to identify claims eligible for encounter, considering both recently adjudicated claims and old, pended claims. Claims pended pre-submission due to specific errors are reevaluated, and if deemed ready, they are resent after allowing time for corrections.

File processing involves individual subcontractors' processing dental claims and creating 837D files, which are either submitted directly to OHA or by the CCO themselves. Files submitted directly to OHA are mostly shared with the CCOs for reporting purposes. CCOs receive the 999 response files from OHA, which are then shared and are addressed by the subcontractors. The subcontractors make necessary corrections and resend the files to OHA. The 835 files that OHA sends to the CCOs undergo reconciliation with 837 files. Any discrepancies are addressed by the encounter team to ensure accurate reporting before subsequent file submissions.

The CCOs receive a "PendStatus" file, which is treated similarly to the 835, and distribute claims for each subcontractor, aiding in monitoring pends and facilitating corrections. The 837D reconciliation process involves the Claim Count Verification (CCV) file, a weekly report that OHA sends to the CCOs. This report reconciles submitted encounter data with claims rejected and pended. The entire process encompasses secure file transfer protocol file transfers, responses, and thorough reconciliation efforts to align reported encounter data accurately. This detailed encounter data submission and reconciliation

process showcases a robust system, ensuring compliance, accuracy, and collaboration among stakeholders, ultimately contributing to the reliability of dental encounter data reporting.

Feedback from OHA

Upon receiving dental encounters from either the subcontractors or the CCOs, OHA generated a series of response files. The CCOs were asked to provide information regarding the total number of dental encounters submitted, initially rejected, and initially rejected but later resubmitted during the measurement period (i.e., January 1, 2022–December 31, 2022). Table 4-33 displays the percentage of dental encounters that were rejected and not yet accepted by OHA. The column labeled "EDI Rejections" represents the percentage of encounters initially rejected due to OHA electronic data interchange (EDI) translator compliance checks based on established EDI standards and guidelines. The column labeled "OHA Edit Rejections" indicates the percentage of encounters initially rejected due to OHA encounter edits. CCOs had the capability to make corrections to these rejected encounters and subsequently resubmit them to OHA. The "Resubmitted and Not Yet Accepted" column illustrates the percentage of total encounters that were initially rejected (either due to OHA's EDI translator or OHA's encounter edits) and were later resubmitted but have not yet been accepted.

Table 4-33—Percentage of Dental Encounters Initially Rejected and Not Yet Accepted by OHA

CCO	EDI Rejections	OHA Edit Rejections	Resubmitted and Not Yet Accepted
AH	0.00%	0.00%	0.00%
AllCare	0.00%	0.05%	0.00%
CHA	5.17%	0.00%	0.00%
CPCCO	0.03%	0.05%	0.01%
EOCCO	0.01%	0.05%	0.00%
Health Share	0.03%	0.08%	0.01%
IHN	0.00%	0.00%	0.00%
JCC	0.01%	0.02%	0.00%
PCS-CO	0.01%	0.02%	0.00%
PCS-CG	0.01%	0.08%	0.00%
PCS-Lane	0.01%	0.03%	0.00%
PCS-MP	0.01%	0.04%	0.00%
TCHP-North	0.04%	0.10%	0.08%
TCHP-South	0.02%	0.16%	0.15%
UHA	0.00%	0.10%	0.00%
YCCO	0.00%	0.11%	0.00%

Results for Encounter Data Quality Monitoring

This section evaluated how the CCOs monitor their dental encounter data quality based on the following questions:

1. Does the subcontractor submit dental encounter files directly to OHA on behalf of the CCO?
2. Does the CCO receive copies of the dental encounters/encounter files from subcontractors?
3. Does the CCO integrate dental encounter data into its information systems for internal monitoring, reporting, and/or storage?
4. Does the CCO perform any quality checks on the dental encounter data/files from the subcontractor prior to submitting them to OHA?
5. Does the CCO modify the dental encounter data/files received from the subcontractor prior to submitting them to OHA?
6. Does the CCO perform any quality checks on the dental encounter data/files received from the subcontractor after submitting them to OHA?

Encounter Data Collected by the CCOs' Subcontractors

Table 4-34 displays the information on the CCOs' practices related to storing, receiving, integrating data into CCO systems, and reviewing, or modifying encounters prior to submitting them to OHA. It also indicates whether the CCOs reviewed the encounters after submitting them to OHA. Of note, the "Mixed" responses in the table indicate varying responses among the CCOs' subcontractors.

Table 4-34—CCO Processes for Dental Encounters From Subcontractors

CCO	Subcontractor Submits to OHA	CCO Receives Encounters	Integrated Into CCO Systems	Reviewed Prior to Submission	Modified Prior to Submission	Reviewed by CCO After Submission
AH	No	Yes	Yes	Yes	No	Yes
AllCare	Mixed	Yes	Mixed	Yes	No	Yes
CHA	Yes	Yes	Yes	Yes	No	Yes
CPCCO	Yes	Yes	Yes	No	No	Yes
EOCCO	Yes	Yes	Yes	Mixed	No	Yes
Health Share	Yes	Yes	Yes	No	No	Yes
IHN	Yes	Yes	Yes	No	No	Yes
JCC	Yes	Yes	Yes	No	No	Yes
PCS-CO	No	Yes	Yes	Yes	No	No
PCS-CG	No	Yes	Yes	Yes	No	No
PCS-Lane	No	Yes	Yes	Yes	No	No
PCS-MP	No	Yes	Yes	Yes	No	No
TCHP-North	No	Yes	Yes	Yes	No	Yes
TCHP-South	No	Yes	Yes	Yes	No	Yes

CCO	Subcontractor Submits to OHA	CCO Receives Encounters	Integrated Into CCO Systems	Reviewed Prior to Submission	Modified Prior to Submission	Reviewed by CCO After Submission
UHA	Mixed	Yes	Mixed	Yes	No	Yes
YCCO	Mixed	Yes	Yes	Yes	Yes	Yes

Data Quality Checks

HSAG collected responses from the CCOs regarding the quality checks performed by both their subcontractors and the CCOs themselves. To facilitate the categorization of these responses, HSAG included a set of standard data quality checks for the CCOs to choose from in their questionnaire. Table 4-35 shows a list of checks provided in the questionnaire.

Table 4-35—Data Quality Checks

Data Quality Checks
Claim Volume by Submission Month
Claim Volume per Member per Month (PMPM)
Field-Level Completeness
Field-Level Validity
Timeliness
Reconciliation With Financial Reports
EDI Compliance Edits

Table 4-36 presents the data quality checks conducted by either the CCOs or their subcontractors on the dental encounter data collected by the subcontractors. The "Completeness and Accuracy" column included quality checks such as EDI compliance edits, field-level completeness, or field-level accuracy. Data quality checks confirmed as being conducted by the CCOs or their subcontractors are shaded green.

Table 4-36—Data Quality Checks by the CCOs and/or Their Subcontractors

CCO	Claim Volume by Submission Month	Completeness and Accuracy	Timeliness	Reconciliation With Financial Reports
AH	Yes	Yes	Yes	Yes
AllCare	Yes	Yes	—	—
CHA	Yes	Yes	Yes	—
CPCCO	Yes	Yes	Yes	—
EOCCO	Yes	Yes	Yes	Yes
Health Share	Yes	Yes	Yes	—
IHN	Yes	Yes	Yes	—

CCO	Claim Volume by Submission Month	Completeness and Accuracy	Timeliness	Reconciliation With Financial Reports
JCC	—	Yes	Yes	—
PCS-CO	—	Yes	Yes	Yes
PCS-CG	—	Yes	Yes	Yes
PCS-Lane	—	Yes	—	Yes
PCS-MP	—	Yes	—	Yes
TCHP-North	Yes	Yes	Yes	—
TCHP-South	Yes	Yes	Yes	—
UHA	Yes	Yes	Yes	Yes
YCCO	Yes	Yes	—	—

— indicates that a CCO did not provide a response to the specific type of data quality check.

Adjusted Claims

The CCOs were asked to describe their processes, in coordination with their subcontractor(s), for submitting adjustments for dental encounters that were previously submitted to and accepted by OHA. Table 4-37 outlines the CCOs' and their respective subcontractor(s)' responses.

Table 4-37—Adjusted Claims Submission Process

CCO	Process Description
AH	**Advantage Dental**: Claims adjustments may be necessary in cases of billing errors by providers or issues with the claims adjudication system. Providers are expected to notify Advantage Dental of any necessary adjustments, and these adjustments should be addressed within seven days of the notification date. However, if the adjustment involves claims adjudication issues and requires substantial corrections, the process may extend to a maximum of 30 days, depending on the volume of claims requiring adjustments.
AllCare	**Ayin**:* Ayin manages rejected encounters through specific policies. Successful OHA MMIS entries follow "Must Correct Encounter Data Policy 3," while front-end failures are governed by "Encounter 999 Errors (Rejected Claims) Policy_3." Adjusted claims, excluding specific cases, are submitted to OHA using the "Encounter Only Submission Policy" guidelines for updates such as a frequency code change to 7 (i.e., adjustment) and inclusion of an internal control number (ICN).
CHA	Weekly status files are loaded to pull all pending claims, which are then analyzed to determine if providers can be contacted for corrected claims or if refunds are necessary. If a corrected claim is obtained, the original claim in production will be corrected and resubmitted with frequency code 7. If a refund is required, the claim will be adjusted, voided, and resubmitted with frequency code 8 using a corrections and reversal adjustment code and reason code 129. All claims are completed within the 63-day window, or a formal work plan is devised in collaboration with the State liaison to address non-compliant issues.
CPCCO	**Advantage Dental**: Same response as AH.

CCO	Process Description
EOCCO	**ODS Community Dental**: An adjusted claim is flagged for selection when the ICN of the original encounter claim matches the adjusted claim, triggering the creation of a new 837 encounter submission. During the 837 submission process, the system is configured to recognize the adjustment, and the job extracts and submits it on the new 837. The new submission includes the original ICN and a replacement indicator, prompting OHA to update the original claim. Upon receiving the 835, the ICN on the adjustment claim is updated, completing the resubmission process and preventing further resubmission of the adjusted claim. EOCCO's system is designed to receive notifications for review and tracking of these submissions. **Advantage Dental**: Same response as AH.
Health Share	**CareOregon** utilizes two methods of performing adjustments: Manual adjustments in MMIS. Adjustments in its claims processing system. **ODS**: Complete an Encounter Data MMIS Adjustment/Void Request Form (one form per claim). **Advantage Dental**: Same response as AH.
IHN	**IHN**: The CCO issues a report to each subcontractor detailing pended encounters that necessitate correction. Each subcontractor adheres to its internal policies and procedures for pend correction. **Advantage Dental**: Same response as AH. **Ayin/Capitol Dental**: Adjusted claims are submitted to IHN unless they fall under the exclude group. The submission process for adjusted claims mirrors that of new claims, but with a modification—the frequency code is updated to 7, and an ICN is included. **Moda**: Utilizing the Web portal, Moda rectifies errors and fill out an Encounter Data MMIS Adjustment/Void Request Form, then transmits it securely via email. The submission includes the new ICN, along with details on total pends and dollar amounts. **Willamette Dental Group (WDG)**: WDG Insurance team initiates processing of any pends within 24 hours of receipt. WDG indicated that it is committed to resolving all pends promptly, aiming to complete the process within 63 days.
JCC	**Advantage Dental**: Same response as AH. **WDG**: Adjustments are corrected through the encounter data system. **ODS**: Same response as Health Share. **Capitol Dental**: Same response as Ayin/Capitol Dental for IHN.
PCS-CO	**PCS-CO**: After PacificSource's dental partner makes adjustments, replacements, voids, or corrections, PacificSource proceeds to submit the adjusted dental claim to the State during the next weekly submission. **Capitol Dental**: Same response as Ayin/Capitol Dental for IHN. **Advantage Dental**: Same response as AH. **ODS**: Same response as Health Share.
PCS-CG	Same response as PCS-CO.
PCS-Lane	Same response as PCS-CO.

CCO	Process Description
PCS-MP	Same response as PCS-CO.
TCHP-North	**Ayin/Capitol Dental**: Same response as Ayin/Capitol Dental for IHN. **Moda**: Same response as IHN. **Advantage Dental**: Same response as AH.
TCHP-South	Same response as TCHP-North.
UHA	**Advantage Dental**: Same response as AH. **Ayin**: Same response as Ayin for AllCare.
YCCO	**Ayin/Capitol Dental**: Same response as Ayin/Capitol Dental for IHN.

*Ayin and Performance Health Technology (PH Tech) are considered the same organization for the purposes of this report.

Challenges and Changes Noted by the CCOs

The CCOs and their subcontractors were asked about challenges they encounter or anticipate when submitting encounter data to OHA. Additionally, they provided insights into any upcoming changes in their encounter submission processes. Table 4-38 outlines the internal/external challenges and upcoming changes reported by the CCOs and/or their subcontractors in their responses, if any. None of the CCOs or subcontractors identified any challenges in submitting encounter data to OHA. However, a number of CCOs reported upcoming changes related to 837 segments, as described below.

Table 4-38—Internal and External Challenges and Upcoming Changes

CCO	Type of Challenges and/ or Upcoming Changes	Description
AH	No challenges or upcoming changes.	Not applicable.
AllCare	Vendor updates for 837 segments.	Ayin has updated the 837 segments to meet OHA requirements, incorporating HCP01 and HCP02 beginning April 14th, 2023. Both Ayin and Capitol Dental are currently in compliance with these changes. Future adjustments are planned to further enhance this process, incorporating additional rules to the code, ensuring alignment with State-provided pay and list edits.
CHA	No challenges or upcoming changes.	Not applicable.
CPCCO	No challenges or upcoming changes.	Not applicable.
EOCCO	No challenges or upcoming changes.	Not applicable.
Health Share	No challenges or upcoming changes.	Not applicable.

CCO	Type of Challenges and/ or Upcoming Changes	Description
IHN	Vendor updates for 837 segments.	Ayin/Capitol Dental has updated the 837 segments to meet OHA requirements, incorporating HCP01 and HCP02 beginning April 14th, 2023. Both Ayin and Capitol Dental are currently in compliance with these changes. Future adjustments are planned to further enhance this process, incorporating additional rules to the code, ensuring alignment with State-provided pay and list edits.
JCC		
PCS-CO		
PCS-CG		
PCS-Lane		
PCS-MP		
TCHP-North		
TCHP-South		
UHA	No challenges or upcoming changes.	Not applicable.
YCCO	Vendor updates for 837 segments.	Ayin/Capitol Dental has updated the 837 segments to meet OHA requirements, incorporating HCP01 and HCP02 beginning April 14th, 2023. Both Ayin and Capitol Dental are currently in compliance with these changes. Future adjustments are planned to further enhance this process, incorporating additional rules to the code, ensuring alignment with State-provided pay and list edits.

*Ayin and PH Tech are considered the same organization for the purposes of this report.

Results for Comparative Analysis

This section presents findings from the results of the comparative analysis of the dental encounter data maintained by OHA and the CCOs' dental subcontractors. The analysis examined the extent to which dental encounters submitted by the CCOs' dental subcontractors and maintained in OHA's data warehouse (and data subsequently extracted and submitted by OHA to HSAG for the study) were complete and accurate when compared to data submitted by the CCOs' dental subcontractors to HSAG.

HSAG requested both OHA and the CCOs' dental subcontractors submit the final status dental claims/encounters in their data submissions for the study. To compare OHA's and the CCOs' dental subcontractors' submitted data, HSAG developed a comparable match key between the two data sources. Data fields used in developing the match key varied by CCO but generally included the *Internal Control Number* (*ICN*) field and the associated claim line number. HSAG concatenated these field values to create a unique match key, which became the unique identifier for each dental encounter detail line in OHA's and each CCO's subcontractors' data.

Record Completeness

As described in Section 3—Encounter Data Validation Methodology, two aspects of record completeness were used—record omission and record surplus.

Encounter record omission and surplus rates are summary metrics designed to evaluate discrepancies between two data sources—i.e., primary and secondary. The primary data source refers to data maintained by an organization (e.g., the CCOs' source claims data) responsible for sending data to another organization (e.g., OHA). The secondary data source refers to data acquired by the receiving organization. By comparing these two data sources (i.e., primary and secondary), the analysis yields the percentage of records contained in one source and not the other, and vice versa. As such, encounter record omission refers to the percentage of encounters reported in the primary data source but missing from the secondary data source. For this analysis, the omission rate identifies the percentage of encounters reported by a CCO but missing from OHA's data. Similarly, the encounter record surplus rate refers to the percentage of encounters reported in the secondary data source (OHA) but missing from the primary data source (CCO).

Encounter Data Record Omission and Record Surplus

Table 4-39 displays the percentage of records present in the files submitted by the CCOs' subcontractors that were not found in OHA's files (record omission), and the percentage of records present in OHA's files but not present in the files submitted by the CCOs' subcontractors (record surplus). **Lower rates indicate better performance for both record omission and record surplus.** Fully detailed tables for each CCO are provided in the CCO-specific appendices.

Table 4-39—Record Omission and Record Surplus Rates

CCO	Omission	Surplus
AH	0.6%	0.1%
AllCare	14.2%	0.3%
CHA	0.0%	0.9%
CPCCO	0.4%	9.3%
EOCCO	1.7%	0.1%
Health Share	0.3%	13.8%
IHN	0.3%	10.2%
JCC	0.2%	4.8%
PCS-CO	1.6%	0.2%
PCS-CG	1.2%	0.2%
PCS-Lane	0.5%	0.2%
PCS-MP	0.6%	0.2%
TCHP-North	0.1%	1.9%
TCHP-South	0.7%	3.9%
UHA	<0.1%	0.7%
YCCO	0.1%	0.1%
Overall	**1.3%**	**5.9%**

Red text highlights noteworthy results, and further explanation can be found in the Statewide Conclusions, Opportunities for Improvement, and Recommendations Related to Encounter Data Validation section.

Data Element Completeness

HSAG based data element completeness measures on the number of records that match in both the OHA-submitted data files and the CCOs' subcontractor-submitted data files. HSAG evaluates element-level completeness based on element omission and element surplus rates. The element omission rate represents the percentage of records with values present in the CCOs' subcontractor-submitted data files but not in the OHA-submitted data files. Similarly, the element surplus rate reports the percentage of records with values present in the OHA-submitted data files but not in the CCOs' subcontractor-submitted data files. HSAG considers the data elements relatively complete when they have low element omission and surplus rates.

Data element accuracy is limited to those records present in both data sources with values present in both data sources. HSAG does not include records in the denominator if values are missing in at least one data source. The numerator is the number of records with the same non-missing values for a given data element. Higher data element accuracy rates indicate that the values populated for a data element in OHA-submitted encounter data are more accurate.

Finally, this section presents the all-element accuracy results for records present in both data sources with the same values (missing or non-missing) for all key data elements relevant to dental claim type. The denominator for the all-element accuracy rate is defined differently from the denominator for the element accuracy rate since it includes data elements even if values are missing in both sources. If any of the data elements are in element omission, element surplus, or an inaccurate value match, the record will not be a positive hit for the all-element accuracy numerator.

Element Omission and Element Surplus

Table 4-40 displays the number of CCOs with data element omission and element surplus results for each key data element from the dental encounters. **For the element omission and element surplus indicators, rates less than or equal to 5.0 percent indicates better performance**.

Table 4-40—Data Element Omission and Surplus

Data Element	Element Omission		Element Surplus	
	Number of CCOs With Rate ≤5%	Number of CCOs With Rate >5%	Number of CCOs With Rate ≤5%	Number of CCOs With Rate >5%
Member ID	16	0	16	0
Header Service From Date	16	0	16	0
Header Service To Date	16	0	16	0
Detail Service From Date	16	0	16	0
Detail Service To Date	16	0	16	0
Billing Provider NPI	16	0	16	0
Rendering Provider NPI	16	0	6	10

Data Element	Element Omission		Element Surplus	
	Number of CCOs With Rate ≤5%	Number of CCOs With Rate >5%	Number of CCOs With Rate ≤5%	Number of CCOs With Rate >5%
CDT Code	16	0	16	0
Tooth Number	15	1	15	1
Tooth Surface 1–5[1]	15	1	16	0
Tooth Surface 1	15	1	16	0
Tooth Surface 2	16	0	16	0
Tooth Surface 3	16	0	16	0
Tooth Surface 4	16	0	16	0
Tooth Surface 5	16	0	16	0
Oral Cavity Code 1–5[2]	16	0	16	0
Oral Cavity Code 1	16	0	16	0
Oral Cavity Code 2	16	0	16	0
Oral Cavity Code 3	16	0	16	0
Oral Cavity Code 4	16	0	16	0
Oral Cavity Code 5	16	0	16	0
Header Paid Amount	16	0	16	0

[1]The results were derived by comparing all five tooth surface field values that were submitted.
[2]The results were derived by comparing all five oral cavity code field values that were submitted.
Red text highlights noteworthy results, and further explanation can be found in the Statewide Conclusions, Opportunities for Improvement, and Recommendations Related to Encounter Data Validation section.

Element Accuracy

Table 4-41 displays the number of CCOs with key data element associated with dental encounters, where the elements were present in both data sources. For these records, the values were the same in both the CCOs' subcontractors' submitted data and OHA's submitted data (accuracy indicator). Of note, since accuracy rates were calculated only when the data elements were present in both data sources, instances when data values were missing in at least one data source no accuracy was calculated. **For this indicator, a rate of 95.0 percent or higher indicates better performance**. All data elements were evaluated at detail line level unless otherwise indicated.

Table 4-41—Data Element Accuracy

Data Element	Element Accuracy	
	Number of CCOs With Rate ≥95%	Number of CCOs With Rate <95%
Member ID	16	0
Header Service From Date	16	0
Header Service To Date	16	0
Detail Service From Date	16	0
Detail Service To Date	16	0
Billing Provider NPI	16	0
Rendering Provider NPI	16	0
CDT Code	15	1
Tooth Number	15	1
Tooth Surface 1–5[1]	15	1
Tooth Surface 1	15	1
Tooth Surface 2	15	1
Tooth Surface 3	15	1
Tooth Surface 4	14	2
Tooth Surface 5	14	0
Oral Cavity Code 1–5[2]	16	0
Oral Cavity Code 1	16	0
Oral Cavity Code 2	NA	NA
Oral Cavity Code 3	NA	NA
Oral Cavity Code 4	NA	NA
Oral Cavity Code 5	NA	NA
Header Paid Amount	16	0

[1]The results were derived by comparing all five tooth surface field values that were submitted.
[2]The results were derived by comparing all five oral cavity code field values that were submitted.
NA indicates that there were no records with data element values present in both data sources to assess accuracy.
Red text highlights noteworthy results, and further explanation can be found in the Statewide Conclusions, Opportunities for Improvement, and Recommendations Related to Encounter Data Validation section.

All-Element Accuracy

Table 4-42 displays the all-element accuracy results for the percentage of records present in both data sources and the same values (missing or non-missing) for all key data elements associated with the dental encounters. **For this indicator, higher rates indicate better performance.** Note: The numerator and denominator for the all-element accuracy rates are defined differently than what is used for the individual data element accuracy rates. They are not derived from the accuracy rate of each data element.

Table 4-42—All-Element Accuracy: Dental Encounters

CCO	Denominator	Numerator	Rate
AH	110,531	109,558	99.1%
AllCare	211,265	209,699	99.3%
CHA	77,032	76,381	99.2%
CPCCO	100,785	99,378	98.6%
EOCCO	333,869	331,753	99.4%
Health Share	1,374,291	1,333,457	97.0%
IHN	277,737	239,795	86.3%
JCC	233,136	232,696	99.8%
PCS-CO	254,200	252,548	99.4%
PCS-CG	61,979	61,591	99.4%
PCS-Lane	351,321	350,267	99.7%
PCS-MP	640,919	638,704	99.7%
TCHP-North	61,449	43,364	70.6%
TCHP-South	105,834	105,433	99.6%
UHA	177,260	176,865	99.8%
YCCO	138,300	137,993	99.8%
Overall	**4,509,908**	**4,399,482**	**97.6%**

Red text highlights noteworthy results, and further explanation can be found in the Statewide Conclusions, Opportunities for Improvement, and Recommendations Related to Encounter Data Validation section.

Statewide Conclusions, Opportunities for Improvement, and Recommendations Related to Encounter Data Validation

For the CCOs statewide, the following conclusions were made:

- The targeted assessment of encounter data information systems and processes questionnaire responses showed that the CCOs and their subcontractors have the capability to collect, process, and transmit claims and encounter data to OHA that align with encounter data submission requirements.
- Except for CHA, all CCOs delegated claims processing and dental provider management to subcontractors.
- Of the CCOs that used dental subcontractors to collect and process dental encounters, only six CCOs retained responsibility for submitting dental encounters to OHA; seven of the CCOs delegated this responsibility to subcontractors. Three CCOs reported mixed responses with only some subcontractors managing encounter submissions directly to OHA. All CCOs received copies of dental encounters from subcontractors, with nearly all integrating this data for internal purposes. Reviewing encounters before or after OHA submission was a common practice for all CCOs. While most refrained from altering encounters, one CCO (YCCO) acknowledged that it edited subcontractor data before submission.
- Overall, all CCOs and their subcontractors used one or more methods to assess and monitor the quality of dental encounter submissions. The most prevalent quality checks assessed the completeness and accuracy of dental encounters and were reported by all CCOs followed by the monitoring of timeliness (12 CCOs) and claim volume by month (11 CCOs). Notably, only seven CCOs or their subcontractors mentioned assessing alignment of payment fields in claims with financial reports, with others not addressing this aspect in their responses.
- The overall data element omission rates and surplus rates were very low for most of the evaluated data elements. However, TCHP-North exhibited high omission rates for *Tooth Number* and *Tooth Surface 1*, which were attributed to data misalignment from the subcontractor, Capitol Dental. Additionally, there were high surplus rates for *Tooth Number* for IHN and *Rendering Provider NPI* for 10 of the CCOs. In the case of IHN, records with *Tooth Number* surplus were associated with the subcontractor, Advantage Dental, and nearly half of them had the same *Billing Provider NPI*. For the 10 CCOs with high *Rendering Provider NPI* element surplus rates, further investigation revealed that more than 99.9 percent of the *Rendering Provider NPI* values in the OHA-submitted data that were not in the CCO-submitted data had the same values as the *Billing Provider NPI*. This was likely due to how OHA processes data and handles this data element in the MMIS.
- Overall, among records that could be matched between the OHA-submitted data and the CCO-submitted data, a high level of data element accuracy was observed. However, exceptions were noted, particularly in tooth information for CPCCO and TCHP-North's data, where some discrepancies in accuracy rates were identified.
- For CPCCO, the discrepancy in tooth surface values resulted from four total tooth surface values being populated in the OHA-submitted data and five populated in the CPCCO-submitted data, causing misalignment during comparison and contributing to a lower accuracy rate for *Tooth Surface 4*. Similarly, overall misalignment in the Capitol Dental data submitted by TCHP-North led to lower accuracy rates for *CDT Code*, *Tooth Number,* and *Tooth Surface 1* through *Tooth Surface 4.*

- The overall all-element accuracy rate was high at 97.6 percent. With the exception of IHN and TCHP-North, all CCOs had an all-element accuracy rate greater than or equal to 97.0 percent. In the case of IHN, the high element surplus rate for *Tooth Number* (13.1 percent) contributed to the lower all-element accuracy rate of 86.3 percent, while for TCHP-North, the previously mentioned misalignment in Capitol Dental's data resulted in the lower all-element accuracy rate of 70.6 percent.

For the CCOs statewide, the following opportunities for improvement were identified:

- During the review of the CCOs' and their dental subcontractors' questionnaire responses, HSAG noted five CCOs that did not mention conducting an encounter data quality check on claim volume by submission month. In addition, four CCOs or their subcontractors did not specify timeliness for monitoring dental encounter data.
- The CCOs' subcontractors encountered challenges in extracting and submitting required data elements, revealing potential limitations in knowledge and oversight. The report highlighted issues such as missing data and duplicated records, indicating a need for improved data extraction procedures. These challenges may stem from an inability to accurately query and report data from their encounter data systems.
- Some CCOs had missing values in the MMIS *ICN* field within their submitted claims data. During its development of the match key for the comparative analysis, HSAG noted instances where *ICN* values were absent in CCO-submitted data. This absence may have resulted in higher record omission and surplus rates given that HSAG's match key for the analysis was based on *ICN* and *Line Number*.
- While overall results from the comparative analysis indicated a high degree of element completeness and accuracy for key data elements across all CCOs, specific findings associated with tooth information showed high omission rates and/or low accuracy rates.
- Errors in data files extracted for the study were observed in some of the CCOs; consequently, the errors resulted in discrepancies in the comparative analysis.

For the CCOs statewide, the following recommendations were identified:

- HSAG recommends the CCOs enhance dental encounter data QA practices by incorporating specific checks, including claim volume by submission month. Additionally, the CCOs should establish clear and documented processes for monitoring the timeliness of data.
- The CCOs should ensure their subcontractors implement and/or augment standard quality controls to ensure accurate report and data extract production. Data quality checks should encompass various aspects, including adherence to data submission requirements, reasonable control totals, assessment of duplicate records, evaluation of data field value distributions, presence checks for missing values, and validation of data field values for reasonability.
- All CCOs should collect and retain *ICN* values within information systems to enhance data integrity and support monitoring activities.
- HSAG recommends all CCOs to work with OHA to determine the root cause(s) and resolve any identified issue(s) related to tooth information that resulted in high omission rates and/or low accuracy rates.

Mental Health Parity

Results for Mental Health Parity

Treatment Limitation Reviews

The following results highlight the types of treatment limitations used by the CCOs to manage the administration of MH/SUD and M/S covered benefits. Four types of treatment limitations were evaluated across IP, OP, Rx, and EC services:

- Financial Requirements—*payments by members for services received that are in addition to payments made by the CCO (e.g., copayments and deductibles*).
- Aggregate Lifetime or Annual Dollar Limits—*dollar limits on the total amount of a specified benefit over a lifetime or on an annual basis.*
- Quantitative Treatment Limitations—*limits*[4-8] *on the scope or duration of a benefit that are expressed numerically (e.g., days or visit limits).*
- Non-Quantitative Treatment Limitations—*limits on the scope or duration of benefits, such as PA or network admission standards. NQTLs were separated into three main categories—i.e., Medical Management, Provider Network, and Pharmacy Management.*

Responses to the *MHP Treatment Limitation Review Tool*, along with supplemental documentation (e.g., policies, procedures, processes, and workflows), were used to assess the extent to which treatment limitations were implemented and whether documentation demonstrated compliance with how MH parity requirements for MH/SUD and M/S services and benefits. To assess compliance, CCO documentation was reviewed to determine:

- The rationale for implementing the treatment limitation.
- The process and strategy for applying the treatment limitation.
- The evidentiary standards used to define the treatment limitation and assess medical necessity.
- The frequency and stringency with which the treatment limitation was applied.

Information collected was then used to determine whether processes were standardized, implemented, and applied with comparable frequency and rigor across MH/SUD and M/S benefits.

Financial Requirements

None of the CCOs reported the use of FRs in the administration of MH/SUD or M/S benefits across IP, OP, Rx, or EC services.

[4-8] Soft limits, or benefit limits that allow an individual to exceed numerical limits for MH/SUD or M/S benefits on the basis of medical necessity, are considered NQTLs.

Aggregate Lifetime or Annual Dollar Limits

None of the CCOs reported the use of an AL or ADL in the administration of MH/SUD or M/S benefits across IP, OP, Rx, or EC services.

Quantitative Treatment Limitations

Although most CCOs reported that their organizations did not apply QTLs in the administration of MH/SUD and M/S benefits across IP, OP, Rx, or EC services, seven CCOs reported using QTLs in the management of MH/SUD or M/S benefits. Specifically:

- EOCCO, IHN, PCS-CG, PCS-CO, PCS-Lane, and PCS-MP noted implementation of quantity limits on the day's supply for MH/SUD and M/S prescriptions.
- UHA noted implementation of limits on the number of hours and/or visits associated with select MH/SUD services (e.g., withdrawal management, residential treatment, and testing) and M/S services (e.g., acupuncture, home health services, and occupational/physical therapy).

However, upon review, the QTLs were identified as soft limits and incorrectly categorized since the seven CCOs allowed members to receive additional services based on an evaluation of medical necessity through PA or concurrent review (CR). As such, none of the CCOs reported the use of QTLs in the administration of MH/SUD or M/S benefits across IP, OP, Rx, or EC services.

Non-Quantitative Treatment Limitations

Since the regulatory structure of Medicaid and the OHP makes the implementation of FRs, AL/ADLs, and QTLs unlikely, NQTLs represent a key mechanism used by the CCOs to manage and ensure members' health care is necessary and appropriate. To facilitate the comprehensive review of NQTLs implemented by the CCOs, the *MHP Treatment Limitation Review Tool* included pre-populated listings of possible NQTLs across three domains—Medical Management, Provider Network, and Pharmacy Management. Table 4-43 lists the types of NQTLs pre-populated in the tool to assist the CCOs in identifying NQTLs used by each organization.

Table 4-43—Prepopulated NQTLs

Medical Management	Provider Network	Pharmacy Management
• Medical necessity criteria • Practice guidelines selection/criteria • Prior authorization • Concurrent review • Retrospective review • Outlier management • Experimental/investigational determinations	• Provider enrollment, admission, and credentialing requirements • Reimbursement rates • Geographic restrictions • Specialty requirements or exclusions • Facility type requirements • Network tiers	• Methods for determining usual, customary, and reasonable charges • Formulary design for prescription drugs • Prescription drug benefit tiers (e.g., generic versus brand name, high cost versus low cost).

Medical Management	Provider Network	Pharmacy Management
• Fail-first/step therapy requirements • Failure to complete exclusions • Medical appropriateness reviews • Requirements for lower cost therapies to be tried first	• Out-of-network/out-of-state access requirements or exclusions	

For each NQTL reported, the CCOs were required to provide appropriate documentation (e.g., descriptions, policies, procedures, processes, and flowcharts) that addressed the following questions:

1. Why was the NQTL assigned? What evidence supports the rationale for using the NQTL?
2. What procedures/processes/requirements are used to apply the NQTL by benefit and service type (e.g., time frames, evidentiary standards/documentation requirements, reviewer qualifications, monitoring/oversight of processes)?
3. How frequently/strictly is the NQTL applied (e.g., frequency of application, penalties associated with NQTL)?
4. What evidence supports the rationale for how frequently/strictly the NQTL is applied?

Table 4-44 highlights the overall ratings of compliance with parity requirements for the CCOs for NQTLs, by domain and overall.

Table 4-44—Overall Compliance With Parity Requirements by CCO and NQTL Domain

CCO Name	Medical Management	Provider Network	Pharmacy Management	Overall Compliance Rating
AH	Partially Compliant	–	Partially Compliant	**Partially Compliant**
AllCare	Partially Compliant	–	Partially Compliant	**Partially Compliant**
CHA	Compliant	Compliant	Compliant	**Compliant**
CPCCO	Compliant	Compliant	Compliant	**Compliant**
EOCCO	Partially Compliant	Compliant	Partially Compliant	**Partially Compliant**
Health Share	Partially Compliant	Partially Compliant	Partially Compliant	**Partially Compliant**
IHN	Compliant	Compliant	Compliant	**Compliant**
JCC	Compliant	Compliant	Compliant	**Compliant**
PCS-CG	Compliant	Compliant	Partially Compliant	**Partially Compliant**
PCS-CO	Compliant	Compliant	Partially Compliant	**Partially Compliant**
PCS-Lane	Compliant	Compliant	Partially Compliant	**Partially Compliant**
PCS-MP	Compliant	Compliant	Partially Compliant	**Partially Compliant**
TCHP-North	Compliant	–	Compliant	**Compliant**

CCO Name	Medical Management	Provider Network	Pharmacy Management	Overall Compliance Rating
TCHP-South	Compliant	–	Compliant	**Compliant**
UHA	Compliant	Compliant	Partially Compliant	**Partially Compliant**
YCCO	Compliant	–	Compliant	**Compliant**

– indicates the CCO reported it did not apply the category of NQTL treatment limitation to any service classification for MH/SUD or M/S benefits.

Availability of Information

In addition to understanding the various financial and treatment limitations that affect the administration of MH/SUD and M/S benefits, the Medicaid/CHIP parity rule also includes a requirement regarding the availability of information related to MH/SUD benefits. Specifically, the CCOs must make the criteria for medical necessity determinations for MH/SUD benefits available to members, potential members, and affected providers, upon request. Table 4-45 shows the parity ratings for the CCOs and OHP related to compliance with availability of information requirements.

Table 4-45—Overall Compliance With Availability of Information Requirements by CCO

CCO Name	Compliance Rating
AH	Partially Compliant
AllCare	Partially Compliant
CHA	Compliant
CPCCO	Compliant
EOCCO	Compliant
Health Share	Compliant
IHN	Compliant
JCC	Compliant
PCS-CG	Compliant
PCS-CO	Compliant
PCS-Lane	Compliant
PCS-MP	Compliant
TCHP-North	Compliant
TCHP-South	Compliant
UHA	Compliant
YCCO	Compliant

Administrative Data Profiles

The following Administrative Data Profile identified key patterns and outcomes associated with the administration of MH/SUD and M/S covered benefits across three domains:

- Claims, including IP and OP services[4-9]
- UM, including IP, OP, and Rx coverage determinations
- Provider enrollment

Each of the following subsections examines the extent to which performance metrics differed for MH/SUD and M/S services in order to identify potential areas of parity concerns. To facilitate the presentation of results, the differences noted between MH/SUD and M/S performance metrics are displayed as an absolute value, or difference.[4-10] As such, the larger the number in the figure, the greater the difference between the MH/SUD and M/S performance metrics.

Claims

To conduct the claims analysis, the CCOs submitted claims counts that encompassed all covered services (except NEMT and Rx[4-11]) by claim type (i.e., IP and OP) and provider network status (i.e., in-network and out-of-network at the header and detail claim level. Since claims are paid at the detail (service) line level, aggregate header counts were categorized as paid, partially paid, and denied. Claims were defined as *partially paid* if at least one detail claim line was denied; claims that included all paid detail lines or all denied detail lines should be classified as paid claims and denied claims, respectively. The total number of IP and OP claims was evaluated at the header level and reported as the total number paid (i.e., paid and partially paid claims) and denied overall, and by network status. The aggregate counts from the CCOs were then used to generate the percentage of claims paid by benefit type; the difference between the percentage of paid claims for MH/SUD versus M/S services was then evaluated as the core metric for evaluating parity. The absolute difference was used to classify the deviation in the rates of claims paid between MH/SUD and M/S services to determine if the difference was negligible (less than 5 percentage points), moderate (greater than or equal to 5 percentage points, but less than 10 percentage points), or substantial (greater than or equal to 10 percentage points).

Although data were not available to determine the types of services that were paid versus denied, moderate and substantial differences in rates identify areas where operational policies and procedures (i.e., claims submission requirements, authorization determinations, claims processing, provider billing, etc.) highlight instances where MH/SUD and M/S outcomes were different and warrant further review, especially when the differences were outliers compared to other CCOs and the CCO aggregate. In

[4-9] Claims data included dental claims but excluded NEMT and Rx claims.

[4-10] The *absolute value* is the actual magnitude of a numerical value or measurement. As such, the *absolute difference* represents the difference, taken without regard to sign, between the values of two variables.

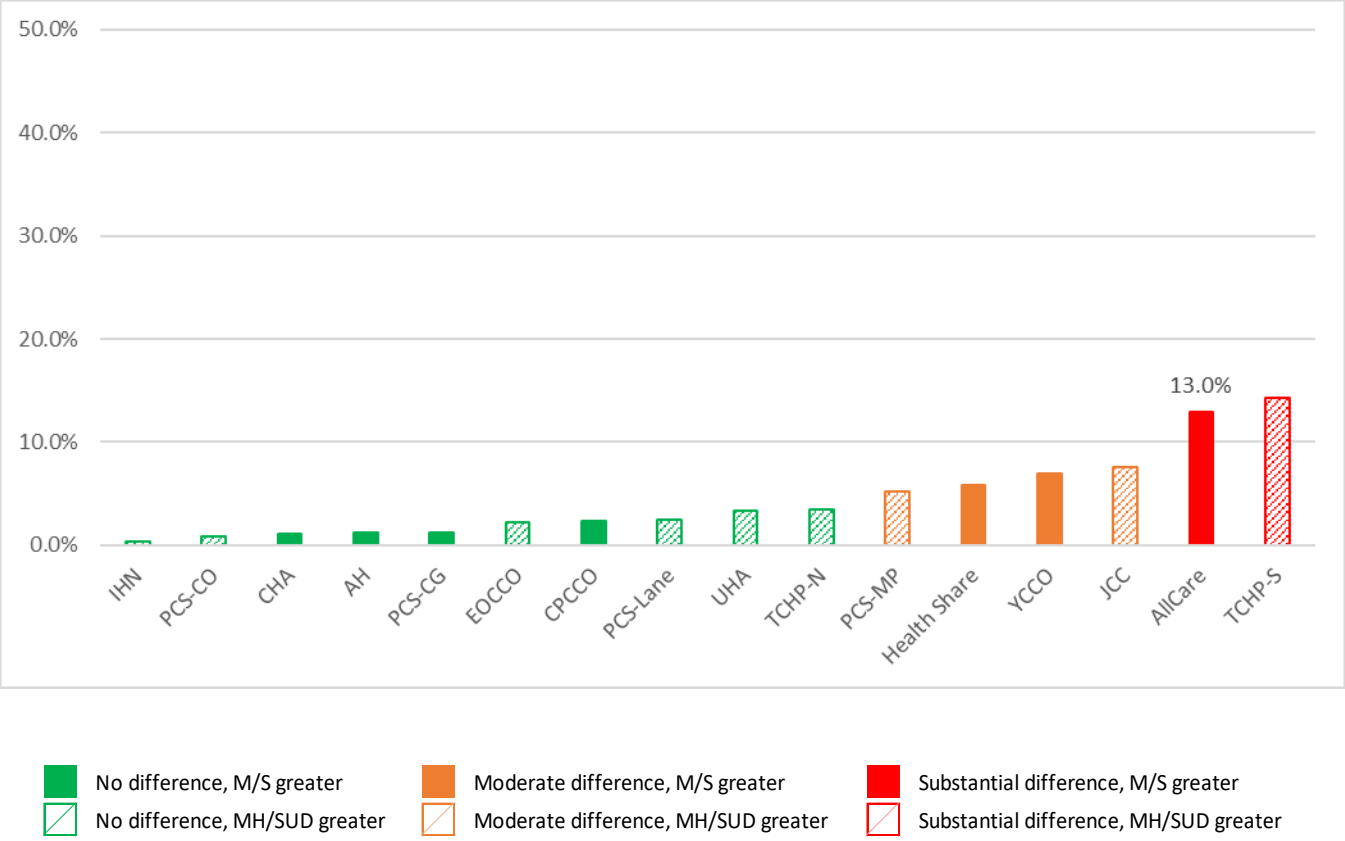
[4-11] NEMT and Rx claims were excluded from the analysis due to a general diagnosis code used for NEMT and the absence of a diagnosis code on incoming Rx claims. As a result, the CCOs were unable to distinguish and classify individual claims as MH/SUD or M/S.

addition to assessing the absolute difference in the percentage of paid claims, the analysis indicated whether the difference reflected greater rates of payment for MH/SUD services over M/S services.

Inpatient Claims

Figure 4-44 shows the absolute difference in the percentage of paid MH/SUD and M/S IP claims for all CCOs.

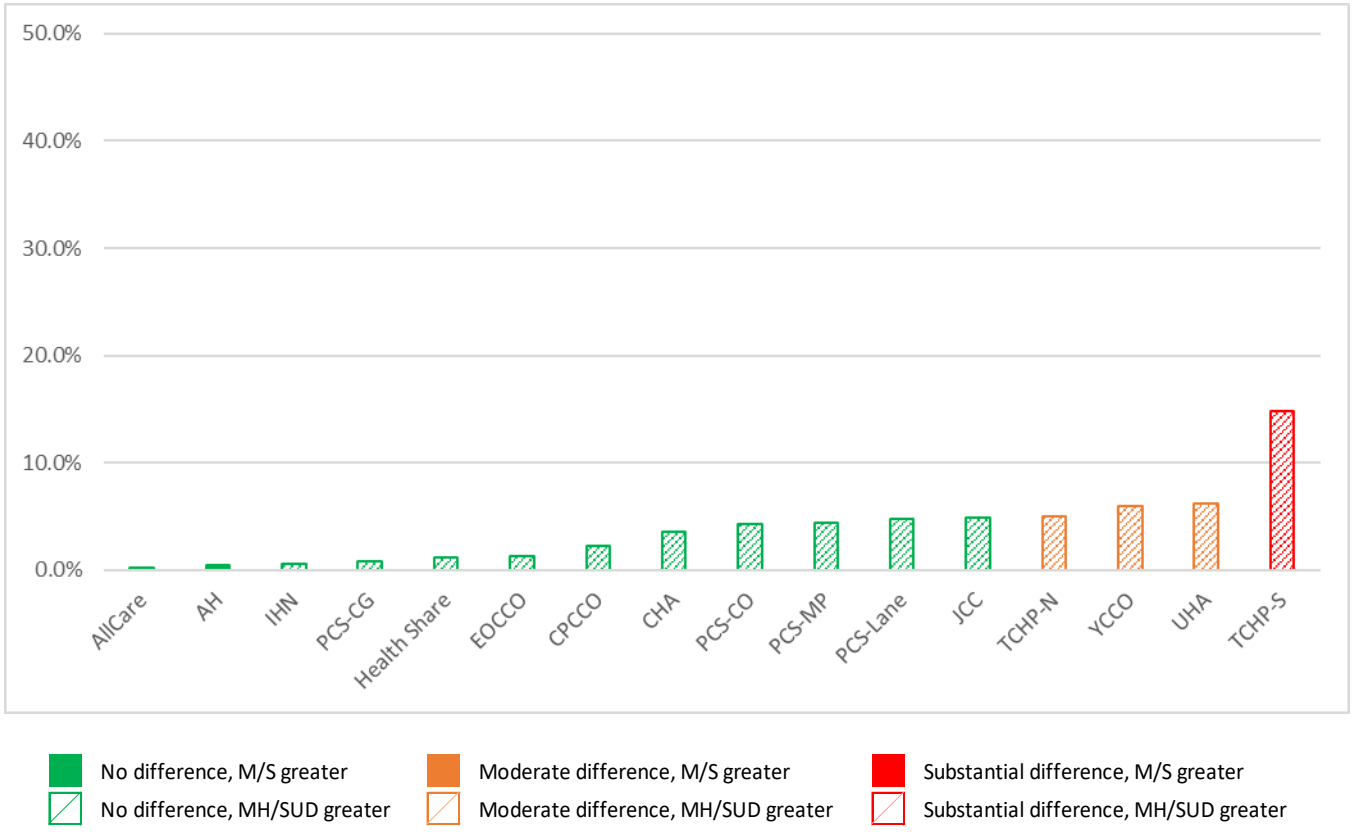
Figure 4-44—Absolute Difference in the Percentage of Paid Inpatient Claims



Outpatient Claims

Figure 4-45 shows the absolute difference in the percentage of paid MH/SUD and M/S OP claims for all CCOs.

Figure 4-45—Absolute Difference in the Percentage of Paid Outpatient Claims



Out-of-Network Paid Claims

Figure 4-46 shows the absolute difference in the percentage of paid IP MH/SUD and M/S claims for out-of-network providers for all CCOs.

Figure 4-46—Absolute Difference in the Percentage of Inpatient Paid Claims for Out-of-Network Providers

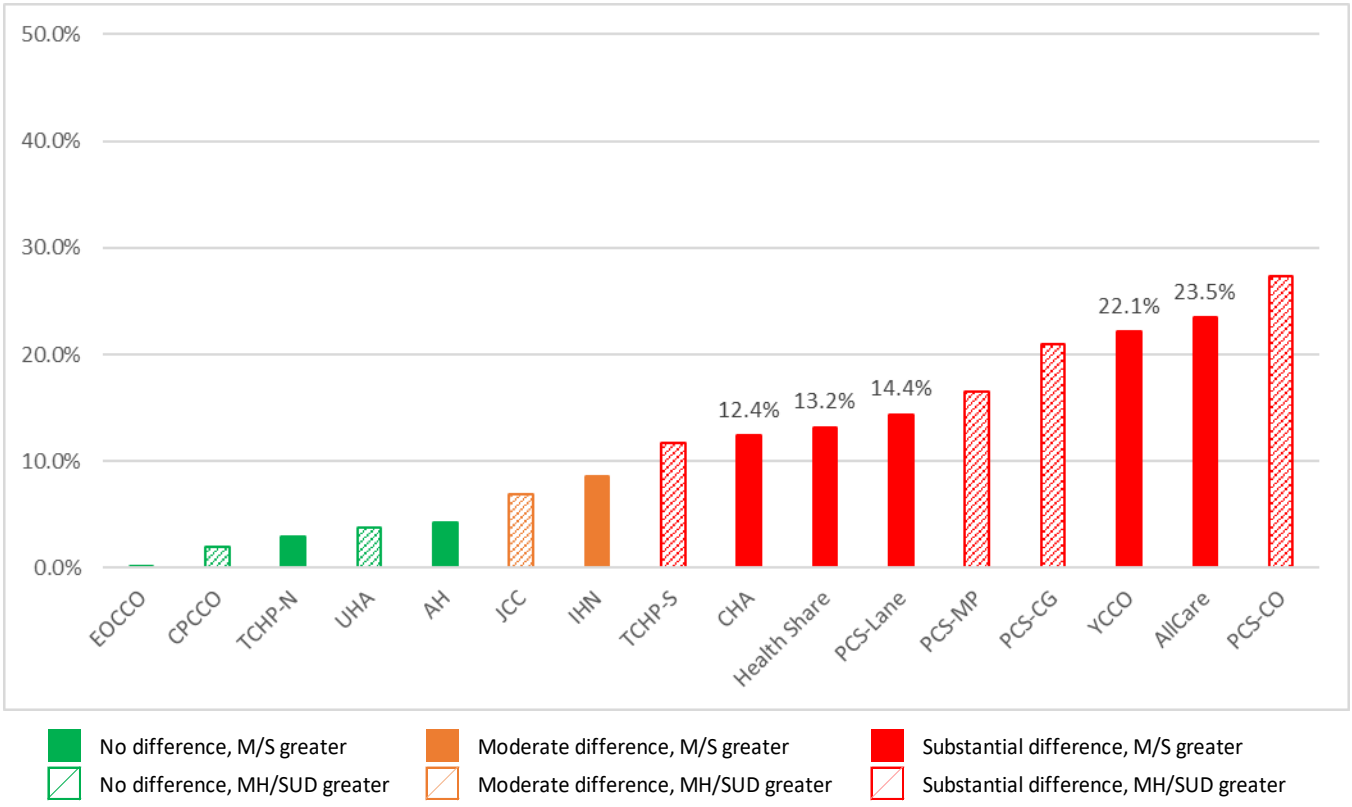
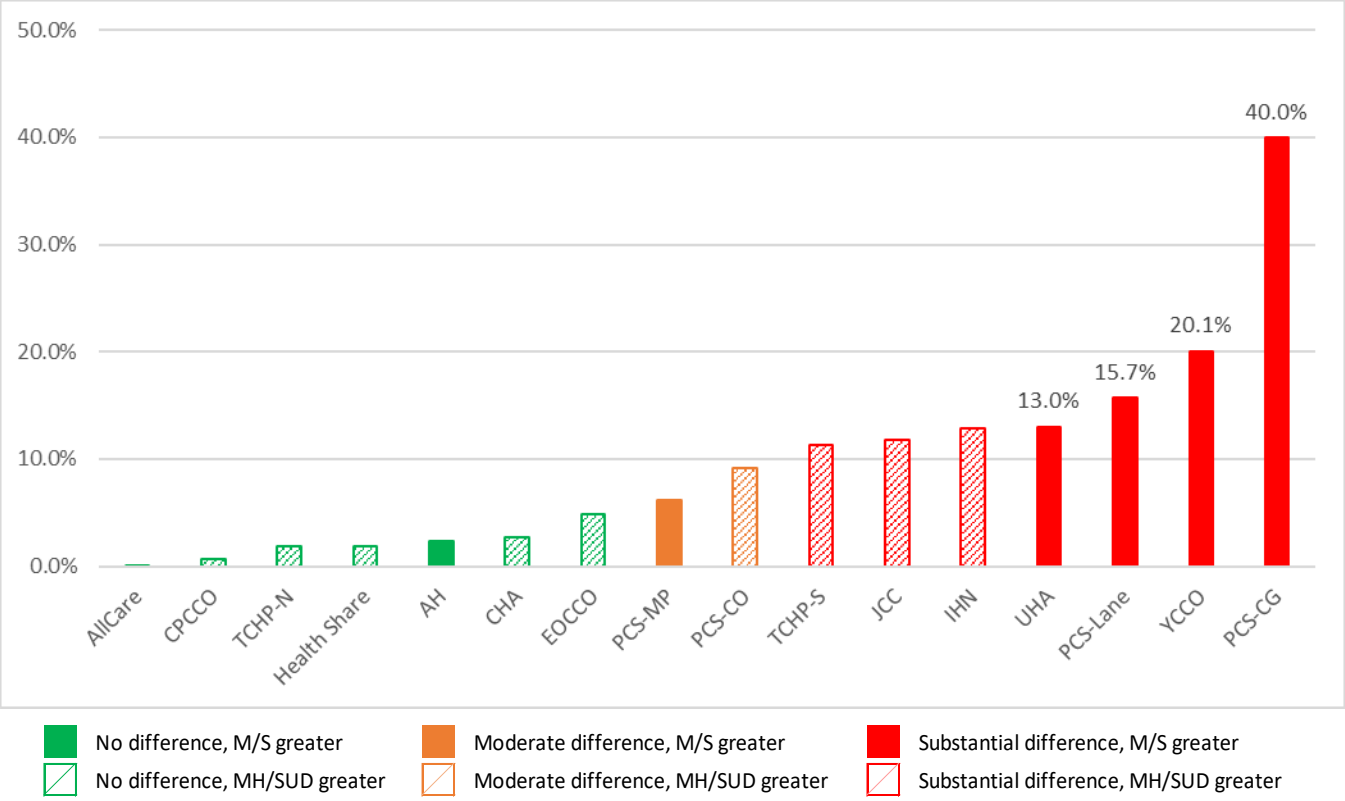


Figure 4-47 shows the absolute difference in the percentage of paid OP MH/SUD and M/S claims for out-of-network providers for all CCOs.

Figure 4-47—Absolute Difference in the Percentage of Outpatient Paid Claims for Out-of-Network Providers



Utilization Management

To conduct the UM analysis, the CCOs submitted authorization, coverage determination, and appeals and administrative hearing counts that encompassed all covered services by service type (i.e., IP, OP, and Rx). The total number of PA requests and denials was identified, reported, and stratified by M/S and MH/SUD services. The CCOs also provided aggregate counts on the number of authorization denials that were subsequently appealed and the associated outcome (i.e., upheld or overturned), as well as information regarding subsequent requests for administrative hearings. Both sets of results were stratified based on whether the denial was related to M/S or MH/SUD services. The aggregate counts from the CCOs were then used to generate the percentage of denied authorizations by benefit type; the difference between the percentage of denied authorizations for MH/SUD versus M/S services was then evaluated as the core metric for evaluating parity. The absolute difference was used to classify the deviation in denial rates between MH/SUD and M/S services to determine if the difference was negligible (less than 5 percentage points), moderate (greater than and equal to 5 percentage points, but less than 10 percent), or substantial (greater than or equal to 10 percentage points). Aggregate data on appeals and administrative hearings are not presented in the main report since the overall number of appeals and administrative hearings was too small to produce reliable statistics; however, any CCO-

specific strengths or weaknesses identified are included in the CCO Individual Plan Results and Conclusions. As such, the results in this section will focus on comparison of authorization denials. In addition to assessing the absolute difference in the percentage of authorization denials, the analysis indicates whether the difference identified greater denial rates for MH/SUD services over M/S services.

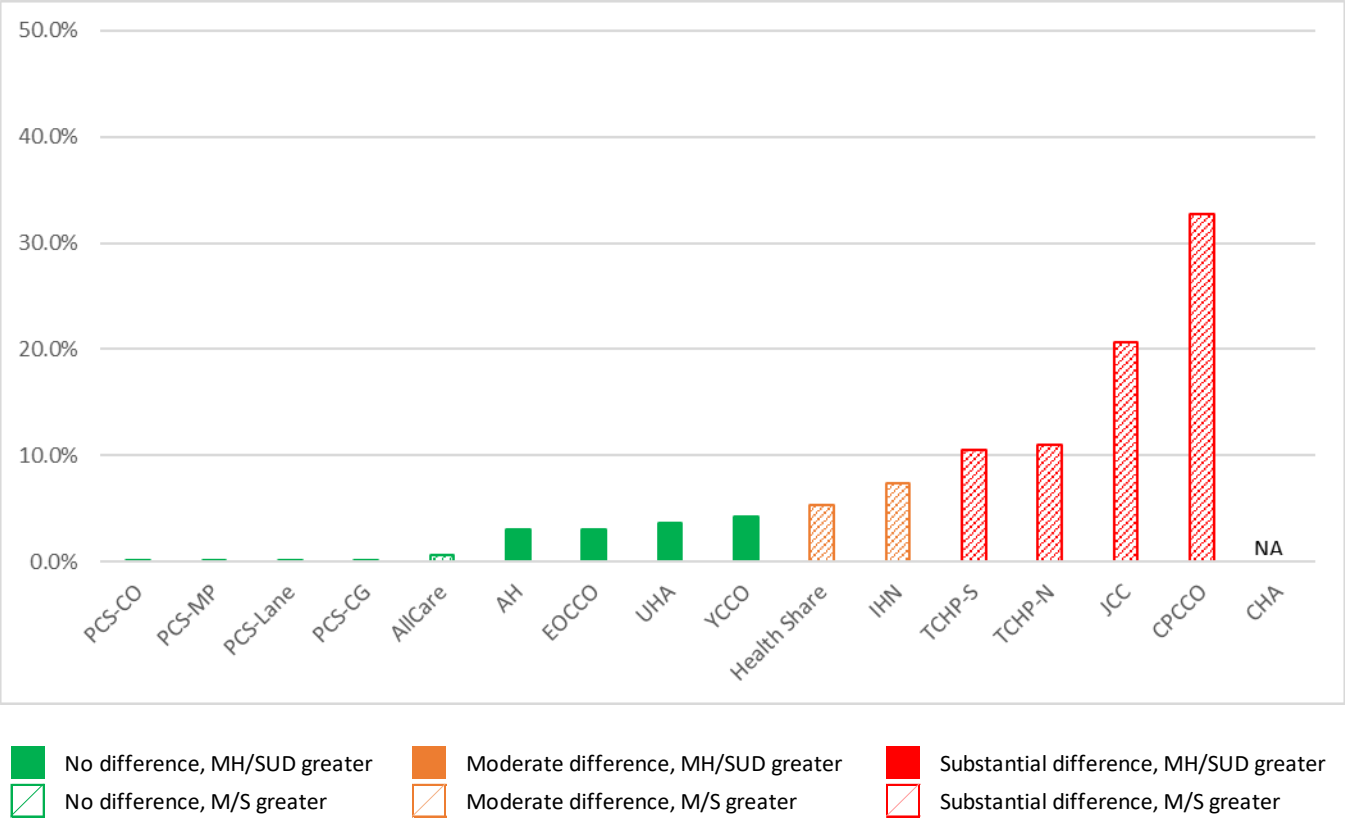
Member-level data were also captured for all PA denials. These data were reviewed to provide context for identifying potential factors contributing to moderate and substantial differences in aggregate denial rates. Results from this analysis are presented at the end of this section.

The following figures display the results of the comparisons in the percentage of IP, OP, and Rx denials for MH/SUD and M/S PA requests for all CCOs. The larger the number, the greater the difference between the percentage of PA denials between MH/SUD and paid M/S. Green bars indicate a deviation rating of *None*, while the orange and red bars indicate a rating of *Moderate* and *Substantial*, respectively. Solid bars, along with the absolute percentage-point difference, indicate that a higher percentage of MH/SUD PA requests were denied compared to M/S PA requests.

Inpatient Authorization Denials

Figure 4-48 shows the absolute difference in the percentage of denied IP MH/SUD and M/S PA requests for all CCOs. CHA reported no IP MH/SUD PA requests for CY 2022 and was, therefore, excluded from this comparative analysis.

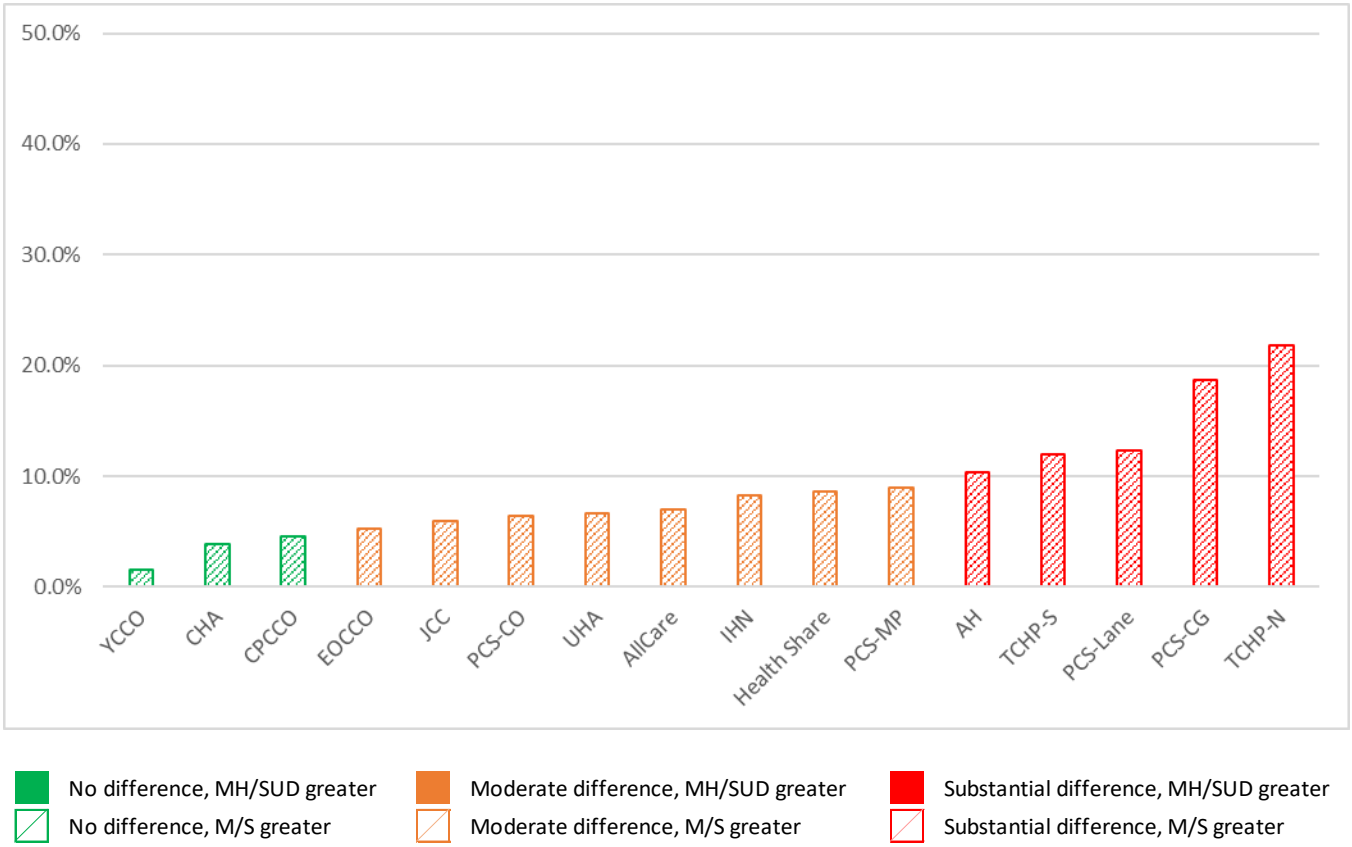
Figure 4-48—Absolute Difference in the Percentage of Inpatient PA Denials



Outpatient Authorization Denials

Figure 4-49 shows the absolute difference in the percentage of denied OP MH/SUD and M/S PA requests for all CCOs.

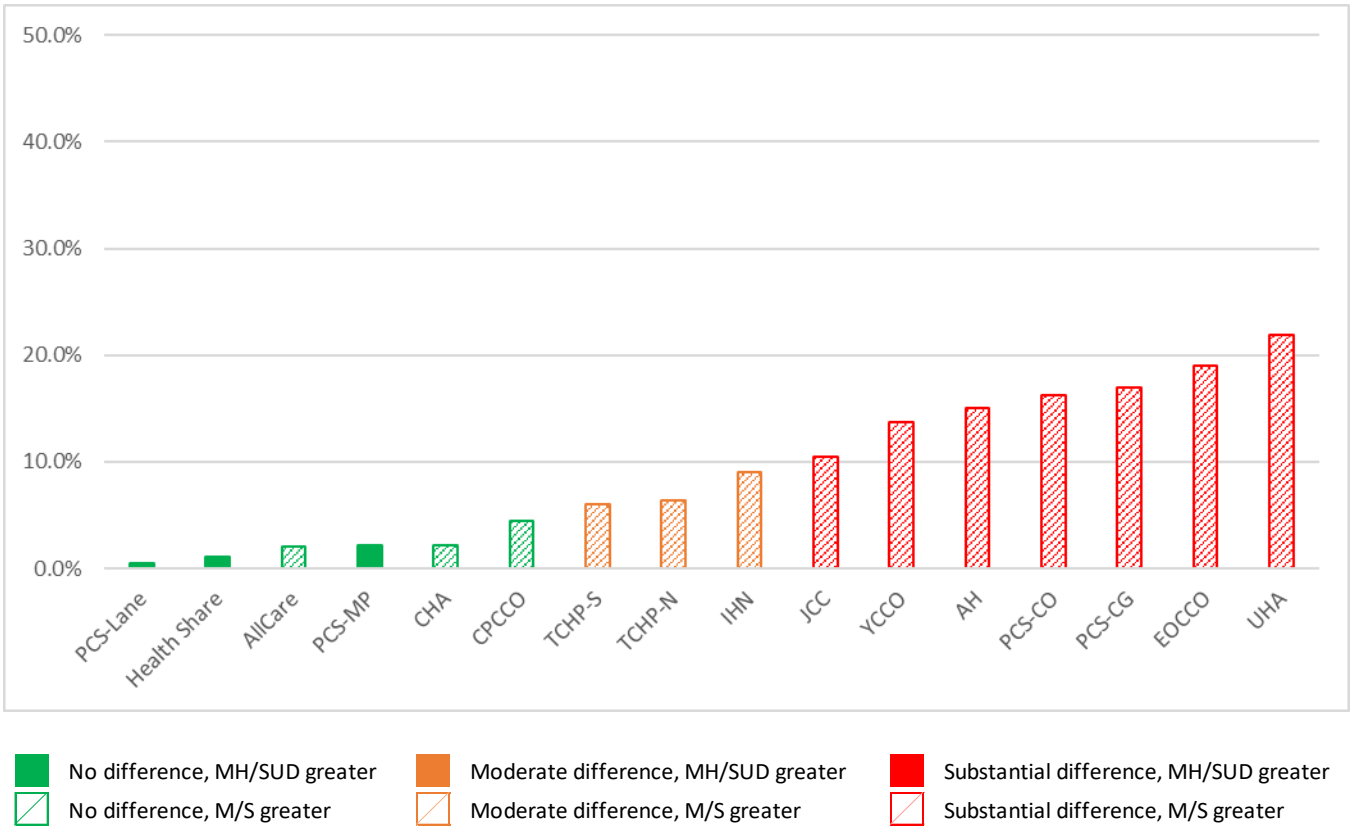
Figure 4-49—Absolute Difference in the Percentage of Outpatient PA Denials



Pharmacy Authorization Denials

Figure 4-50 shows the absolute difference in the percentage of denied Rx MH/SUD and M/S PA requests for all CCOs.

Figure 4-50—Absolute Difference in the Percentage of Pharmacy PA Denials



Member-Level Denial Reasons

To facilitate comparisons across the nonstandard categorizations of denials used by individual CCOs, denial reasons were qualitatively and thematically organized to allow for aggregation and comparison. When more than one denial reason was documented by a CCO, the primary denial reason was categorized. Following this process, denial reasons were grouped into five key categories:

- Administrative Denial—denial due to administrative issues associated with the PA request (e.g., insufficient documentation, member eligibility)
- Below the Line service requested was below the line on the OHP Prioritized List[4-12]
- Does Not Meet Criteria—requested service does not meet clinical treatment guidelines for medical necessity or appropriateness
- Not a Covered Benefit—variety of noncoverage denials (e.g., noncovered services, benefit exclusions)
- Treatment Limitations—UM controls implemented by health plans to manage member health care (i.e., provider network, visit limits, drug utilization procedures)
- Out-of-Network Provider—denial of request to receive services from a provider that is not within the CCO's provider network
- Unknown—documentation insufficient to categorize

Table 4-46 shows the statewide aggregate percentage of denial reasons by benefit (i.e., MH/SUD and M/S) for IP, OP, and Rx PA requests. Results are sorted in descending order from the most to least frequent denial reason.

Table 4-46—Statewide PA Denial Reasons by Service Type and Benefit

Denial Reason	Total	Inpatient		Outpatient		Pharmacy	
		MH/SUD	M/S	MH/SUD	M/S	MH/SUD	M/S
Does Not Meet Criteria	41.5%	81.6%	48.8%	41.6%	45.5%	62.9%	32.6%
Not a Covered Benefit	26.6%	0.7%	14.1%	10.1%	35.7%	6.4%	18.9%
Treatment Limitation	12.5%	6.9%	22.8%	12.4%	3.0%	22.6%	22.9%
Service is *Below the Line*	9.6%	0.0%	0.9%	1.2%	5.0%	2.4%	17.4%
Administrative Denial	4.7%	8.2%	9.7%	11.3%	2.8%	4.4%	6.9%
Out-of-Network Provider	3.2%	0.3%	1.4%	19.8%	5.4%	0.1%	0.4%
Unknown	1.9%	2.3%	2.3%	3.6%	2.7%	1.2%	0.9%

[4-12] Oregon Health Authority. Prioritized List of Health Services. Available at: https://www.oregon.gov/oha/hsd/ohp/pages/prioritized-list.aspx. Accessed on: Feb 26, 2024.

Record Review—Denials and Appeals

To further assess the quality and timeliness of UM determinations, HSAG requested, reviewed, and obtained clinical and administrative records from the CCOs for service authorizations resulting in a NOABD and subsequent member appeals for CCOs. The file review included:

- Assessing compliance with federal and State regulations governing the processing of member NOABDs for service authorization denials and NOARs, including timeliness and accessibility.
- Assessing the timeliness of service authorization denials and member appeal decisions.

In alignment with prior findings, the file reviews continued to demonstrate generalized issues with the CCOs' compliance with federal and State regulatory requirements surrounding the processing of NOABDs and NOARs. However, these issues were related to general implementation of the CCOs' procedures and did not reveal substantial differences in the application to MH/SUD and M/S services. Overall, the file reviews showed the CCOs had consistent issues meeting readability and accessibility standards (i.e., materials are to be written at a sixth-grade reading level) for both denial and appeal written notices, while CCOs were generally compliant with denial and appeal time frames.

Provider Enrollment

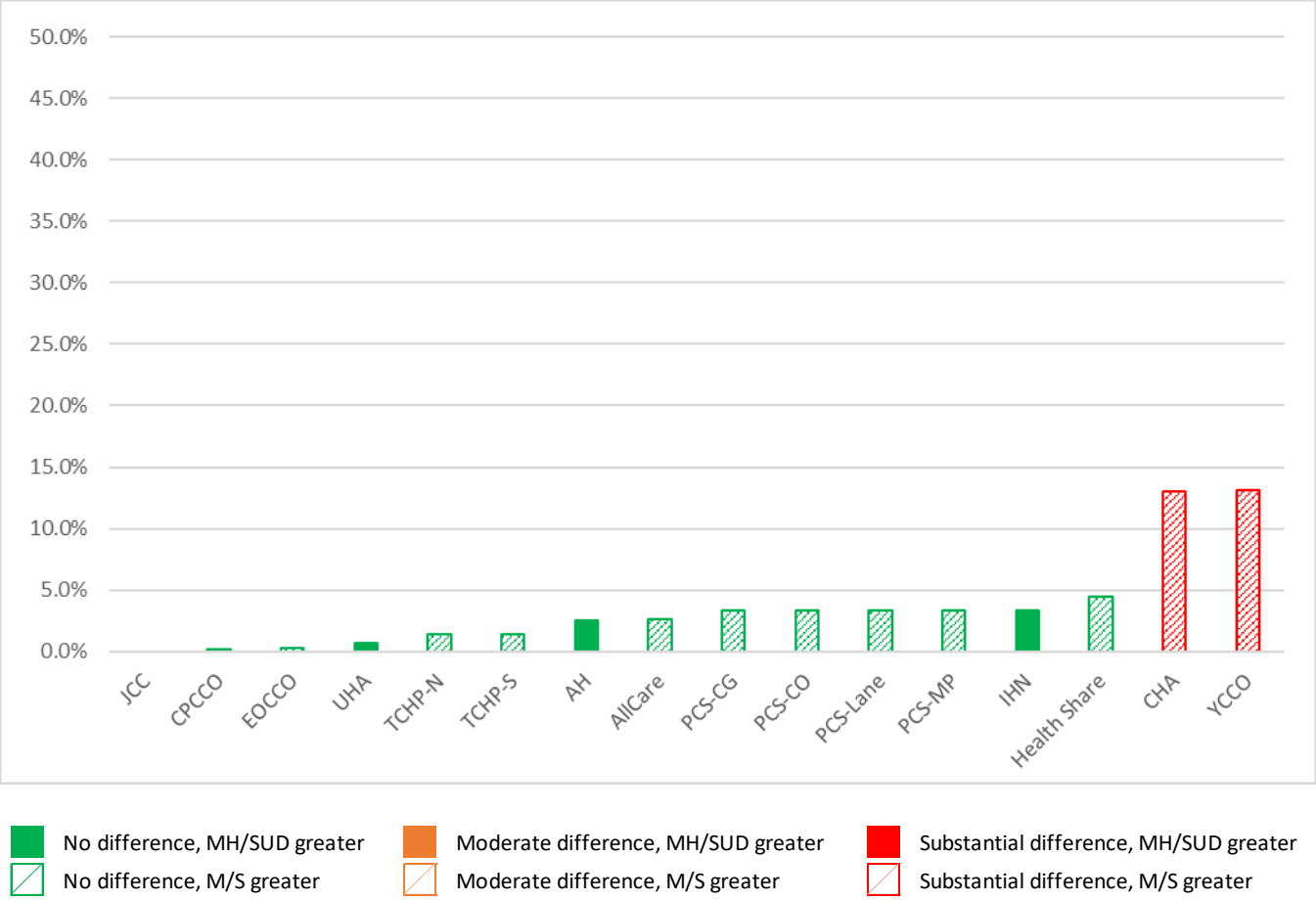
In order to assess parity related to management of provider networks, the CCOs submitted the average monthly count of MH/SUD and M/S providers along with the total number of provider applications processed, approved, and denied as well as terminated (including not being recredentialed) in CY 2022. All counts were stratified by benefit type to facilitate comparisons. These data points were collected to offer information on parity of provider credentialing practices between MH/SUD and M/S. The aggregate counts from the CCOs were then used to generate the percentage of providers terminated and approved by benefit type; the difference between the percentage of providers terminated and approved MH/SUD and M/S providers was then evaluated as the core metric for evaluating parity. The absolute difference was used to classify the deviation in termination and approval rates between MH/SUD and M/S providers to determine if the difference was negligible (less than 5 percentage points), moderate (greater than or equal to 5 percentage points, but less than 10 percentage points), or substantial (greater than or equal to 10 percentage points). In addition to assessing the absolute difference in the percentage of terminated and approved providers, the analysis indicated whether the difference identified greater rates of termination/approval for MH/SUD providers versus M/S providers.

The following figures display the results of the comparisons in the percentage of terminated and approved applications for MH/SUD and M/S providers for all CCOs, where available.

Provider Terminations

Figure 4-51 shows the absolute difference in the percentage of terminated MH/SUD and M/S providers for all CCOs. The larger the number, the greater the difference between the percentage of MH/SUD and M/S provider terminations. Green bars indicate a deviation rating of *None*, while the orange and red bars indicate a *Moderate* or *Substantial* difference, respectively. Solid bars, along with the absolute percentage-point difference, indicate that a higher percentage of MH/SUD providers were terminated compared to M/S providers.

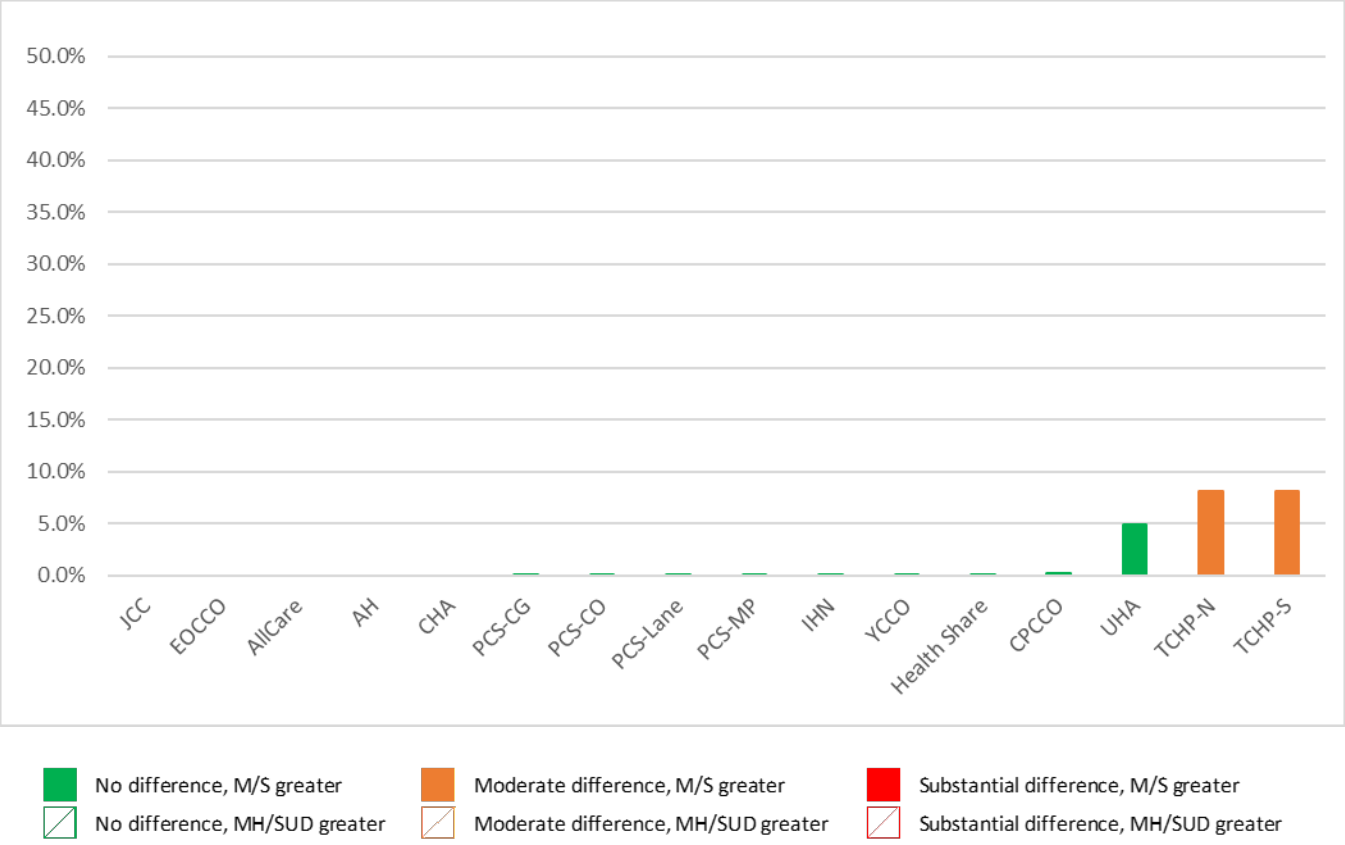
Figure 4-51—Absolute Difference in the Percentage of Providers Terminated



Provider Approvals

Figure 4-52 shows the absolute difference in the percentage of approved provider applications for MH/SUD and M/S providers for all CCOs. The larger the number, the greater the difference between the percentage of approvals between MH/SUD and M/S provider applications. Green bars indicate a deviation rating of *None*, while the orange and red bars indicate a *Moderate* or *Substantial* difference, respectively. Solid bars, along with the absolute percentage-point difference, indicate that a higher percentage of M/S provider applications were approved compared to MH/SUD provider applications.

Figure 4-52—Absolute Difference in the Percentage of Provider Applications Approved



Adequacy of MH/SUD Provider Networks

In addition to assessing the outcomes of organizational policies and procedures via a review of claims and UM, HB 3046 also requires an annual assessment of the adequacy of the provider network and timeliness of access to MH/SUD treatment and services as prescribed by the authority by rule. HSAG assessed the adequacy of the CCOs' MH/SUD provider network by evaluating several interrelated measures of members' access to MH and SUD services.

Provider Network Capacity

To address provider network capacity, HSAG conducted a review of the CCOs' provider network data files and synthesized the results to understand the provider network infrastructure in place to provide MH/SUD services to members. Using CCO data captured in OHA's quarterly *DSN Provider Capacity Reports*, HSAG aggregated the data and reported two core metrics:

- **Provider Counts**—The number and percentage of MH and SUD providers, as well as changes over time to determine the stability of each network.
- **Provider-to-Member Ratios**—The ratio of MH and SUD providers to members with at least one MH/SUD claim during the measurement year.

Provider Counts

Table 4-47 shows the total number of providers in network (i.e., Total) and total number and percentage of MH providers contracted with each CCO (i.e., MH [#] and MH [%], respectively). The table also indicates, for each CCO, whether the change from Q2 2022 to Q1 2023 resulted in a substantial increase (i.e., ↑, or 10 percent) or decrease (i.e., ↓, or 10 percent) in the total number of MH providers. The data represent a calendar difference of approximately nine months to one year. Although a comparative review of the distribution of providers showed substantial changes in many cases, caution should be used when interpreting network stability due to differences in reporting across calendar years. Provider data used to generate Q2 2022 network capacity counts and provider-to-member ratios used different data elements to classify providers than were used in Q1 2023, in accordance with OHA reporting requirements.

Table 4-47—Number and Percentage of MH Practitioners by Quarter

	Q2 2022			Q1 2023			Difference	
CCO	Total	MH (#)	MH (%)	Total	MH (#)	MH (%)	#	% Change
AH	682	159	23.3%	807	202	25.0%	43	27.0% ↑
AllCare	1,097	118	10.8%	2,326	526	22.6%	408	345.8% ↑
CHA	712	148	20.8%	657	141	21.5%	-7	-4.7%
CPCCO	16,003	2,255	14.1%	11,981	2,409	20.1%	154	6.8%
EOCCO	15,194	1,373	9.0%	9,353	1,358	14.5%	-15	-1.1%
Health Share	16,791	1,902	11.3%	14,372	2,503	17.4%	601	31.6% ↑
IHN	5,811	1,271	21.9%	6,878	1,608	23.4%	337	26.5% ↑
JCC	15,894	2,258	14.2%	12,235	2,528	20.7%	270	12.0% ↑
PCS-CG	11,488	3,607	31.4%	13,203	4,250	32.2%	643	17.8% ↑
PCS-CO	11,852	3,608	30.4%	13,520	4,251	31.4%	643	17.8% ↑

CCO	Q2 2022			Q1 2023			Difference	
	Total	MH (#)	MH (%)	Total	MH (#)	MH (%)	#	% Change
PCS-Lane	12,155	3,610	29.7%	13,823	4,250	30.7%	640	17.7% ↑
PCS-MP	12,132	3,612	29.8%	13,751	4,253	30.9%	641	17.7% ↑
TCHP-North	12,014	1,971	16.4%	7,783	1,993	25.6%	22	1.1%
TCHP-South	7,773	1,598	20.6%	6,768	1,814	26.8%	216	13.5% ↑
UHA	1,206	147	12.2%	901	177	19.6%	30	20.4% ↑
YCCO	7,728	1,868	24.2%	8,635	2,382	27.6%	514	27.5% ↑

— indicates data were not available.

NA—indicates calculation included one or more missing data elements.

Note: Counts for Q1 2023 were based on provider counts captured for time and distance analysis and may represent inflated numbers due to the counting of multiple provider locations.

Table 4-48 shows the total number of providers in network (i.e., Total), total number and percentage of SUD providers contracted with each CCO (i.e., SUD [#] and SUD [%], respectively). The table also indicates, for each CCO, whether the change from Q2 2022 to Q1 2023 resulted in a substantial increase (i.e., ↑, or 10 percent) or decrease (i.e., ↓, or 10 percent) in the total number of SUD providers. The data represent a calendar difference of approximately nine months to one year. Although a comparative review of the distribution of providers showed substantial changes in some cases, caution should be used when interpreting network stability due to differences in reporting across calendar years. Provider data used to generate Q2 2022 network capacity counts and provider-to-member ratios used different data elements to classify providers than were used in Q1 2023, in accordance with OHA reporting requirements.

Table 4-48—Number and Percentage of SUD Practitioners by Quarter

CCO	Q2 2022			Q1 2023			Difference	
	Total	SUD (#)	SUD (%)	Total	SUD (#)	SUD (%)	#	% Change
AH	682	33	4.8%	807	56	6.9%	23	69.7% ↑
AllCare	1,097	38	3.5%	2,326	144	6.2%	106	278.9% ↑
CHA	712	66	9.3%	657	69	10.5%	3	4.5%
CPCCO	16,003	486	3.0%	11,981	528	4.4%	42	8.6%
EOCCO	15,194	337	2.2%	9,353	292	3.1%	-45	-13.4% ↓
Health Share	16,791	522	3.1%	14,372	582	4.0%	60	11.5% ↑
IHN	5,811	334	5.7%	6,878	412	6.0%	78	23.4% ↑
JCC	15,894	486	3.1%	12,235	534	4.4%	48	9.9%
PCS-CG	11,488	505	4.4%	13,203	551	4.2%	46	9.1%

CCO	Q2 2022			Q1 2023			Difference	
	Total	SUD (#)	SUD (%)	Total	SUD (#)	SUD (%)	#	% Change
PCS-CO	11,852	505	4.3%	13,520	551	4.1%	46	9.1%
PCS-Lane	12,155	505	4.2%	13,823	551	4.0%	46	9.1%
PCS-MP	12,132	505	4.2%	13,751	551	4.0%	46	9.1%
TCHP-North	12,014	293	2.4%	7,783	293	3.8%	0	0.0%
TCHP-South	7,773	357	4.6%	6,768	415	6.1%	58	16.2% ↑
UHA	1,206	82	6.8%	901	100	11.1%	18	22.0% ↑
YCCO	7,728	304	3.9%	8,635	417	4.8%	113	37.2% ↑

— indicates data were not available.

NA—indicates calculation included one or more missing data elements.

Note: Counts for Q1 2023 were based on provider counts captured for time and distance analysis and may represent inflated numbers due to the counting of multiple provider locations.

Provider-to-Member Ratios

Table 4-49 shows the unique counts of MH and SUD providers, the number of members identified as having an MH or SUD diagnosis,[4-13] and the ratio of providers to members within each CCO's network. The provider-to-member ratio was calculated by dividing the number of members with an MH or SUD diagnosis enrolled with a CCO by the number of MH or SUD providers in the CCO's network. This metric serves as a way to standardize estimations of a CCO's provider network as it adjusts for membership size. Since OHA did not have specific provider-to-member ratio standards for any provider type, the results below are presented for information only.

Table 4-49—Provider-to-Member Ratios by CCO and Provider Type

CCO	MH			SUD		
	Providers (N)	Members (N)	Ratio	Providers (N)	Members (N)	Ratio
AH	202	8,416	1:42	56	4,634	1:83
AllCare	526	9,814	1:19	144	3,350	1:24
CHA	141	2,869	1:21	69	2,519	1:37
CPCCO	2,409	6,837	1:3	528	1,940	1:4
EOCCO	1,358	11,438	1:9	292	3,639	1:13
Health Share	2,503	85,559	1:35	582	20,323	1:35

[4-13] The member population used to determine provider-to-member ratios was restricted to members with at least one IP or OP claim with an MH or SUD diagnosis during CY 2022 to better reflect the population in need of MH and SUD providers.

CCO	MH			SUD		
	Providers (N)	Members (N)	Ratio	Providers (N)	Members (N)	Ratio
IHN	1,608	19,147	1:12	412	14,632	1:36
JCC	2,528	12,866	1:6	534	3,230	1:7
PCS-CG	4,250	3,221	1:1	551	595	1:2
PCS-CO	4,251	18,512	1:5	551	4,137	1:8
PCS-Lane	4,250	22,986	1:6	551	5,106	1:10
PCS-MP	4,253	26,498	1:7	551	6,095	1:12
TCHP-North	1,993	4,072	1:3	293	1,205	1:5
TCHP-South	1,814	6,998	1:4	415	2,331	1:6
UHA	177	5,707	1:33	100	1,562	1:16
YCCO	2,382	8,996	1:4	417	3,947	1:10

Time and Distance

As part of its evaluation, HSAG assessed the geographic distribution of MH and SUD providers relative to members with an MH or SUD diagnosis[4-14] to assess the percentage of members with access to an MH and SUD provider within the OHA-defined time and distance standards. These standards included the average travel time (in minutes) and driving distance (in miles) to the nearest provider for each type of provider. Additionally, the analysis included the travel time and distance to the subsequent second and third nearest provider to further assess the overall availability of MH and SUD providers.

Table 4-50 presents the average time and distance to the nearest three MH providers, by CCO and geographic setting (i.e., urban or rural). If the average driving time or distance exceeded the time and distance requirements set forth by OHA, the result is shaded in red. AH, CHA, PCS-CG, and UHA do not have urban settings within their service regions and are listed as NA and shaded gray for those categories.

Table 4-50—Average Time and Distance to the Nearest Three MH Providers by CCO and Geography

CCO	Urban						Rural					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
AH	NA	NA	NA	NA	NA	NA	3.2	4.0	4.6	2.9	3.7	4.3
AllCare	2.6	2.9	3	2.4	2.6	2.7	7.1	8.0	8.2	6.6	7.3	7.5

[4-14] The member population used to determine time and distance was restricted to members with at least one IP or OP claim with an MH or SUD diagnosis during CY 2022 to better reflect the population in need of MH and SUD providers.

CCO	Urban						Rural					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
CHA	NA	NA	NA	NA	NA	NA	4.7	5.2	5.4	4.3	4.8	5.0
CPCCO	6.2	6.2	12.6	5.7	5.7	11.6	4.0	4.3	5.4	3.7	3.9	5.0
EOCCO	1.5	1.5	1.5	1.5	1.5	1.5	5.8	7.0	7.4	5.3	6.4	6.8
Health Share	1.3	1.5	1.6	0.8	0.9	1	5.1	5.1	8.3	4.7	4.7	7.7
IHN	0.8	1	1.1	0.8	0.9	1.1	2.3	3.2	3.8	2.2	2.9	3.5
JCC	1.1	1.2	1.4	1	1.1	1.2	4.6	5.1	5.2	4.3	4.7	4.8
PCS-CG	NA	NA	NA	NA	NA	NA	3.4	3.9	4.2	3.1	3.6	3.9
PCS-CO	1.2	1.3	1.5	1.1	1.2	1.4	3.7	4.1	4.3	3.4	3.8	4.0
PCS-Lane	1	1.3	1.4	0.8	1	1.2	3.3	3.8	3.9	3.1	3.5	3.6
PCS-MP	1	1.5	1.7	0.9	1.3	1.5	3.0	3.5	3.8	2.7	3.2	3.5
TCHP-North	1.4	1.6	1.8	0.8	1	1.1	6.2	8.0	8.0	5.7	7.4	7.4
TCHP-South	1.5	1.7	1.8	1.3	1.4	1.5	3.5	4.0	4.1	3.3	3.7	3.8
UHA	NA	NA	NA	NA	NA	NA	3.1	3.9	4.0	2.9	3.7	3.7
YCCO	1.9	2.2	2.9	1.7	2	2.6	4.2	4.6	4.7	3.9	4.3	4.4

Table 4-51 presents the average time and distance to the nearest three MH providers, by CCO and geographic setting (i.e., urban or rural). If the average driving time or distance exceeded the time and distance requirements set forth by OHA, the result is shaded in red. Again, AH, CHA, PCS-CG, and UHA do not have urban settings within their service regions and are listed as NA and shaded gray for those categories.

Table 4-51—Average Time and Distance to the Nearest Three SUD Providers by CCO and Geography

CCO	Urban						Rural					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
AH	NA	NA	NA	NA	NA	NA	7.6	11.8	12.1	7.0	10.9	11.1
AllCare	3.2	3.3	3.4	3	3.1	3.1	10.6	10.7	10.7	9.6	9.7	9.7
CHA	NA	NA	NA	NA	NA	NA	5.4	5.5	5.8	5.0	5.1	5.4
CPCCO	15.8	16.3	16.3	14.5	15	15	6.0	6.1	11.8	5.5	5.6	10.8
EOCCO	1.7	1.8	33.3	1.6	1.7	30.6	6.4	6.7	7.0	5.9	6.2	6.5
Health Share	2.2	2.9	3.2	1.4	1.8	2	12.9	18.6	18.9	11.9	16.6	16.8

CCO	Urban						Rural					
	Times (Min)			Distance (Miles)			Times (Min)			Distance (Miles)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
IHN	1.8	2	2.1	1.7	1.8	1.9	12.8	13.1	13.2	11.7	12.1	12.1
JCC	2.5	2.9	2.9	2.1	2.6	2.6	12.1	17.6	17.6	10.3	15.0	15.0
PCS-CG	NA	NA	NA	NA	NA	NA	11.8	11.8	11.8	10.8	10.8	10.8
PCS-CO	2.2	2.6	2.8	2.1	2.5	2.6	6.5	6.8	7.1	6.0	6.3	6.6
PCS-Lane	2.7	2.9	3.4	2.3	2.4	2.9	10.2	30.4	32.0	9.4	27.6	29.0
PCS-MP	2.1	3.4	4.1	1.7	2.9	3.4	4.6	6.7	7.6	4.2	6.2	6.9
TCHP-North	3	3.4	3.6	1.9	2.2	2.3	19.1	19.2	19.3	17.0	17.2	17.2
TCHP-South	3	3.2	3.3	2.5	2.7	2.7	14.2	23.6	23.6	13.0	21.6	21.6
UHA	NA	NA	NA	NA	NA	NA	4.0	5.7	8.4	3.7	5.3	7.7
YCCO	3.2	3.6	3.6	2.8	3.2	3.2	5.4	13.1	13.4	5.0	12.0	12.1

Table 4-52 presents the percentages of CCO members[4-15] with access to MH and SUD services, by CCO and geographic setting. AH, CHA, PCS-CG, and UHA do not have urban settings within their service regions and are listed as NA and shaded gray for those categories. Results showing less than 95 percent of members meeting the state-defined time and distance access standards are shaded red.

Table 4-52—Time and Distance Results by CCO and Geography

CCO	MH		SUD	
	Urban	Rural	Urban	Rural
AH	NA	100%	NA	100%
AllCare	100%	100%	100%	100%
CHA	NA	100%	NA	100%
CPCCO	100%	100%	92.6%	100%
EOCCO	100%	99.6%	100%	99.0%
Health Share	100%	100%	100%	100%
IHN	100%	100%	100%	100%
JCC	100%	100%	100%	100%
PCS-CG	NA	100%	NA	100%
PCS-CO	100%	100%	100%	100%
PCS-Lane	100%	100%	100%	100%

[4-15] The member population used to determine time and distance was restricted to members with at least one IP or OP claim with an MH or SUD diagnosis during CY 2022 to better reflect the population in need of MH and SUD providers.

CCO	MH		SUD	
	Urban	Rural	Urban	Rural
PCS-MP	100%	100%	100%	100%
TCHP-North	100%	100%	100%	100%
TCHP-South	100%	100%	100%	100%
UHA	NA	100%	NA	100%
YCCO	100%	100%	100%	100%

Appointment Availability

Even with adequate capacity and the appropriate distribution of services, assessing the timeliness of access to relevant services is critical to ensuring adequate access to care. *Appointment Availability* addresses how quickly OHP members are able to make an appointment and get in to see a provider. Although not directly captured in this evaluation, the CCOs' responses to the CY 2023 DSN Provider Narrative were reviewed to understand how each organization monitored the availability of appointments to MH/SUD and M/S services and providers. HSAG assessed the scope and consistency of each CCO's methodology and approach to monitoring appointment availability across MH/SUD and M/S services. Table 4-53 presents a summary of each CCO's appointment availability monitoring.

Table 4-53—Monitoring of Appointment Availability by CCO

CCO	Is the Plan Generally Monitoring Appointment Availability?	Is the Plan Specifically Monitoring Appointment Availability of MH/SUD?	Description of Monitoring Method
AH	Yes	Yes	Provider clinics surveyed electronically each quarter. Annual verbal survey of 500 members. Assessed appointment wait time average, cancellations, reschedules, and third next available appointment (TNAA). Included surveys of MH/SUD providers. The CCO conducted member grievance monitoring.
AllCare	No	No	None determined.
CHA	Yes	Yes	Monthly secret shopper calls to randomly selected providers. Provider type rotated monthly between PCP, PCD, and BH. However, aggregate results were not provided. The CCO conducted member grievance monitoring.
CPCCO	Undetermined	Undetermined	CCO provided a description of methodology including BH - specific provider surveys and site visits. However, evidence was insufficient to determine implemented monitoring of M/S or MH/SUD providers for appointment availability. The CCO conducted member grievance monitoring.

CCO	Is the Plan Generally Monitoring Appointment Availability?	Is the Plan Specifically Monitoring Appointment Availability of MH/SUD?	Description of Monitoring Method
EOCCO	Yes	Yes	Provider surveys and quarterly data submissions for appointment availability compliance. However, for all service categories except dental, evidence suggested that quarterly grievance monitoring remained the primary appointment availability monitoring method, which suggested an insufficient monitoring process.
Health Share	Yes	Yes	Convened a workgroup across health plans and BH providers to review aggregate information on TNAAs, provider surveys, site visits, and grievance monitoring. However, subcontractors' monitoring methods varied greatly, making overall comparison opaque across plans and for Health Share overall. Additionally, BH monitoring focused on outpatient appointments only. The CCO conducted member grievance monitoring.
IHN	Yes	Yes	Annual provider surveys, including BH. The CCO conducted member grievance monitoring.
JCC	Undetermined	Undetermined	CCO provided a description of methodology including BH-specific provider surveys and site visits. However, evidence was insufficient to determine implemented monitoring of M/S or MH/SUD providers for appointment availability. The CCO conducted member grievance monitoring.
PCS-CO	Yes	Yes	Third party conducted random sample of 4,000 members per month by CCO region selected by eligible claim type including MH/SUD. Third party conducted monthly provider surveys, ensuring MH/SUD providers were included in representative sample. Internal threshold of 90 percent provider compliance with State timeliness standards. Results reviewed by multiple committees; evidence of follow-up with noncompliant providers submitted. The CCO conducted member grievance monitoring.
PCS-CG	Yes	Yes	See PCS-CO.
PCS-Lane	Yes	Yes	See PCS-CO.
PCS-MP	Yes	Yes	See PCS-CO.
TCHP-North	Yes	Yes	Third party vendor conducted annual provider appointment availability survey, including prescribing and non-prescribing MH/SUD providers. The CCO conducted member grievance monitoring.

CCO	Is the Plan Generally Monitoring Appointment Availability?	Is the Plan Specifically Monitoring Appointment Availability of MH/SUD?	Description of Monitoring Method
TCHP-South	Yes	Yes	See TCHP-North.
UHA	Yes	Yes	Conducted quarterly provider surveys and monthly secret shopper calls, including for BH providers and subcontractors. The CCO conducted member grievance monitoring.
YCCO	Yes	Yes	Conducted quarterly provider surveys. However, survey results show very low response rates. The CCO was working to correct this. The CCO conducted member grievance monitoring.

Access-Related Grievances

The CY 2023 MHP Evaluation also reviewed the percentage of access-related MH and SUD grievances to identify potential areas of concern with the availability of MH and SUD providers within each CCO's network. Table 4-54 shows the percentage of access-related grievances compared to the overall number of grievances for MH and SUD services.

Table 4-54—Percentage of Access-Related MH/SUD Grievances

CCO	Total Grievances	MH/SUD		MH/SUD Access-Related Grievances	
		Number	Percent	Number	Percent
AH	361	15	4.2%	4	26.7%
AllCare	184	70	38.0%	4	5.7%
CHA	107	1	0.9%	0	0.0%
CPCCO	309	8	2.6%	2	25.0%
EOCCO	809	43	5.3%	10	23.3%
Health Share	7,414	149	2.0%	31	20.8%
IHN	743	9	1.2%	4	44.4%
JCC	332	4	1.2%	1	25.0%
PCS-CG	118	1	0.8%	0	0.0%
PCS-CO	730	7	1.0%	0	0.0%
PCS-Lane	2,044	9	0.4%	1	11.1%
PCS-MP	1,675	21	1.3%	3	14.3%
TCHP-North	356	8	2.2%	0	0.0%

CCO	Total Grievances	MH/SUD		MH/SUD Access-Related Grievances	
		Number	Percent	Number	Percent
TCHP-South	716	17	2.4%	1	5.9%
UHA	695	10	1.4%	2	20.0%
YCCO	322	11	3.4%	2	18.2%

Statewide Conclusions, Opportunities for Improvement, and Recommendations Related to Mental Health Parity

For the CCOs statewide, the following conclusions were made:

- Based on the findings outlined in the CY 2023 MHP Evaluation, and in collaboration with the CP groups, the administration of MH/SUD and M/S benefits was largely found to be in parity for the CCOs. Although the evaluation identified several opportunities for improvement, results did not identify systemic issues that negatively impacted parity between MH/SUD and M/S services. Rather, findings frequently highlighted general regulatory compliance issues affecting both MH/SUD and M/S benefits uniformly.
- Of the four treatment limitations, the CCOs used a variety of NQTLs (i.e., Medical Management, Provider Network, and Pharmacy Management) to manage and ensure members' health care services received were necessary and appropriate. Among the most prevalent were UM processes (i.e., PA, CR, and retrospective review, medical necessity criteria, provider credentialing requirements, and drug utilization review mechanisms (i.e., formulary design). Overall, the CCOs demonstrated a high level of compliance with parity requirements for individual NQTLs when sufficient information and supporting documentation were provided for the implemented NQTL. Seven CCOs demonstrated full compliance across all NQTL domains while nine CCOs received an overall parity rating of *Partially Compliant* due to one or more domains being *Partially Compliant*—most frequently NQTLs associated with Pharmacy Management.
- Overall, the CCOs demonstrated that medical necessity criteria information was made available to members, potential members, and network providers through a variety of formats, including member handbooks, provider manuals, CCO websites, and via notices to members when a service or reimbursement for an MH/SUD service was denied. Two CCOs (i.e., AH and AllCare) received *Partially Compliant* parity ratings due to insufficient documentation demonstrating how medical necessity criteria were disseminated to all required individuals or evidence that these criteria were shared.
- For the Administrative Data Profile, parity between MH/SUD and M/S benefit administration was evaluated across three domains: claims (i.e., paid IP and OP claims, including in- and out-of-network providers); UM (i.e., IP, OP, and Rx PA denials); and provider enrollment (i.e., terminations and provider application approvals). Overall, CCO aggregate results across each domain continued to show minimal differences in the administration of MH/SUD and M/S benefits across the CCOs, although considerable variation in CCO performance remains within each of the measures.

- Overall, the difference in the percentage of paid MH/SUD and M/S claims for the CCO aggregate across all claims (i.e., IP, OP, in-network, and out-of-network) was negligible, although individual CCOs exhibited considerable variation in payment rates across all stratifications. When individual CCO differences were moderate or substantial for paid IP and OP claims, the deviation was generally due to a higher percentage of paid MH/SUD claims versus paid M/S claims.
- Overall, differences in the percentage of denials for MH/SUD and M/S PA requests continued to vary across all service types (i.e., IP, OP, and Rx). While the percentage point differences in the CCO aggregate denial rates were negligible between IP and Rx MH/SUD and M/S services, the percentage point difference in the CCO aggregate OP denial rate was substantial (greater than 10 percentage points).
- Overall, the difference in the statewide CCO percentage of terminated providers for MH/SUD and M/S providers was negligible, with 14 CCOs exhibiting little to no difference in the percentage of MH/SUD and M/S providers terminated or not recredentialed in CY 2022, While the remaining CCOs showed substantial differences in the percentage of terminated providers, those differences were related to higher termination rates among M/S providers. Similarly, the difference in the statewide CCO percentage of provider applications approved for MH/SUD and M/S providers was also negligible, with all but two CCOs exhibiting little to no difference in the percentage of MH/SUD and M/S provider applications approved in CY 2022.
- Between 2022 and 2023, CCOs exhibited substantial increases in the number of contracted MH and SUD provider counts across all CCOs, with only a few demonstrating decreases in the count of MH and SUD providers. Several factors likely contributed to these increases, including the CCOs' efforts to increase enrollment and contracting with MH providers in response to members' needs as well as improvements to the quality of provider data and changes in study protocols (e.g., provider categorization). Additionally, provider-to-member ratios were low, indicating the CCOs had a large number of providers contracted to perform MH and SUD services relative to members with an MH or SUD diagnosis.
- The CY 2023 MHP Evaluation assessed the geographic distribution of MH and SUD providers relative to members with an MH or SUD diagnosis. In general, the results demonstrated that the average drive time and distance to the nearest three MH and SUD providers were within time and distance requirements set by OHA for both urban and rural geographic settings (i.e., 30 minutes/30 miles for urban areas and 60 minutes/60 miles for rural areas). Moreover, with one exception, the CCOs were in compliance with OHA time and distance standards, demonstrating that 95 percent of members with an MH or SUD diagnosis had access to MH and SUD services. However, while these results suggest that MH and SUD providers were distributed in proportion to members' locations, the findings should be interpreted with caution, as the specific types of MH and SUD providers within time and distance parameters may or may not be relevant to specific member needs. Additionally, time and distance metrics represent only one of several network monitoring metrics used to assess provider network adequacy.
- Overall, only 2.2 percent of all CCO grievances were associated with MH/SUD benefits or service, with an average CCO rate of 3.1 percent. The results showed a consistent distribution of MH/SUD-related grievances, with most CCOs having less than 6 percent of all grievances related to MH/SUD services (excluding AllCare at 38.0 percent). Further, while the percentage of access-related

grievances associated with MH/SUD services was low for CCOs, with an aggregate rate of 17.0 percent, the range of access-related MH/SUD grievances across individual CCOs was substantially wider. It is important to note that grievances are a limited monitoring tool for CCOs, given that members must have both the means and the inclination to file a grievance. These results reinforce OHA's guidance that grievance monitoring, while required and valuable, likely captures only a fraction of members' overall experiences and should not be used as the total or primary mechanism for monitoring network adequacy and decision making. Further, due to the nature of MH/SUD clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health plan than those with a M/S diagnosis, contributing to the low rate of grievances and thereby underestimating these results.

For the CCOs statewide, the following opportunities for improvement were identified:

- Overall, the CCOs reported that their organizations did not apply FRs or AL/ADLs in the administration of MH/SUD and M/S benefits for IP, OP, Rx, or EC services. Additionally, while some CCOs reported using QTLs in the management of MH/SUD and M/S benefits, the QTLs were identified as soft limits and incorrectly categorized by the CCOs. This finding suggests confusion among CCO staff regarding the nature of benefit limitations and how they apply to understanding parity across MH/SUD and M/S benefits. These findings align with prior MHP evaluations and the regulatory structure of the Oregon managed care program.
- The majority of the *Partially Compliant* and *Not Compliant* findings resulted from insufficient information or clear evidence of parity associated with selection of the NQTL and the consistency and stringency with which it was applied to MH/SUD and M/S benefits across service types (i.e., IP, OP, and Rx). Only two CCOs were *Partially Compliant* across all reported domains, due to the lack of information regarding delegated subcontractors' policies and procedures, or challenges addressing MHP requirements.
- The review of availability of information identified that several organizations included links to the Health Evidence Review Commission Prioritized List of Health Services without interpretive guidelines or instructions, which could represent a barrier to members' understanding of these resources.
- The review of administrative data from the CCOs raised concerns related to the quality and consistency of data and/or implementation of claims, UM, and provider enrollment processes, although this is not necessarily indicative of an impact on parity across benefit types. Identified differences in claims, UM, and provider enrollment outcome patterns suggest additional review by the CCOs is needed.
- When CCO absolute differences in the percentage of PA denials were *moderate* or *substantial*, MH/SUD PA requests were typically denied less frequently than M/S PA requests. A review of denial reasons across benefit type and services revealed that most denials were related to services not meeting clinical criteria or for non-covered services. However, while patterns of denial reasons were relatively stable, OP PA denials demonstrated variations in between MH/SUD and M/S services with a greater percentage of MH/SUD OP PA denials related to UM controls and treatment limitations, administrative denials, and out-of-network providers suggesting an area requiring greater review to ensure parity across MH/SUD and M/S services.

- At least half of the CCOs exhibited moderate or substantial differences in the percentages of out-of-network paid IP and OP claims wherein the deviation was due to a lower percentage of paid MH/SUD claims compared to paid M/S claims when analysis was restricted to out-of-network paid IP and OP claims. Although differences in the percentage of paid out-of-network claims may be legitimate, they may also indicate procedural or network differences that highlight potential barriers to members' access to MH/SUD services.
- Overall, nearly all CCOs reported assessing appointment availability as part of their ongoing monitoring of network adequacy using provider surveys. In some cases, CCOs conducted secret shopper surveys of providers or surveyed members about their experience with appointment availability. However, the CCOs described a variety of approaches to collecting and using these data, with widely varying degrees of relevance, rigor, and utility. As a result, data are not comparable across plans and, in some cases, are of limited value to support network adequacy monitoring for CCOs. Importantly, these provider surveys frequently stratified results by provider type and included assessments of appointment availability to MH/SUD providers.

For the CCOs statewide, the following recommendations were identified:

- Based on the findings in this report, HSAG recommends that, in addition to completing planned attestations in 2024 and 2025, CCOs receiving a treatment limitation rating of *Partially Met* or *Not Met* for medical management, provider network, or pharmacy management controls should be required to resubmit responses and documentation to demonstrate compliance with parity requirements until all outstanding items are resolved.
- The CCOs should review out-of-network claim denials to understand factors affecting the lower percentage of paid MH/SUD IP and OP claims compared to M/S IP and OP claims, and assess whether any barriers exist for members accessing MH/SUD services, including the need to seek services outside the CCO's network (e.g., appointment availability).
- The CCOs should take steps to ensure that available information is readily accessible to members.

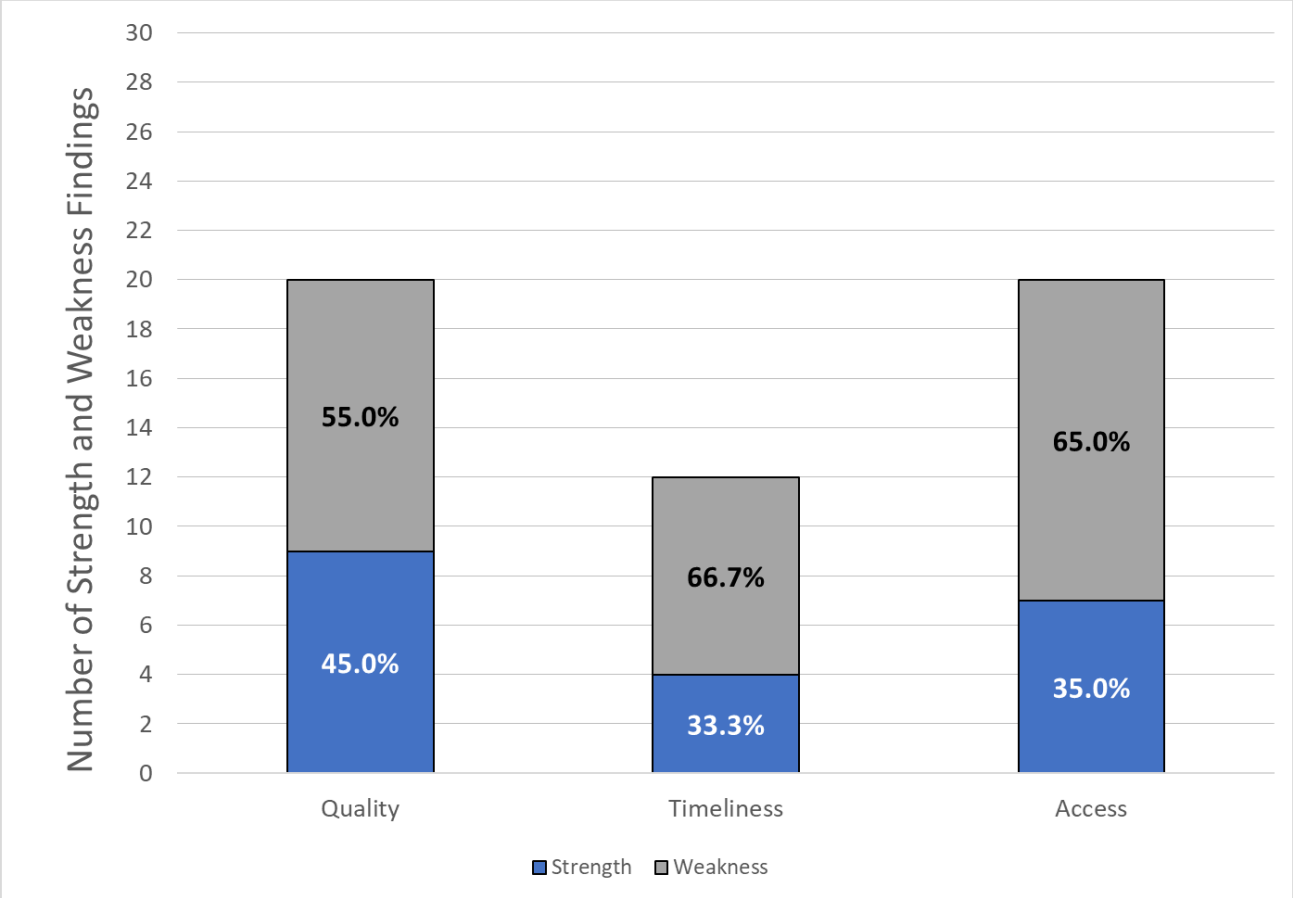
5. CCO Individual Plan Results and Conclusions

Advanced Health

Results and Conclusions

HSAG assessed the strengths and weaknesses of each CCO with respect to the quality, timeliness, and accessibility of health care services. Figure 5-1 illustrates the number of strengths exhibited by AH relative to the number of weaknesses identified during the CY 2023 EQR activities across the three domains. The greater the proportion of weaknesses, the greater opportunities for improvement.

Figure 5-1—AH Overall Number of Findings (Strengths and Weaknesses) by Domain



Detailed results from the EQR's substantive findings are summarized in Table 5-1 for each activity. This table highlights the extent to which AH furnishes high quality, timely, and appropriate access to health care services, and recommendations for how AH can best address issues identified for each activity.[5-1]

[5-1] See Section 4—Comparative Statewide Results for detailed, CCO-specific scores associated with EQR activity.

Table 5-1—AH Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)[5-2]
Compliance Monitoring Review		
−	**Weakness:** AH received a score of 72.2 percent in Standard III—Coordination and Continuity of Care due to a lack of operational structure and failure to appropriately screen and assess/reassess members for care management and intensive care coordination (ICC) services. **Why the weakness exists:** AH's policies and procedures did not align with federal and State requirements. Additionally, AH failed to notify lower acuity members of the person formally designated as primarily responsible for coordinating the services accessed by the member. Finally, AH failed to demonstrate a streamlined method of assessing and reassessing members and updating the member's care plan within the appropriate time frame for members enrolled in case management. **Recommendations:** AH must revise its policies and procedures to align with federal and State requirements. AH must also demonstrate notification to members at all levels of the person formally designated as primarily responsible for coordinating the services accessed by the member. Finally, AH must demonstrate implementation of appropriate assessments, reassessments, and revision of treatment plans according to federal and State requirements.	
−	**Weakness:** AH received a score of 63.9 percent in Standard IV—Coverage and Authorization of Services due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting AH's ability to adhere to federal and State requirements for authorizing services and to ensure proper and timely notification of adverse benefit determinations. **Why the weakness exists:** AH's policies and procedures did not align with federal and State requirements. Additionally, AH demonstrated reversing service authorization decisions outside the appeal process. AH also failed to demonstrate mechanisms for ensuring consistent application of medical necessity criteria. Finally, AH failed to adhere to requirements for the appropriate decision-makers, proper outreach to retrieve the information needed to process service authorization requests, time frames and required content for NOABDs, and adherence to federal and State extension requirements. **Recommendations:** AH must revise its policies and procedures to align with federal and State requirements. AH must demonstrate adherence to federal and State requirements for authorization of services, and	

[5-2]  = Quality,  = Timeliness,  = Access

Strength/ Weakness	Description	Domain(s)[5-2]
	required content and time frames for notification of adverse benefit determinations.	
–	**Weakness:** AH received a score of 90.0 percent in Standard VII—Member Rights and Protections due to deficits in its operational structure, impacting AH's ability to ensure that member rights are respected and members are notified of their rights as required by federal and State requirements. **Why the weakness exists:** AH's policies and procedures and member- and provider-facing materials did not align with federal and State requirements. **Recommendations:** AH must revise its policies and procedures and member- and provider-facing materials to align with federal and State requirements.	
–	**Weakness:** AH received a score of 79.6 percent in Standard X—Grievance and Appeal Systems due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting AH's ability to ensure member grievances and appeals are addressed and responded to appropriately. **Why the weakness exists:** AH's policies and procedures did not align with federal and State requirements. Additionally, AH failed to adhere to requirements for appropriate decision-makers, time frames for acknowledging and responding to grievances and/or appeals, and readability of notices. AH also failed to communicate grievance and/or appeal requirements to members, providers, and subcontractors. Finally, AH failed to demonstrate maintaining one level of appeal, being the final adjudicator on appeals, and adherence to federal and State appeal extension requirements. **Recommendations:** AH must revise its policies and procedures to align with federal and State requirements. Additionally, AH must demonstrate adherence to requirements for appropriate decision-makers; time frames for acknowledging and responding to grievances and/or appeals; readability of notices; and implementation of federal and State requirements within communications to members, providers, and subcontractors. AH must also demonstrate maintaining one level of appeal, being the final adjudicator on appeals, and adherence to federal and State appeal extension requirements.	
–	**Weakness:** AH received a score of 84.1 percent in Standard XIV—Member Information due to deficits in its operational structure and failure to demonstrate implementation of an established process, impacting AH's ability to ensure timely and proper member communication.	

Strength/ Weakness	Description	Domain(s)[5-2]
	Why the weakness exists: AH's policies and procedures and member-facing materials, including the member handbook and medication formulary, did not align with federal and State requirements. **Recommendations:** AH must revise its policies, procedures, and member-facing materials to align with federal and State requirements.	
−	**Weakness:** AH received a score of 70.8 percent in Standard XVI—Emergency and Poststabilization Services due to a lack of operational structure to ensure poststabilization services are covered appropriately. **Why the weakness exists:** AH failed to demonstrate plan documents, such as policies and procedures, and the provider manual did not appropriately define "emergency and poststabilization services" and communicate the appropriate requirements. **Recommendations:** AH must revise the applicable plan documents to define "emergency and poststabilization services" and communicate the appropriate requirements.	
Performance Improvement Projects		
Statewide Mental Health Service Access Monitoring PIP		
+	**Strength:** AH successfully continued the Implementation stage for the PIP, receiving a *Met* score for 100 percent of applicable evaluation elements in the PIP validation tool. In the Implementation stage, AH accurately reported baseline and RY 1 performance indicator data, identified and analyzed barriers to improving MH service access, carried out interventions to address those barriers, and refined interventions based on intervention evaluation results.	
+	**Strength:** AH's RY 1 performance indicator results demonstrated statistically significant improvement in MH service access compared to baseline indicator results.	
Statewide Substance Use Disorder PIP		
+	**Strength:** AH successfully initiated the Implementation stage for the PIP, receiving a *Met* score for 100 percent of applicable evaluation elements in the PIP validation tool. In the Implementation stage, AH accurately reported baseline performance indicator data; identified and analyzed barriers for initiation, engagement, and treatment of alcohol and other drug use disorders; and began to carry out interventions to address those barriers.	
Performance Measure Validation		
+	**Strength:** AH's MY 2022 performance on the *Members Receiving Preventive Dental or Oral Health Services—Ages 1 to 5 Years* and *Ages 6 to 14 Years* measure indicators improved by more than 5 percentage	

Strength/ Weakness	Description	Domain(s)[5-2]
	points compared to MY 2021; 7.4 percentage points for members ages 1 to 5 years and 12.5 percentage points for members ages 6 to 14 years. The CCO's performance on this measure demonstrated ongoing improvement for members in both age groups since MY 2020. In addition, the CCO's MY 2022 rates in both age groups exceeded the 2020 CCO 75th percentile benchmark set by OHA for MY 2022 by 5 percentage points or more.	
+	**Strength:** AH's performance on the *Oral Evaluation for Adults With Diabetes* measure demonstrated ongoing improvement since MY 2020.	
+	**Strength:** AH's performance on the *Child and Adolescent Well-Care Visits—Ages 3 to 6 Years* measure indicator demonstrated ongoing improvement since MY 2020.	
−	**Weakness:** AH's MY 2022 rates on the *Initiation of SUD Treatment* and *Engagement of SUD Treatment* measure indicators for members ages 18 years and older fell below the statewide aggregate and the 2020 HEDIS national Medicaid median benchmarks set by OHA for MY 2022 by 5 percentage points or more. **Why the weakness exists:** In response to EQR recommendations, AH noted that access to reliable, real-time, and actionable data on the utilization of SUD treatment services continues to be a consistent barrier to performance on the *Initiation and Engagement of SUD Treatment* measure. **Recommendations:** AH took several steps in 2022 to improve performance on this measure. AH used internal claims-based dashboards to visualize utilization of SUD treatment services and identify gaps in the provider network. Additionally, AH participated in the statewide *Substance Use Disorder* PIP introduced by OHA in 2022 and supported peer support specialists with the work of reaching members in rural and remote communities who are ready to receive SUD treatment. AH should continue implementing these efforts to raise its rates on this measure to the level of the benchmarks set by OHA.	
Validation of Network Adequacy		
Delivery System Network Evaluation		
+	**Strength:** AH showed general stability in its provider network and timely access to key primary care service and specialty providers. AH also showed substantial increases in provider types lacking in previous years through additional contracting (i.e., MH and SUD providers).	
−	**Weakness:** AH did not fully demonstrate key components of its DSN monitoring and analysis process. **Why the weakness exists:** AH's DSN Provider Narrative submission did not sufficiently describe how collected information on provider	

Strength/ Weakness	Description	Domain(s)[5-2]
	panel status, telehealth utilization, and the availability of physical accessibility accommodations was used to inform its network adequacy monitoring and decision-making. **Recommendations:** AH should ensure that its responses within the DSN Provider Narrative Template describe and demonstrate how information collected for provider panel status, telehealth utilization, and the availability of physical accessibility accommodations is used to inform and support its network adequacy monitoring and decision-making.	
Secret Shopper Survey		
−	**Weakness:** The total secret shopper survey response rate was 74.3 percent across all PCP and PCD cases. Of the total PCD locations, 64.3 percent were reached. Of the total responsive cases, 65.4 percent of the offices offered the requested services, 50.0 percent accepted OHP and the CCO, and 46.2 percent accepted new patients. Although 92.3 percent of the total cases confirmed the location, the rate for PCD cases was 88.9 percent. **Why the weakness exists:** In addition to limitations related to the secret shopper approach, the accuracy of AH's provider data may have contributed to the low response rate and accuracy results. **Recommendations:** HSAG recommends that AH use the case-level analytic data files to address the data deficiencies identified during the secret shopper survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
−	**Weakness:** Of the total secret shopper responsive cases, only 11.5 percent resulted an appointment, and none of the appointments offered by PCD and PCP offices were within the wait time compliance standard. **Why the weakness exists:** In addition to limitations related to the secret shopper approach, the accuracy of AH's provider data may have contributed to the low appointment availability rate. Additionally, internal office procedures may have contributed to the long wait times. **Recommendations:** HSAG recommends that AH confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. AH should use the case-level analytic data files containing data deficiencies identified during the secret shopper survey calls.	

Strength/ Weakness	Description	Domain(s)[5-2]
Revealed Telephone Survey		
−	**Weakness:** Overall, 37.8 percent of the total revealed telephone survey sampled cases were reached, of which none refused to participate in the survey. Of the total responsive cases, 76.5 percent of the offices confirmed the location, 64.7 percent offered the requested specialty, 64.7 percent accepted OHP and AH, 52.9 percent accepted new patients, and 72.7 percent offered translation or interpreter services. **Why the weakness exists:** In addition to limitations related to the revealed telephone approach, the accuracy of AH's provider data may have contributed to the low response rate and accuracy results. **Recommendations:** HSAG recommends that AH use the case-level analytic data files to address the data deficiencies identified during the revealed telephone survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, program information, and translation/interpreter services offered).	
−	**Weakness:** Of the revealed telephone survey sampled cases, only 15.6 percent of the survey respondents offered a new patient appointment, while only 20.0 percent of survey respondents offered an appointment for an existing patient. Of the total cases that offered an appointment, 68.8 percent of routine appointments and 46.7 percent of urgent appointments were within the wait time compliance standard. **Why the weakness exists:** In addition to limitations related to the revealed telephone approach, the accuracy of AH's provider data may have contributed to the low appointment availability rate. Additionally, internal office staffing structures and procedures may have contributed to the long wait times. **Recommendations:** HSAG recommends that AH confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. AH should use the case-level analytic data files containing data deficiencies identified during the revealed telephone survey calls and work with BH outpatient offices to identify the root cause for delays in appointment availability.	
Encounter Data Validation		
+	**Strength:** The AH-submitted data exhibited high record-level data completeness, with low record omission and surplus rates.	
+	**Strength:** Encounters that could be matched between data extracted from OHA's data warehouse and data extracted from AH's or the subcontractor's data system exhibited a high level of element completeness (i.e., low element omission and surplus rates) across all evaluated key data elements.	

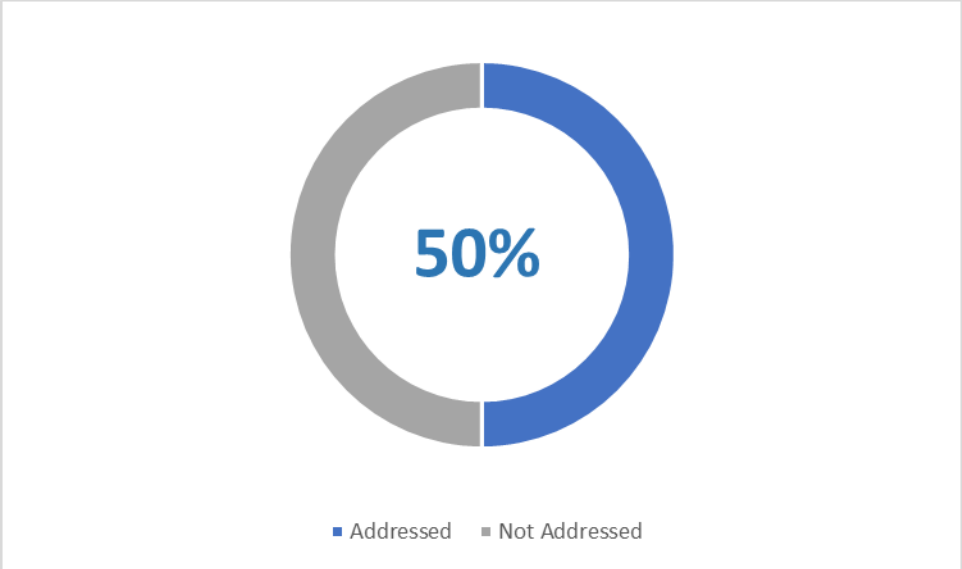
Strength/ Weakness	Description	Domain(s)[5-2]
+	**Strength:** Among records that could be matched between the two data sources, a high level of element accuracy (i.e., data elements from both sources had the same values when populated) was exhibited across all evaluated key data elements.	
+	**Strength:** The AH-submitted data had high all-element accuracy for all evaluated key data elements, indicating that the values (missing or non-missing) in both data sources (AH and OHA) were the same for almost all records.	
Mental Health Parity Evaluation		
−	**Weakness:** AH was partially compliant with the Medical Management NQTL requirement. **Why the weakness exists:** AH did not demonstrate that the processes and requirements used to apply concurrent and retrospective review NQTLs by benefit and service classification to MH/SUD benefits are applied with no more stringency than M/S benefits in the same classification. **Recommendations:** AH should review its implementation of concurrent and retrospective review NQTLs for OP MH/SUD services to ensure that the additional limitation based on the benefit does not impede the member's ability to access OP care more so than M/S.	
−	**Weakness:** AH was partially compliant with the Pharmacy Management—Formulary Design NQTL requirement. **Why the weakness exists:** AH did not provide its rationale for the assignment of the NQTL (i.e., prescription drug formulary); procedures used for the development formulary (e.g., individuals involved in formulary development, professional guidelines used, and how often the formulary is reviewed and updated/by whom); or how frequently or strictly the NQTL is applied (e.g., ability of the provider to request an exception). **Recommendations:** AH should identify processes, strategies, evidentiary standards, and other factors used in formulary design and application for prescription drugs.	

Follow-Up on Prior Year Recommendations

HSAG evaluated AH's approach to addressing the recommendations and/or findings issued during CY 2022 and unresolved findings from CY 2020 and CY 2021 while conducting the CY 2023 EQR activities. The CCOs not addressing findings and recommendations are at risk of being out of compliance with their contracts.

Figure 5-2 illustrates the degree in which the CCO sufficiently addressed the recommendations for QI made by HSAG during the CY 2022 EQR.

Figure 5-2—Percentage of CY 2022 EQR Recommendations Addressed by AH



AH-specific CY 2022 recommendations and follow-up CY 2023 assessments are summarized in Table 5-2.

Table 5-2—Assessment of AH's Approach to Addressing Previous Annual Recommendations

CY 2022 Recommendation	CY 2023 Assessment
Compliance Monitoring Review	
Standard I—Availability of Services	
This recommendation was initially given during the CY 2021 EQR. HSAG recommends AH revise its policies and procedures and provider communications to include complete and accurate network access information. In addition, AH should ensure processes include ongoing monitoring of provider network compliance and corrective actions when providers fail to meet network access requirements.	**AH did not sufficiently address the recommendation.** AH revised its policies and procedures to include all family planning services. However, AH continued to lack sufficient mechanisms to ensure ongoing monitoring of network provider compliance with the state-established network access standards and corrective actions when providers fail to meet the requirements. HSAG recommends AH implement processes to ensure ongoing monitoring of provider network compliance and corrective actions when providers fail to meet network access requirements.

CY 2022 Recommendation	CY 2023 Assessment
Standard II—Assurances of Adequate Capacity and Services	
This recommendation was initially given during the CY 2021 EQR. AH should ensure its processes for monitoring provider network capacity include monitoring individual specialty types. AH should also ensure its methodology for monitoring provider network capacity includes data collected from monitoring appointment wait times and access issues identified during audits.	**AH did not sufficiently address the recommendation.** AH did not demonstrate a consistent and established process for monitoring the number, mix, and geographic locations of individual specialty types. Additionally, AH lacked evidence of monitoring results of appointment compliance in its evaluation of provider network capacity. AH should implement formal monitoring of the number, mix, and geographic locations of its individual specialty provider network to demonstrate the provider network meets the needs of its members. AH should also ensure that it demonstrates, through committee meeting minutes or related documentation, that it included results of appointment compliance in its evaluation of provider network capacity.
Standard III—Coordination and Continuity of Care	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard IV—Coverage and Authorization of Services	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard V—Provider Selection	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard VI—Subcontractual Relationships and Delegation	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard VII—Member Rights and Protections	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard VIII—Confidentiality	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard IX—Enrollment and Disenrollment	
AH should revise its policy, procedures, and documents to align with federal and State	**AH did not sufficiently address the recommendation.** AH revised its policies,

CY 2022 Recommendation	CY 2023 Assessment
requirements. AH should also demonstrate oversight and monitoring of disenrollment reasons and evidence of efforts to ensure compliance with regulatory requirements.	procedures, and member-facing documents to align with federal and State enrollment and disenrollment requirements. The CCO also reported monitoring of disenrollment reasons at its PCP Assignment Committee meeting and provided an example of the report. However, the materials that were used to train enrollment and disenrollment staff did not align with federal and State requirements. AH should ensure its documents align with federal and State requirements.
Standard X—Grievance and Appeal Systems	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard XI—Practice Guidelines	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard XII—Quality Assessment and Performance Improvement	
AH should revise its QAPI program structure to align with federal and State requirements for a QAPI program. AH should also demonstrate implementation and appropriate oversight of its QAPI program.	**AH did not sufficiently address the recommendation.** AH began revising its QAPI program structure to align with federal and State requirements for a QAPI program; however, the CCO did not demonstrate appropriate oversight of its QAPI program, including implementing a QI committee that meets the State's requirements. AH should ensure appropriate oversight of its QAPI program, including implementing a QI committee that meets the State's requirements.
Standard XIII—Health Information Systems, including ISCA	
AH should ensure its staff are trained and knowledgeable of oversight processes as defined within its policies and procedures, and that staff implement these processes. AH staff should also maintain appropriate documentation of all oversight activities, including follow-up and corrective actions taken when issues are identified.	**AH sufficiently addressed the recommendation.** Documentation reviewed during the CY 2023 CMR activity demonstrated compliance with the standard.
Standard XIV—Member Information	
This standard was not assessed during the 2022 CMR.	Not applicable.

CY 2022 Recommendation	CY 2023 Assessment
Performance Improvement Projects	
Statewide Mental Health Service Access Monitoring PIP	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Statewide Substance Use Disorder PIP	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Performance Measure Validation	
In response to the EQR recommendations provided last year, AH acknowledged the MY 2021 decline in performance on the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Ages 18 Years and Older* measure. AH is participating in a statewide *Substance Use Disorder* PIP introduced by OHA in 2022. AH should continue to monitor its provider network to identify gaps in access to alcohol and other drug abuse and dependence care, and work with providers to identify alternative approaches to ensuring the quality, timeliness, and accessibility of treatment services (e.g., telehealth strategies, mobile clinics).	**AH sufficiently addressed the recommendation.** AH reported using internal claims-based dashboards to visualize utilization of SUD treatment services at both the member and organizational level, enabling AH to identify gaps in the provider network. AH reported collaborating with existing SUD care providers to expand efforts to recruit and retain providers. Lastly, AH participated in the statewide *Substance Use Disorder* PIP introduced by OHA in 2022 and supported work by peer support specialists to engage members that are ready to receive SUD treatment regardless of their geographic location. AH should continue implementing these efforts to raise its rates on this measure to the level of the benchmarks set by OHA.
Validation of Network Adequacy	
This recommendation was initially given during the CY 2021 EQR. AH should ensure that it reports DSN Provider Capacity Reporting data values for all required data fields and seek technical assistance from OHA as needed.	**AH sufficiently addressed the recommendation.** AH's reported data quality results for Q1 2023 showed a high degree of confidence in data fields that were present, complete, and in a valid format.
Encounter Data Validation	
AH should investigate the root cause for the omissions and consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews would then be provided to providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.	**AH sufficiently addressed the recommendation.** Based on the response, AH implemented the Health Care Fraud Shield system in April 2023, allowing the identification of trends in claims submissions. The audits conducted focused on professional coding scenarios and addressed potential overuse of modifiers 25 and 59. The response indicated progress in addressing the recommendation. Performance improvement was noted in the form of program integrity audits

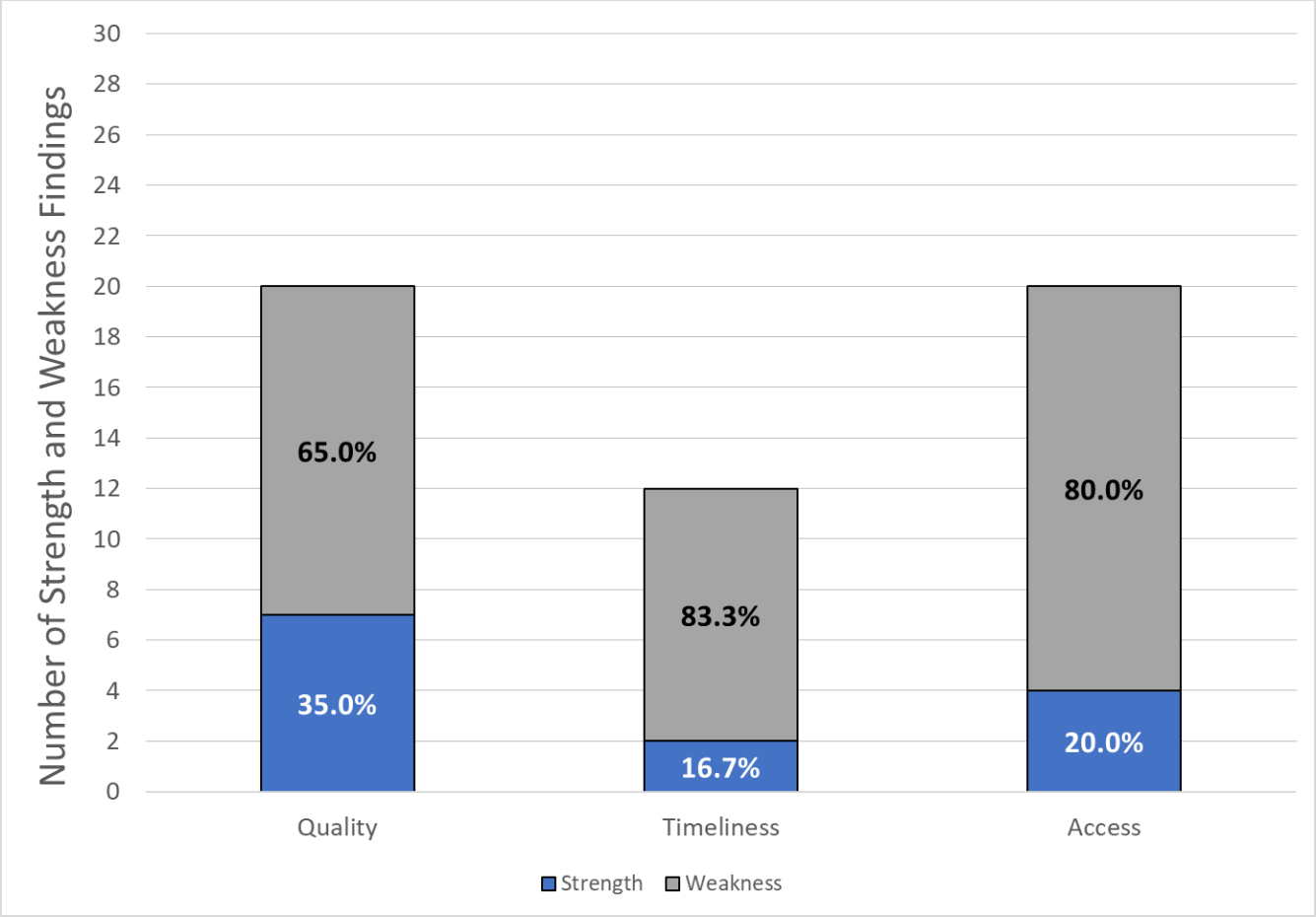
CY 2022 Recommendation	CY 2023 Assessment
	and increased focus on providers with risk scores over 850. The response suggested a proactive approach to identifying issues and educating providers. No identified barriers were mentioned, and the strategy for continued improvement involves an expansion of program integrity audits in the 2024 plan. Overall, it appears that AH has taken steps to address the recommendation and is actively working on improving its processes.
Mental Health Parity Evaluation	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.

AllCare CCO, Inc.

Results and Conclusions

HSAG assessed the strengths and weaknesses of each CCO with respect to the quality, timeliness, and accessibility of health care services. Figure 5-3 illustrates the number of strengths exhibited by AllCare relative to the number of weaknesses identified during the CY 2023 EQR activities across the three domains. The greater the proportion of weaknesses, the greater opportunities for improvement.

Figure 5-3—AllCare Overall Number of Findings (Strengths and Weaknesses) by Domain



Detailed results from the EQR's substantive findings are summarized in Table 5-3 for each activity. This table highlights the extent to which AllCare furnishes high quality, timely, and appropriate access to health care services, and recommendations for how AllCare can best address issues identified for each activity.[5-3]

[5-3] See Section 4—Comparative Statewide Results for detailed, CCO-specific scores associated with EQR activity.

Table 5-3—AllCare Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)[5-4]
Compliance Monitoring Review		
−	**Weakness:** AllCare received a score of 88.9 percent in Standard III—Coordination and Continuity of Care due to a lack of operational structure and failure to appropriately assess/reassess members of prioritized populations and members with SHCN for ICC services. **Why the weakness exists:** AllCare's policies and procedures did not align with State requirements. Additionally, AllCare failed to demonstrate a streamlined method of assessing and reassessing members and updating the member's care plan within the appropriate time frame for members enrolled in ICC. **Recommendations:** AllCare must revise its policies and procedures to align with State requirements. AllCare must also demonstrate implementation of appropriate assessments, reassessments, and revision of treatment plans according to federal and State requirements.	
−	**Weakness:** AllCare received a score of 75.0 percent in Standard IV—Coverage and Authorization of Services due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting AllCare's ability to ensure it offers the appropriate services, appropriate and consistent coverage determinations, and proper and timely notification of adverse benefit determinations to members. **Why the weakness exists:** AllCare's policies and procedures did not align with federal and State requirements. Additionally, AllCare failed to demonstrate mechanisms for ensuring the services offered by AllCare were appropriate, and consistent application of medical necessity criteria. AllCare also failed to adhere to requirements for the appropriate decision-makers and time frames for notification of adverse benefit determinations. **Recommendations:** AllCare must revise its policies and procedures to align with federal and State requirements. AllCare must also demonstrate implementation of appropriate service offerings and consistent application of medical necessity criteria according to federal and State requirements. AllCare must also demonstrate adherence to federal and State required time frames for notification of adverse benefit determinations.	
−	**Weakness:** AllCare received a score of 60.0 percent in Standard VII—Member Rights and Protections due to a lack of operational structure and failure to demonstrate implementation of an established process, impacting AllCare's ability to ensure that member rights are respected	

[5-4] = Quality, = Timeliness, = Access

Strength/ Weakness	Description	Domain(s)[5-4]
	and allowed to be exercised freely without affecting the treatment of members, advance directive requirements are met, and members are notified of their rights as required by federal and State requirements. **Why the weakness exists:** AllCare's policies and procedures and member- and provider-facing materials did not align with federal and State requirements. **Recommendations:** AllCare must revise its policies and procedures and member- and provider-facing materials to align with federal and State requirements.	
−	**Weakness:** AllCare received a score of 85.2 percent in Standard X—Grievance and Appeal Systems due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting AllCare's ability to ensure member grievances and appeals are addressed and responded to appropriately. **Why the weakness exists:** AllCare's policies and procedures did not align with federal and State requirements. Additionally, AllCare failed to use the appropriate staff messaging. AllCare also failed to adhere to requirements for the appropriate decision-makers on clinically-related grievances, time frames for acknowledging receipt of grievances, and readability of notices. AllCare also failed to communicate grievance and/or appeal requirements to members, providers, and subcontractors. **Recommendations:** AllCare must revise its policies and procedures to align with federal and State requirements. AllCare must also demonstrate implementation of federal and State requirements within staff messaging. AllCare must also demonstrate adherence to federal and State requirements for decision-makers on clinically-related grievances, time frames for acknowledging receipt of grievances, and readability of notices. AllCare must also demonstrate implementation of federal and State requirements within communications to members, providers, and subcontractors.	
−	**Weakness:** AllCare received a score of 70.5 percent in Standard XIV—Member Information due to a lack of operational structure and failure to demonstrate implementation of an established process, impacting AllCare's ability to ensure timely and proper member communication. **Why the weakness exists:** AllCare's policies and procedures and member-facing materials (i.e., the member handbook, member notices, medication formulary, and provider directory) did not align with federal and State requirements. Additionally, AllCare did not provide proper notification to members of the availability of member information. AllCare also failed to demonstrate monitoring for timeliness of providing notification to members of significant information changes. **Recommendations:** AllCare must revise its policies, procedures, and member-facing materials to align with federal and State requirements.	

Strength/ Weakness	Description	Domain(s)[5-4]
	AllCare must also demonstrate monitoring for timeliness of notification to members of significant information changes and providing proper notification to members of the availability of member information.	
−	**Weakness:** AllCare received a score of 87.5 percent in Standard XVI—Emergency and Poststabilization Services due to failure to demonstrate implementation of appropriate processes and workflows, impacting AllCare's ability to ensure emergency and poststabilization services are covered appropriately. **Why the weakness exists:** AllCare failed to demonstrate evidence of processes to ensure payment of emergency and poststabilization services. **Recommendations:** AllCare must demonstrate evidence of processes to ensure payment of emergency and poststabilization services.	
Performance Improvement Projects		
Statewide Mental Health Service Access Monitoring PIP		
+	**Strength:** AllCare successfully continued the Implementation stage for the PIP, receiving a *Met* score for 100 percent of applicable evaluation elements in the PIP validation tool. In the Implementation stage, AllCare accurately reported baseline and RY 1 performance indicator data, identified and analyzed barriers to improving MH service access, carried out interventions to address those barriers, and refined interventions based on intervention evaluation results.	
+	**Strength:** AllCare's RY 1 performance indicator results demonstrated statistically significant improvement in MH service access compared to baseline indicator results.	
Statewide Substance Use Disorder PIP		
+	**Strength:** AllCare successfully initiated the Implementation stage for the PIP, receiving a *Met* score for 100 percent of applicable evaluation elements in the PIP validation tool. In the Implementation stage, AllCare accurately reported baseline performance indicator data; identified and analyzed barriers for initiation, engagement, and treatment of alcohol and other drug use disorders; and began to carry out interventions to address those barriers.	
Performance Measure Validation		
+	**Strength:** AllCare's MY 2022 performance on the *Members Receiving Preventive Dental or Oral Health Services—Ages 1 to 5 Years* and *Ages 6 to 14 Years* measure indicators improved by more than 5 percentage points compared to MY 2021, for members ages 1 to 5 years (7.1 percentage points) and members ages 6 to 14 years (7.8 percentage points). The CCO's performance on this measure demonstrated ongoing improvement since MY 2020. In addition, the CCO's MY 2022 rates in	

Strength/ Weakness	Description	Domain(s)[5-4]
	both age groups exceeded the statewide aggregate and the 2020 CCO 75th percentile benchmark set by OHA for MY 2022 5 percentage points or more.	
−	**Weakness:** AllCare's MY 2022 rate on the *Child and Adolescent Well-Care Visits—Ages 3 to 6 Years* measure indicator fell below the statewide aggregate and the 2020 CCO 75th percentile benchmark set by OHA for MY 2022 by 5 percentage points or more with no improvement in performance from MY 2021. **Why the weakness exists:** AllCare's rate on this measure did not change from MY 2021, and OHA's 2022 CCO Performance Metrics Annual Report showed statewide performance for the *Child and Adolescent Well-Care Visits—Ages 3 to 6 Years* measure indicator declined slightly (0.6 percent) from MY 2021. **Recommendations:** AllCare should conduct root cause analyses to identify specific factors affecting performance. Once identified, targeted interventions should be developed, implemented, and evaluated to ensure effective improvement strategies are adopted to increase performance over time. Additionally, AllCare should continue to monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches to ensuring the quality, timeliness, and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	
−	**Weakness:** AllCare's MY 2022 rates on the *Initiation of SUD Treatment* and *Engagement of SUD Treatment* measure indicators for members ages 18 years and older fell below the statewide aggregate and the 2020 HEDIS national Medicaid median benchmarks set by OHA for MY 2022. **Why the weakness exists:** In response to EQR recommendations, AllCare discussed efforts undertaken to address existing gaps in the quality, timeliness, and accessibility of SUD treatment services. These gaps include: (1) the need for real-time hospital event notification to ensure members diagnosed with SUD are contacted by BH providers while in the hospital; and (2) the need for increased outreach to members diagnosed with SUD that have housing challenges and/or have not yet received BH services. **Recommendations:** AllCare took several steps in 2022 to improve performance on this measure. AllCare's BH Clinical Transitions team sent real-time hospital event notifications to contract BH providers to encourage outreach to members in the hospital. AllCare established working agreements with community-based organizations to leverage their peer specialists for outreach to members who are homeless or have housing challenges. Lastly, AllCare reimbursed BH providers for outreach to members in the pre-engagement or pre-contemplation stages of SUD treatment, as allowed by OHA. AllCare should continue	

Strength/ Weakness	Description	Domain(s)[5-4]
	implementing these efforts to raise its rates on this measure to the level of the benchmarks set by OHA.	
Validation of Network Adequacy		
Delivery System Network Evaluation		
	**Strength:** AllCare generally improved the overall completeness and accuracy of its provider data reporting compared to previous years. The CCO's responses within the DSN Provider Narrative Template indicated that this was due to enhanced communication and collaboration with its information technology department.	
	**Weakness:** AllCare's DSN Provider Narrative compliance scores overall (63.5 percent), and for the *DSN Governance Structure* (75.0 percent), *Member Needs and Population Management* (56.3 percent), and *DSN Monitoring and Analysis* (50.0 percent) domains were less than 90 percent and the statewide CCO aggregate rates. This deficiency was also found in the CY 2020, CY 2021, and CY 2022 EQRs. **Why the weakness exists:** AllCare submitted multiple incomplete, insufficient, or irrelevant DSN Provider Narrative Template responses and/or supporting documentation, resulting in a low-quality overall submission. **Recommendations:** AllCare should ensure that all DSN Provider Narrative Template responses are directly relevant to the element being answered and provide sufficient information to demonstrate that collected data are used to inform network adequacy monitoring and decision-making.	
	**Weakness:** AllCare's provider network showed multiple potential barriers to access to care for primary care service and specialty providers, particularly for rural settings in Curry County, urban settings in Josephine County, and members seeking care with a new provider. **Why the weakness exists:** AllCare did not meet time and distance access standards for multiple specialty providers, with affected communities consistently located in the rural settings of Curry County and urban settings of Josephine County. AllCare's provider network, including PCPs, showed an overall low percentage of providers accepting new patients. **Recommendations:** AllCare should ensure it is collecting and reporting provider data accurately, and provide an explanation addressing both noncompliance with State time and distance standards as well as the low rates of providers accepting new patients.	

Strength/ Weakness	Description	Domain(s)[5-4]
Secret Shopper Survey		
−	**Weakness:** The total secret shopper survey response rate was 82.2 percent across all PCP and PCD cases. Of the total responsive cases, 67.6 percent of the offices offered the requested services, 59.5 percent accepted OHP, 47.3 percent accepted AllCare, and 33.8 percent accepted new patients. Although 93.2 percent of the total responsive cases confirmed the location, the rate for PCDs was 84.6 percent. **Why the weakness exists:** In addition to limitations related to the secret shopper approach, the accuracy of AllCare's provider data may have contributed to the low response rate and accuracy results. **Recommendations:** HSAG recommends that AllCare use the case-level analytic data files to address the data deficiencies identified during the secret shopper survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
−	**Weakness:** Of the total secret shopper responsive cases, only 13.5 percent resulted in an appointment. Of the cases that offered an appointment, 50 percent were within the wait time compliance standard. **Why the weakness exists:** In addition to limitations related to the secret shopper approach, the accuracy of AllCare's provider data may have contributed to the low appointment availability rate. Additionally, internal office procedures may have contributed to the long wait times. **Recommendations:** HSAG recommends that AllCare confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. AllCare should use the case-level analytic data files containing data deficiencies identified during the secret shopper survey calls.	
Revealed Telephone Survey		
−	**Weakness:** Overall, 35.8 percent of the total revealed telephone survey sampled cases were reached, of which three, or 12.5 percent, of the survey respondents refused to participate in the survey. Of the total responsive cases, 70.8 percent of the offices confirmed the location, 54.2 percent offered the requested specialty, 54.2 percent accepted OHP, 45.8 percent accepted AllCare, 37.5 percent accepted new patients, and 54.5 percent offered translation or interpreter services. **Why the weakness exists:** In addition to limitations related to the revealed telephone approach, the accuracy of AllCare's provider data may have contributed to the low response rate and accuracy results. **Recommendations:** HSAG recommends that AllCare use the case-level analytic data files to address the data deficiencies identified during	

Strength/ Weakness	Description	Domain(s)[5-4]
	the revealed telephone survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, program information, and translation/interpreter services offered).	
−	**Weakness:** Of the revealed telephone survey sampled cases, only 7.5 percent of the survey respondents offered a new patient appointment, while only 6.0 percent of survey respondents offered an appointment for an existing patient. Of the total cases that offered an appointment, 83.3 percent of routine appointments and 54.5 percent of urgent appointments were within the wait time compliance standard. **Why the weakness exists:** In addition to limitations related to the revealed telephone approach, the accuracy of AllCare's provider data may have contributed to the low appointment availability rate. Additionally, internal office staffing structures and procedures may have contributed to the long wait times. **Recommendations:** HSAG recommends that AllCare confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. AllCare should use the case-level analytic data files containing data deficiencies identified during the revealed telephone survey calls and work with BH outpatient offices to identify the root cause for delays in appointment availability.	
Encounter Data Validation		
+	**Strength:** Encounters that could be matched between data extracted from OHA's data warehouse and data extracted from AllCare's or the subcontractor's data system exhibited a high level of element completeness (i.e., low element omission and surplus rates) across all evaluated key data elements.	
+	**Strength:** Among records that could be matched between the two data sources, a high level of element accuracy (i.e., data elements from both sources had the same values when populated) was exhibited across all evaluated key data elements.	
+	**Strength:** The AllCare-submitted data had high all-element accuracy for all evaluated key data elements, indicating that the values (missing or non-missing) in both data sources (AllCare and OHA) were the same for almost all records.	
−	**Weakness:** There were a high number and percentage of records present in the files submitted by AllCare but not found in the files submitted by OHA (i.e., record omission). **Why the weakness exists:** AllCare explained that Capitol Dental/Ayin underwent a system migration in May 2022. Consequently, this inadvertently led to the inclusion of both the old and new *ICN*s for the	

Strength/ Weakness	Description	Domain(s)[5-4]
	same encounters during the data pull, instead of excluding the old *ICN*. This oversight contributed to a substantial number of duplicate records, causing a high omission rate. **Recommendations:** HSAG recommends that AllCare and Capitol Dental/Ayin consider implementing measures to ensure proper handling of data during system migrations. This could involve refining data extraction protocols and conducting thorough data validation checks post-migration to mitigate the risk of high omission rates. Additionally, establishing a comprehensive communication plan between AllCare and its subcontractor, Capitol Dental/Ayin, during such changes could help in preventing oversights and ensuring data accuracy.	
Mental Health Parity Evaluation		
–	**Weakness:** AllCare's responses in the MHP Treatment Limitation Review Tool and supplemental documentation were insufficient to demonstrate compliance with parity requirements. **Why the weakness exists:** AllCare responses and supplemental documentation were limited to changes to treatment limitations implemented during CY 2022 rather than comprehensive responses addressing all treatment limitations applied by the CCO to manage MH/SUD and M/S benefits as directed by the CY 2023 MHP Protocol. **Recommendations:** AllCare should ensure that submitted descriptions and supplemental documentation are inclusive of all treatment limitations used by the CCO to manage MH/SUD benefits and to demonstrate parity with the treatment limitations applied to M/S benefits. Responses should address the writing prompt questions in the tool related to the CCO's rationale for the NQTL; the procedures/processes/requirements used to apply the NQTL; the frequency and strictness of the NQTL; and the evidentiary standards to support the rationale for how frequently and strictly the NQTL is applied. In addition, AllCare should ensure that individuals completing the MHP Treatment Limitation Review Tool attend the MHP technical assistance webinar and that they request additional assistance, as needed, to ensure their understanding of the requirements.	
–	**Weakness:** AllCare was partially compliant with the Pharmacy Management—Methods for Determining Reasonable Charges, Formulary Design, and Tier Placement NQTL requirements. **Why the weakness exists:** AllCare did not provide its rationale for the assignment of the NQTL; the procedures used for the development of reasonable charges, formulary design, and/or tier placement (e.g., individuals involved in development, professional guidelines used, how often the NQTLs are reviewed and updated/by whom); or how frequently or strictly the NQTL is applied (e.g., ability of the provider to request an exception).	

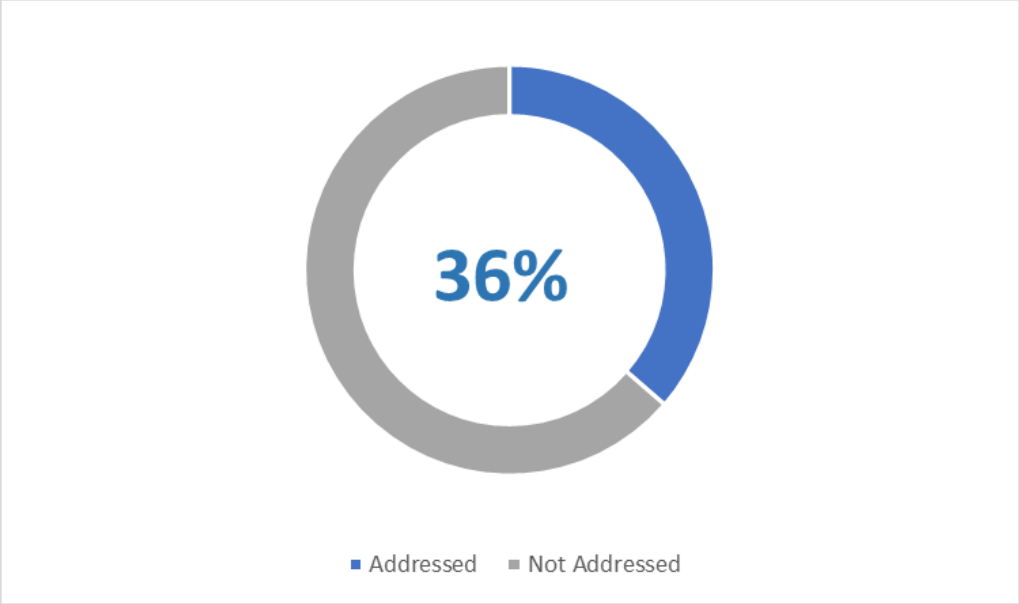
Strength/ Weakness	Description	Domain(s)[5-4]
	Recommendations: AllCare should identify processes, strategies, evidentiary standards, and other factors used in formulary design and application for pharmacy management NQTLs.	
−	**Weakness:** AllCare showed a substantial difference in the percentage of paid, out-of-network MH/SUD IP claims compared to M/S IP claims. Although the difference in the percentage of paid claims may be legitimate, it may also highlight procedural or network differences indicating potential barriers for members accessing MH/SUD services. **Why the weakness exists:** Out-of-network IP MH/SUD claims were paid less frequently than M/S claims. **Recommendations:** AllCare should review out-of-network claim denials to understand factors affecting the lower percentage of paid MH/SUD IP claims compared to M/S IP claims. AllCare should assess whether any barriers exist for members accessing MH/SUD services, including the need to seek services outside of the CCO's network (e.g., appointment availability).	

Follow-Up on Prior Year Recommendations

HSAG evaluated AllCare's approach to addressing the recommendations and/or findings issued during CY 2022 and unresolved findings from CY 2020 and CY 2021 while conducting the CY 2023 EQR activities. The CCOs not addressing findings and recommendations are at risk of being out of compliance with their contracts.

Figure 5-4 illustrates the degree in which the CCO sufficiently addressed the recommendations for QI made by HSAG during the CY 2022 EQR.

Figure 5-4—Percentage of CY 2022 EQR Recommendations Addressed by AllCare



AllCare-specific CY 2022 recommendations and follow-up CY 2023 assessments are summarized in Table 5-4.

Table 5-4—Assessment of AllCare's Approach to Addressing Previous Annual Recommendations

CY 2022 Recommendation	CY 2023 Assessment
Compliance Monitoring Review	
Standard I—Availability of Services	
This recommendation was initially given during the CY 2021 EQR. AllCare should revise policies and procedures as well as member and provider communications to include complete and accurate network access information. In addition, AllCare should ensure processes include ongoing monitoring of provider network compliance and corrective actions when providers fail to meet network access requirements. The CCO should also provide and document oversight of subcontractors to ensure compliance with monitoring and corrective action requirements.	**AllCare did not sufficiently address the recommendation.** AllCare's policies and procedures, member and provider communications, and auditing tools did not always communicate or monitor for the correct state-established network access standards. AllCare should revise policies and procedures, member and provider communications, and auditing tools to include complete and accurate network access information. In addition, AllCare should ensure processes include ongoing monitoring of provider network compliance and corrective actions when providers fail to meet network access requirements. The CCO should also provide and document oversight of subcontractors to ensure compliance with monitoring and corrective action requirements.

CY 2022 Recommendation	CY 2023 Assessment
Standard II—Assurances of Adequate Capacity and Services	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard III—Coordination and Continuity of Care	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard IV—Coverage and Authorization of Services	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard V—Provider Selection	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard VI—Subcontractual Relationships and Delegation	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard VII—Member Rights and Protections	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard VIII—Confidentiality	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard IX—Enrollment and Disenrollment	
AllCare should revise its policies, procedures, and member-facing documents to align with federal and State requirements. AllCare should also demonstrate oversight and monitoring of disenrollment reasons to ensure compliance with the regulatory requirements.	**AllCare sufficiently addressed the recommendation.** Documentation reviewed during the CY 2023 CMR activity demonstrated compliance with the standard.
Standard X—Grievance and Appeal Systems	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard XI—Practice Guidelines	
This standard was not assessed during the 2022 CMR.	Not applicable.

CY 2022 Recommendation	CY 2023 Assessment
Standard XII—Quality Assessment and Performance Improvement	
AllCare should revise its QAPI program structure to align with federal and State requirements for a QAPI program. AllCare must also demonstrate appropriate oversight of its QAPI program.	**AllCare did not sufficiently address the recommendation.** AllCare's QAPI program remained out of compliance with federal and State requirements for a QAPI program, including lack of mechanisms to access the quality and appropriateness of members with SHCN. AllCare also failed to demonstrate a QI committee that met the State requirements, including approval of the annual quality strategy. AllCare should revise its QAPI program structure to align with federal and State requirements for a QAPI program. AllCare should also demonstrate appropriate oversight of its QAPI program.
Standard XIII—Health Information Systems, including ISCA	
AllCare should amend its policies, procedures, and information systems to capture all required data elements and make them available for reporting to align with CCO contract requirements. The CCO should also update its policies and procedures to include oversight processes for monitoring Measures of Outcomes Tracking System (MOTS) data submissions from its BH providers. AllCare should ensure its staff are trained and knowledgeable about these defined processes, including the documentation of all oversight activities and follow-up actions taken when issues are identified, and that staff implement the processes.	**AllCare sufficiently addressed the recommendation.** Documentation reviewed during the CY 2023 CMR activity demonstrated compliance with the standard.
Standard XIV—Member Information	
This standard was not assessed during the 2022 CMR.	Not applicable.
Performance Improvement Projects	
Statewide Mental Health Service Access Monitoring PIP	
AllCare should review the final baseline indicator data file distributed by OHA and seek technical assistance, if needed. The CCO should correct the baseline indicator data prior to next year's annual PIP validation.	**AllCare sufficiently addressed the recommendation.** AllCare correctly reported the baseline and RY 1 indicator data in this year's PIP submission.
AllCare should provide a narrative that describes results of the QI tools and processes used to identify and prioritize barriers. If data reports	**AllCare sufficiently addressed the recommendation.** AllCare documented the QI

CY 2022 Recommendation	CY 2023 Assessment
were used, the narrative description should include details of the data analyses and interpretation.	processes and tools used for identifying and prioritizing barriers in this year's PIP submission.
Statewide Substance Use Disorder PIP	
AllCare met performance expectations. No significant strengths or weaknesses were noted during the review.	Not applicable.
Performance Measure Validation	
AllCare should continue efforts to reach members diagnosed with alcohol and other drug abuse or dependence to encourage timely initiation of treatment. Additionally, AllCare should continue to monitor its provider network to identify gaps in access to alcohol and other drug abuse and dependence care, and work with providers to identify alternative approaches to ensuring the quality, timeliness, and accessibility of treatment services (e.g., telehealth strategies, mobile clinics).	**AllCare sufficiently addressed the recommendation.** AllCare reported working closely with contracted BH providers to effectively coordinate services for members diagnosed with SUD while they are in the ED or hospital. AllCare reported having working agreements with community-based organizations to leverage their peer specialists for outreach to members who are homeless or have housing challenges. Lastly, AllCare reported that OHA allowed for peer outreach codes to be billed and paid without the member getting an assessment and service plan, which enabled AllCare to reimburse BH providers for outreach to members that need but are not yet receiving SUD treatment services. AllCare should continue implementing these efforts to raise its rates on this measure to the level of the benchmarks set by OHA.
Validation of Network Adequacy	
This recommendation was initially given during the CY 2020 EQR. HSAG recommends that the CCO ensure narrative responses go beyond repeating the language of the element, that supporting documentation is listed appropriately and restricted to only what is relevant to the specific requirements of the element, and that supporting documentation is appropriately annotated or otherwise directs the reviewer to components that directly address the element.	**AllCare did not sufficiently address the recommendation.** AllCare's narrative scores indicated a low level of compliance with network monitoring requirements. This was due to an inability to describe all governance structures and operations, inability to describe use of collected data for member needs and populations to inform network adequacy monitoring and decision-making, and inability to describe or demonstrate compliance with key DSN monitoring and analysis requirements established by the State, or to use information collected to inform network adequacy monitoring and decision-making.
This recommendation was initially given during the CY 2020 EQR. AllCare should ensure that it reports DSN Provider Capacity Reporting	**AllCare sufficiently addressed the recommendation.** AllCare's reported data quality results for Q1 2023 showed a high degree of

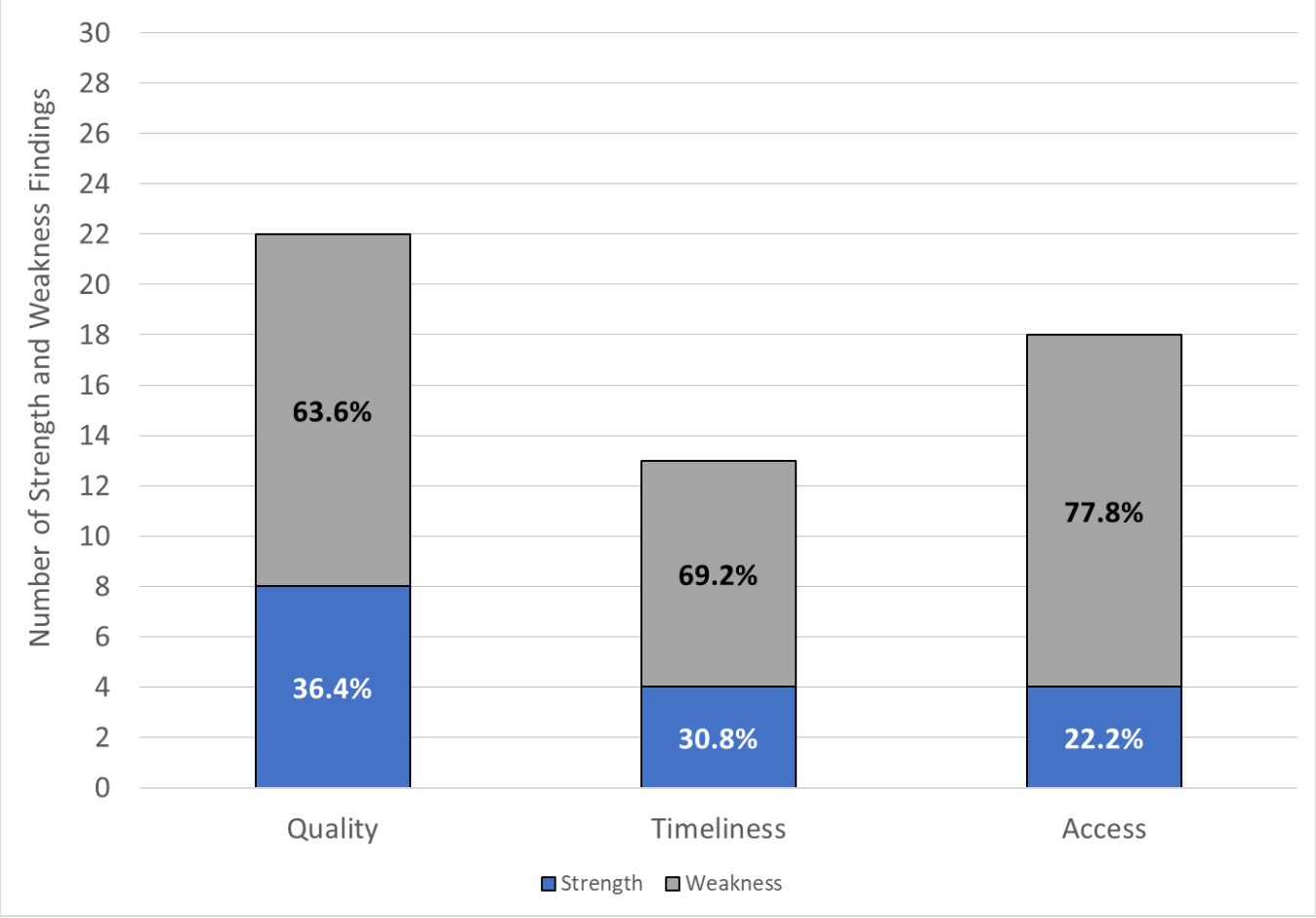
CY 2022 Recommendation	CY 2023 Assessment
data values for all required data fields and provides an explanation addressing its noncompliance with the State time and distance standards.	confidence in data fields that were present, complete, and in a valid format.
This recommendation was initially given during the CY 2021 EQR. AllCare should ensure that it reports DSN Provider Capacity Reporting data values for all required data fields and seek technical assistance from OHA as needed.	**AllCare sufficiently addressed the recommendation.** AllCare's reported data quality results for Q1 2023 showed a high degree of confidence in data fields that were present, complete, and in a valid format.
Encounter Data Validation	
AllCare should investigate the root cause for the omissions and consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews would then be provided to providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.	**AllCare did not sufficiently address the recommendation.** The response indicated that AllCare has implemented initiatives to address the recommendation. AllCare noted that regular provider audits are conducted to ensure coding and billing practices' appropriateness, and educational materials related to audit findings are provided. AllCare also noted that free training opportunities are offered to providers and office staff throughout the year, covering coding, billing, and privacy regulations. AllCare's claims department has reporting tools for encounter data validation and anomaly recognition. While AllCare's response provided some information regarding initiatives that it has implemented in response to the recommendation, it lacked specific details on noted performance improvements, barriers faced during implementation, and a detailed strategy for continued improvement. AllCare should consider providing more specific details on the frequency and scope of the provider audits, as well as any plans for continuous monitoring and improvement based on the audit findings to fully address the recommendation. Additionally, AllCare should mention any specific educational topics covered in the training opportunities offered to providers.
Mental Health Parity Evaluation	
AllCare met performance expectations. No significant strengths or weaknesses were noted during the review.	Not applicable.

Cascade Health Alliance, LLC

Results and Conclusions

HSAG assessed the strengths and weaknesses of each CCO with respect to the quality, timeliness, and accessibility of health care services. Figure 5-5 illustrates the number of strengths exhibited by CHA relative to the number of weaknesses identified during the CY 2023 EQR activities across the three domains. The greater the proportion of weaknesses, the greater opportunities for improvement.

Figure 5-5—CHA Overall Number of Findings (Strengths and Weaknesses) by Domain



Detailed results from the EQR's substantive findings are summarized in Table 5-5 for each activity. This table highlights the extent to which CHA furnishes high quality, timely, and appropriate access to health care services, and recommendations for how CHA can best address issues identified for each activity.[5-5]

[5-5] See Section 4—Comparative Statewide Results for detailed, CCO-specific scores associated with EQR activity.

Table 5-5—CHA Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)[5-6]
Compliance Monitoring Review		
−	**Weakness:** CHA received a score of 72.2 percent in Standard III—Coordination and Continuity of Care due to a lack of operational structure and failure to appropriately screen and assess/reassess members for care management and ICC services. **Why the weakness exists:** CHA's policies and procedures did not align with State requirements. Additionally, CHA failed to demonstrate the implementation of health risk screenings according to State requirements. CHA also did not demonstrate mechanisms for ongoing monitoring of outreach and assessment completions to ensure compliance with established time frames. **Recommendations:** CHA must revise its policies and procedures to align with State requirements. CHA must also demonstrate implementation of appropriate initial health risk screenings, assessments, and reassessments according to federal and State requirements.	
−	**Weakness:** CHA received a score of 86.1 percent in Standard IV—Coverage and Authorization of Services due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting CHA's ability to adhere to federal and State requirements for authorizing services and to ensure proper and timely notification of adverse benefit determinations. **Why the weakness exists:** CHA's policies and procedures did not align with federal and State requirements. Additionally, CHA demonstrated reversing service authorization decisions outside the appeal process. CHA also failed to adhere to requirements for required content and time frames for notification of adverse benefit determinations. **Recommendations:** CHA must revise its policies and procedures to align with federal and State requirements. CHA must demonstrate adherence to federal and State requirements for authorization of services, and required content and time frames for notification of adverse benefit determinations.	
−	**Weakness:** CHA received a score of 70.0 percent in Standard VII—Member Rights and Protections due to a lack of operational structure and failure to demonstrate implementation of an established process, impacting CHA's ability to ensure that member rights are respected and allowed to be exercised freely without affecting the treatment of	

[5-6] = Quality, = Timeliness, = Access

Strength/ Weakness	Description	Domain(s)[5-6]
	members, advance directive requirements are met, and members are notified of their rights as required by federal and State requirements. **Why the weakness exists:** CHA's policies and procedures and member- and provider-facing materials did not align with federal and State requirements. **Recommendations:** CHA must revise its policies and procedures and member- and provider-facing materials to align with federal and State requirements.	
−	**Weakness:** CHA received a score of 81.5 percent in Standard X—Grievance and Appeal Systems due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting CHA's ability to ensure member grievances and appeals are addressed and responded to appropriately. **Why the weakness exists:** CHA's policies and procedures did not align with federal and State requirements. Additionally, CHA failed to adhere to requirements for time frames for acknowledging and responding to grievances and appeals, and the readability and required content of notices. CHA also failed to communicate grievance and/or appeal requirements to members, providers, and subcontractors. **Recommendations:** CHA must revise its policies and procedures to align with federal and State requirements. CHA must also demonstrate adherence to federal and State requirements for time frames for acknowledging and responding to grievances and appeals, and the readability and required content of notices. CHA must also demonstrate implementation of federal and State requirements within communications to members, providers, and subcontractors.	
−	**Weakness:** CHA received a score of 65.9 percent in Standard XIV—Member Information due to a lack of operational structure and failure to demonstrate implementation of an established process, impacting CHA's ability to ensure proper member communication. **Why the weakness exists:** CHA's policies and procedures and member-facing materials (i.e., the member handbook, member notices, medication formulary, and provider directory) did not align with federal and State requirements. **Recommendations:** CHA must revise its policies, procedures, and member-facing materials to align with federal and State requirements.	
−	**Weakness:** CHA received a score of 83.3 percent in Standard XVI—Emergency and Poststabilization Services due to a lack of operational structure to ensure emergency and poststabilization services are covered appropriately. **Why the weakness exists:** CHA failed to demonstrate plan documents (i.e., policies and procedures, the provider manual, and the member	

Strength/ Weakness	Description	Domain(s)[5-6]
	handbook), appropriately define "emergency and poststabilization services," and communicate the appropriate requirements. **Recommendations:** CHA must revise the applicable plan documents to define "emergency and poststabilization services" and communicate the appropriate requirements.	
Performance Improvement Projects		
Statewide Mental Health Service Access Monitoring PIP		
−	**Weakness:** CHA's reported indicator results did not demonstrate any improvement over baseline performance. **Why the weakness exists:** The indicator results demonstrated a decline in performance from baseline to RY 1. **Recommendations:** CHA should revisit root cause analyses identifying barriers to improving access to MH services to determine which barriers to improvement were not effectively addressed. CHA should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to improve indicator results.	
−	**Weakness:** CHA's PIP documentation did not demonstrate significant clinical or programmatic improvement in processes and outcomes. **Why the weakness exists:** CHA did not complete the Clinical and Programmatic Improvement Table; therefore, no evidence was provided to demonstrate significant clinical or programmatic improvement. **Recommendations:** CHA should complete the Clinical and Programmatic Improvement Table to demonstrate significant clinical or programmatic improvement in processes and outcomes.	
Statewide Substance Use Disorder PIP		
+	**Strength:** CHA successfully initiated the Implementation stage for the PIP, receiving a *Met* score for 100 percent of applicable evaluation elements in the PIP validation tool. In the Implementation stage, CHA accurately reported baseline performance indicator data; identified and analyzed barriers for initiation, engagement, and treatment of alcohol and other drug use disorders; and began to carry out interventions to address those barriers.	
Performance Measure Validation		
+	**Strength:** CHA's MY 2022 performance for members ages 6 to 14 years receiving preventive dental or oral health services improved by more than 5 percentage points compared to MY 2021 (13.1 percentage points).	
+	**Strength:** CHA's MY 2022 rate on the *Engagement of SUD Treatment* measure indicator for members ages 18 years and older exceeded the	

Strength/ Weakness	Description	Domain(s)[5-6]
	statewide aggregate and the 2020 HEDIS national Medicaid median benchmarks set by OHA for MY 2022 by 5 percentage points or more.	
+	**Strength:** CHA's performance on the *Oral Evaluation for Adults With Diabetes* measure demonstrated ongoing improvement since MY 2020.	
−	**Weakness:** CHA's performance on the *Child and Adolescent Well-Care Visits—Ages 3 to 6 Years* measure indicator demonstrated declining performance on this measure since MY 2020. In addition, the CCO's MY 2022 rate for this measure fell below the statewide aggregate and the 2020 CCO 75th percentile benchmark set by OHA for MY 2022 by 5 percentage points or more. **Why the weakness exists:** Although CHA's eligible population for this measure increased from MY 2021 to MY 2022, nearly the same number of children ages 3 to 6 years had a comprehensive well-care visit with their PCP in both MY 2021 and MY 2022. OHA's 2022 CCO Performance Metrics Annual Report showed statewide performance for the *Child and Adolescent Well-Care Visits—Ages 3 to 6 Years* measure indicator declined slightly (0.6 percent) from MY 2021. **Recommendations:** CHA should conduct root cause analyses to identify specific factors affecting performance on this measure and develop, implement, and evaluate targeted interventions to ensure improvement strategies are adopted. Additionally, CHA should monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches for ensuring the timeliness and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	
Validation of Network Adequacy		
Delivery System Network Evaluation		
+	**Strength:** CHA generally improved the overall completeness and accuracy of its provider data reporting compared to previous years.	
−	**Weakness:** CHA's DSN Provider Narrative compliance scores overall (63.5 percent), and for the *Member Needs and Population Management* (81.3 percent), *DSN Monitoring and Analysis* (70.0 percent), and *Network Response Strategy* (58.3 percent) domains were less than 90 percent and the statewide CCO aggregate rates. **Why the weakness exists:** CHA was not able to describe or demonstrate compliance with several key DSN monitoring and analysis requirements, use collected data to inform network adequacy monitoring and decision-making for certain services and populations, or provide sufficient explanation for planned network interventions. **Recommendations:** CHA should ensure that all DSN Provider Narrative Template responses provide sufficient information to demonstrate that collected data are used to inform network adequacy	

Strength/ Weakness	Description	Domain(s)[5-6]
	monitoring and decision-making, and should provide sufficient and relevant explanation for planned network interventions.	
−	**Weakness:** CHA's provider data indicated that several potential barriers to care existed, including low percentages of PCPs and PCDs accepting new patients and a lack of several specialty providers (i.e., NEPH and OT). **Why the weakness exists:** Less than 80 percent of CHA's PCPs and PCDs were accepting new patients, and the CCO lacked any NEPH and OT specialty providers within its network. CHA did not address these potential barriers to care within its DSN Provider Narrative Template. **Recommendations:** CHA should investigate the nature of its low new patient acceptance among PCPs and PCDs as well as the lack of NEPH and OT specialty providers, and plan/enact interventions to address these potential barriers as appropriate.	
Secret Shopper Survey		
−	**Weakness:** The total secret shopper survey response rate was 66.7 percent across all PCP and PCD cases. Of the responsive cases, 59.1 percent accepted OHP and CHA, and 45.5 percent accepted new patients. Further, while 100 percent of PCD cases confirmed the location and offered the requested services, only 71.4 percent of PCP cases confirmed the location, and 42.9 percent offered the requested services. **Why the weakness exists:** In addition to limitations related to the secret shopper approach, the accuracy of CHA's provider data may have contributed to the low response rate and accuracy results. **Recommendations:** HSAG recommends that CHA use the case-level analytic data files to address the data deficiencies identified during the secret shopper survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
−	**Weakness:** Of the total secret shopper survey responsive cases, only 27.3 percent resulted in an appointment. **Why the weakness exists:** In addition to limitations related to the secret shopper approach, the accuracy of CHA's provider data may have contributed to the low appointment availability rate. **Recommendations:** HSAG recommends that CHA confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. CHA should use the case-level analytic data files containing data deficiencies identified during the secret shopper survey calls.	

Strength/ Weakness	Description	Domain(s)[5-6]
Revealed Telephone Survey		
−	**Weakness:** Overall, 47.8 percent of the revealed telephone survey total sampled cases were reached, of which none refused to participate in the survey. Of the total responsive cases, 72.7 percent of the offices offered the requested specialty, 72.7 percent accepted OHP, 54.5 percent accepted CHA, 45.5 percent accepted new patients, and 66.7 percent offered translation or interpreter services. **Why the weakness exists:** In addition to limitations related to the revealed telephone approach, the accuracy of CHA's provider data may have contributed to the low response rate and accuracy results. **Recommendations:** HSAG recommends that CHA use the case-level analytic data files to address the data deficiencies identified during the revealed telephone survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, program information, and translation/interpreter services offered).	
−	**Weakness:** Of the revealed telephone survey sampled cases, only 13.0 percent of the survey respondents offered a new patient appointment, while only 17.4 percent of survey respondents offered an appointment for an existing patient. Of the total cases that offered an appointment, 40.0 percent of routine appointments and 42.9 percent of urgent appointments were within the wait time compliance standard. **Why the weakness exists:** In addition to limitations related to the revealed telephone approach, the accuracy of CHA's provider data may have contributed to the low appointment availability rate. Additionally, internal office staffing structures and procedures may have contributed to the long wait times. **Recommendations:** HSAG recommends that CHA confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. CHA should use the case-level analytic data files containing data deficiencies identified during the revealed telephone survey calls and work with BH outpatient offices to identify the root cause for delays in appointment availability.	
Encounter Data Validation		
+	**Strength:** The CHA-submitted data exhibited high record-level data completeness, with low record omission and surplus rates.	
+	**Strength:** Encounters that could be matched between data extracted from OHA's data warehouse and data extracted from CHA's data system exhibited a high level of element completeness (i.e., low element omission and surplus rates) across all evaluated key data elements.	

Strength/ Weakness	Description	Domain(s)[5-6]
+	**Strength:** Among records that could be matched between the two data sources, a high level of element accuracy (i.e., data elements from both sources had the same values when populated) was exhibited across all evaluated key data elements.	
+	**Strength:** The CHA-submitted data had high all-element accuracy for all evaluated key data elements, indicating that the values (missing or non-missing) in both data sources (CHA and OHA) were the same for almost all records.	
−	**Weakness:** CHA deviated from the specified data layout in its submission by stacking the header data and the claim line detail data, instead of merging them by *ICN*, as per the request. **Why the weakness exists:** Not submitting the data in the requested layout caused discrepancies in the original control total count and analyses. The submitted data format posed challenges for HSAG in obtaining accurate results, necessitating data manipulation, approved by CHA, to align it with the correct format. **Recommendations:** HSAG recommends CHA align its data submission practices, adhering closely to the specified layout, ensuring a more seamless integration into the analytical process. This adjustment will facilitate accurate and efficient data handling during subsequent phases of analysis and evaluation.	
Mental Health Parity Evaluation		
−	**Weakness:** CHA showed a substantial difference in the percentage of paid, out-of-network MH/SUD IP claims compared to M/S IP claims. Although differences in the percentage of paid claims may be legitimate, they may also highlight procedural or network differences, indicating potential barriers for members accessing MH/SUD services. **Why the weakness exists:** Out-of-network IP MH/SUD claims were paid less frequently than M/S claims. **Recommendations:** CHA should review out-of-network claim denials to understand factors affecting the lower percentage of paid MH/SUD IP claims compared to M/S IP claims. CHA should assess whether any barriers exist for members accessing MH/SUD services, including the need to seek services outside the CCO's network (e.g., appointment availability).	

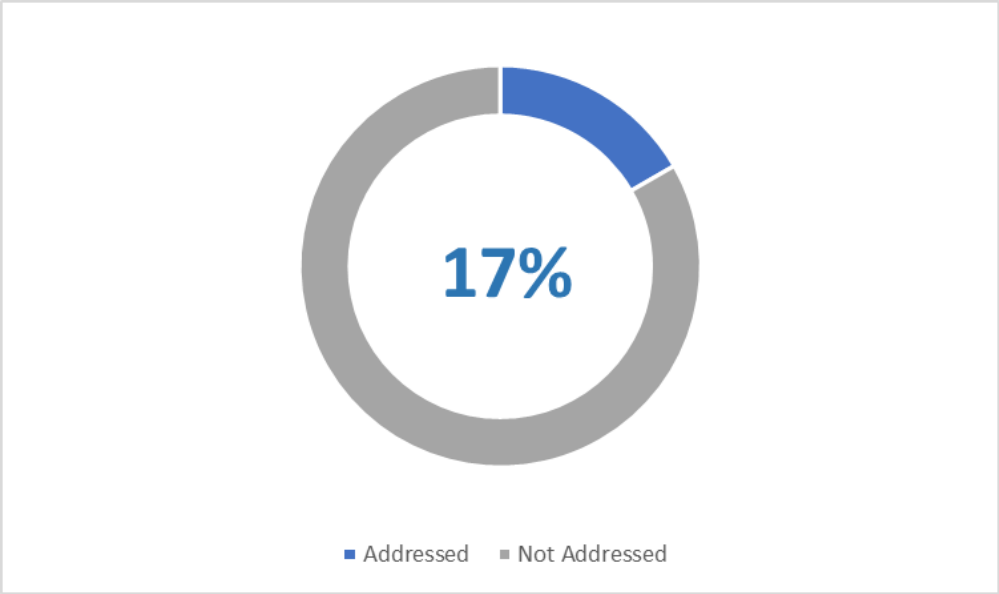
Follow-Up on Prior Year Recommendations

HSAG evaluated CHA's approach to addressing the recommendations and/or findings issued during CY 2022 and unresolved findings from CY 2020 and CY 2021 while conducting the CY 2023 EQR

activities. The CCOs not addressing findings and recommendations are at risk of being out of compliance with their contracts.

Figure 5-6 illustrates the degree in which the CCO sufficiently addressed the recommendations for QI made by HSAG during the CY 2022 EQR.

Figure 5-6—Percentage of CY 2022 EQR Recommendations Addressed by CHA



CHA-specific CY 2022 recommendations and follow-up CY 2023 assessments are summarized in Table 5-6.

Table 5-6—Assessment of CHA's Approach to Addressing Previous Annual Recommendations

CY 2022 Recommendation	CY 2023 Assessment
Compliance Monitoring Review	
Standard I—Availability of Services	
This recommendation was initially given during the CY 2021 EQR. CHA's monitoring of network access did not demonstrate adherence to internal policies and contractual requirements to monitor BH providers, and the CCO lacked evidence of monitoring subcontractors, results of secret shopper calls, evidence of monitoring hours of operation, and corrective actions taken when providers identified during monitoring activities fail to meet network access standards. Revisions to policies, and member and provider communications, appropriately addressed the	**CHA did not sufficiently address the recommendation.** CHA did not demonstrate that it is monitoring compliance with all appointment availability standards (e.g., urgent and routine physical health, including specialists; urgent and routine dental health, including an assessment of pregnant vs. non-pregnant appointment time frames; and urgent and routine BH, including priority populations). CHA also did not demonstrate that it is taking corrective actions when providers identified during monitoring activities fail to meet network access standards.

CY 2022 Recommendation	CY 2023 Assessment
state-required time frames for accessing urgent behavioral and specialty BH care and services; however, the CCO's documents are inconsistent with each other and list incorrect time frames for physical, dental, and routine BH care.	Additionally, CHA's policies remained out of compliance with state-established requirements. CHA should revise policies, procedures, and other documents to include complete and accurate network access information. In addition, CHA should ensure processes include ongoing monitoring of provider network compliance and corrective actions when providers fail to meet network access requirements.
Standard II—Assurances of Adequate Capacity and Services	
This recommendation was initially given during the CY 2021 EQR. CHA should develop a documented process for monitoring provider capacity that includes monitoring specialty providers individually by specialty type, and ensure its network evaluation incorporates key data collected from its monitoring processes and is sufficient in evaluating the needs of its membership.	**CHA did not sufficiently address the recommendation.** CHA did not demonstrate monitoring the specialty provider network's number, types, and geographic location for state-established standards compliance. CHA should develop a documented process for monitoring provider capacity that includes monitoring specialty providers individually by specialty type, and ensure its network evaluation incorporates key data collected from its monitoring processes and is sufficient in evaluating the needs of its membership.
Standard III—Coordination and Continuity of Care	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard IV—Coverage and Authorization of Services	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard V—Provider Selection	
This recommendation was initially given during the CY 2021 EQR. CHA should implement an effective credentialing program that includes recredentialing of providers no less than every three years and oversight of all provider denials of credentialing. Additionally, CHA should develop and implement a documented credentialing and recredentialing process to address verification of certification and qualifications for moderate- and high-risk providers and maintenance of PSV of provider liability coverage. The CCO should also ensure	**CHA did not sufficiently address the recommendation.** CHA continued to demonstrate recredentialing times that exceeded the three-year credentialing requirement and lacked the appropriate training for CCO staff and participating providers and their staff regarding the delivery of covered services, applicable administrative rules, and the CCO's administrative policies. CHA should implement an effective credentialing program that includes recredentialing of providers no less than every three years. The CCO should also ensure proper

CY 2022 Recommendation	CY 2023 Assessment
proper training of staff and participating providers and their staff as required by the CCO contract.	training of staff and participating providers and their staff as required by the CCO contract.
Standard VI—Subcontractual Relationships and Delegation	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard VII—Member Rights and Protections	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard VIII—Confidentiality	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard IX—Enrollment and Disenrollment	
CHA should revise its member-facing documents and training provided to staff to align with federal and State requirements. CHA should also demonstrate oversight and monitoring of disenrollment reasons to ensure compliance with the regulatory requirements.	**CHA did not sufficiently address the recommendation.** Although CHA revised its member handbook to communicate the required enrollment and disenrollment information, the CCO did not demonstrate the appropriate requirements were included in its training or materials for staff. Additionally, CHA continued to lack oversight and monitoring of disenrollment reasons to ensure compliance with the regulatory requirements. CHA should revise its training provided to staff to align with federal and State requirements. CHA should also demonstrate oversight and monitoring of disenrollment reasons to ensure compliance with the regulatory requirements.
Standard X—Grievance and Appeal Systems	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard XI—Practice Guidelines	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard XII—Quality Assessment and Performance Improvement	
CHA should revise its QAPI program structure to align with federal and State requirements for a QAPI program, including appropriate oversight of its QAPI program.	**CHA did not sufficiently address the recommendation.** CHA's QAPI program did not include mechanisms to assess the quality and appropriateness of care provided to members using long-term services and supports (LTSS). Additionally, the CCO did not demonstrate a QI

CY 2022 Recommendation	CY 2023 Assessment
	committee that met the State requirements, including oversight of any delegated functions, quality efforts, and activities performed by other CCO committees, approval of the annual quality strategy, meeting minutes that review the effectiveness of corrective actions recommended at previous meetings. CHA should revise its QAPI program structure to align with federal and State requirements for a QAPI program. CHA should also identify a defined process or mechanism to evaluate the LTSS population and/or relevant subpopulations for the appropriate care. CHA should also demonstrate appropriate oversight of its QAPI program.
Standard XIII—Health Information Systems, including ISCA	
CHA should develop policies, procedures, and information systems to ensure all required data elements are captured, including long-term psychiatric care forms, when appropriate, to align with CCO contract requirements. The CCO should also update its policy and procedure to include oversight processes for monitoring MOTS data submissions from BH providers. CHA should implement and ensure staff are trained and knowledgeable about these defined processes, including the documentation of all oversight activities and follow-up actions taken when issues are identified.	**CHA sufficiently addressed the recommendation.** Documentation reviewed during the CY 2023 CMR activity demonstrated compliance with the standard.
Standard XIV—Member Information	
This standard was not assessed during the 2022 CMR.	Not applicable.
Performance Improvement Projects	
Statewide Mental Health Service Access Monitoring PIP	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Statewide Substance Use Disorder PIP	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.

CY 2022 Recommendation	CY 2023 Assessment
Performance Measure Validation	
This recommendation was initially given during the CY 2021 EQR. CHA should continue to monitor key performance measure rates in alignment with its QAPI goals and objectives. For all key measures that fall below established performance or improvement thresholds, CHA should conduct root cause analyses to identify specific factors affecting performance. Once identified, targeted interventions should be developed, implemented, and evaluated to ensure effective improvement strategies are adopted to increase performance over time. Additionally, CHA should continue to monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches to ensuring the quality, timeliness, and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	**CHA did not provide a response or supporting documentation to address the recommendation.**
Validation of Network Adequacy	
This recommendation was initially given during the CY 2020 EQR. CHA should ensure that it reports DSN Provider Capacity Reporting data values for all required data fields and seek technical assistance from OHA as needed.	**CHA sufficiently addressed the recommendation.** CHA's reported data quality results for Q1 2023 showed a high degree of confidence in data fields that were present, complete, and in a valid format.
This recommendation was initially given during the CY 2021 EQR. CHA should implement mechanisms to monitor provider directory accuracy and appointment availability.	**CHA did not provide a response or supporting documentation to address the recommendation.**
Encounter Data Validation	
This recommendation was initially given during the CY 2021 EQR. HSAG recommends that CHA implement standard quality controls to ensure accurate data extracts. Through the development of standard data extraction procedures and quality control, the number of errors associated with extracted data could be reduced. Additionally, while no other weaknesses were identified, HSAG recommends that CHA continually monitor its encounter submissions to OHA to ensure complete, accurate, and timely encounter data submissions.	**CHA did not provide a response or supporting documentation to address the recommendation.**

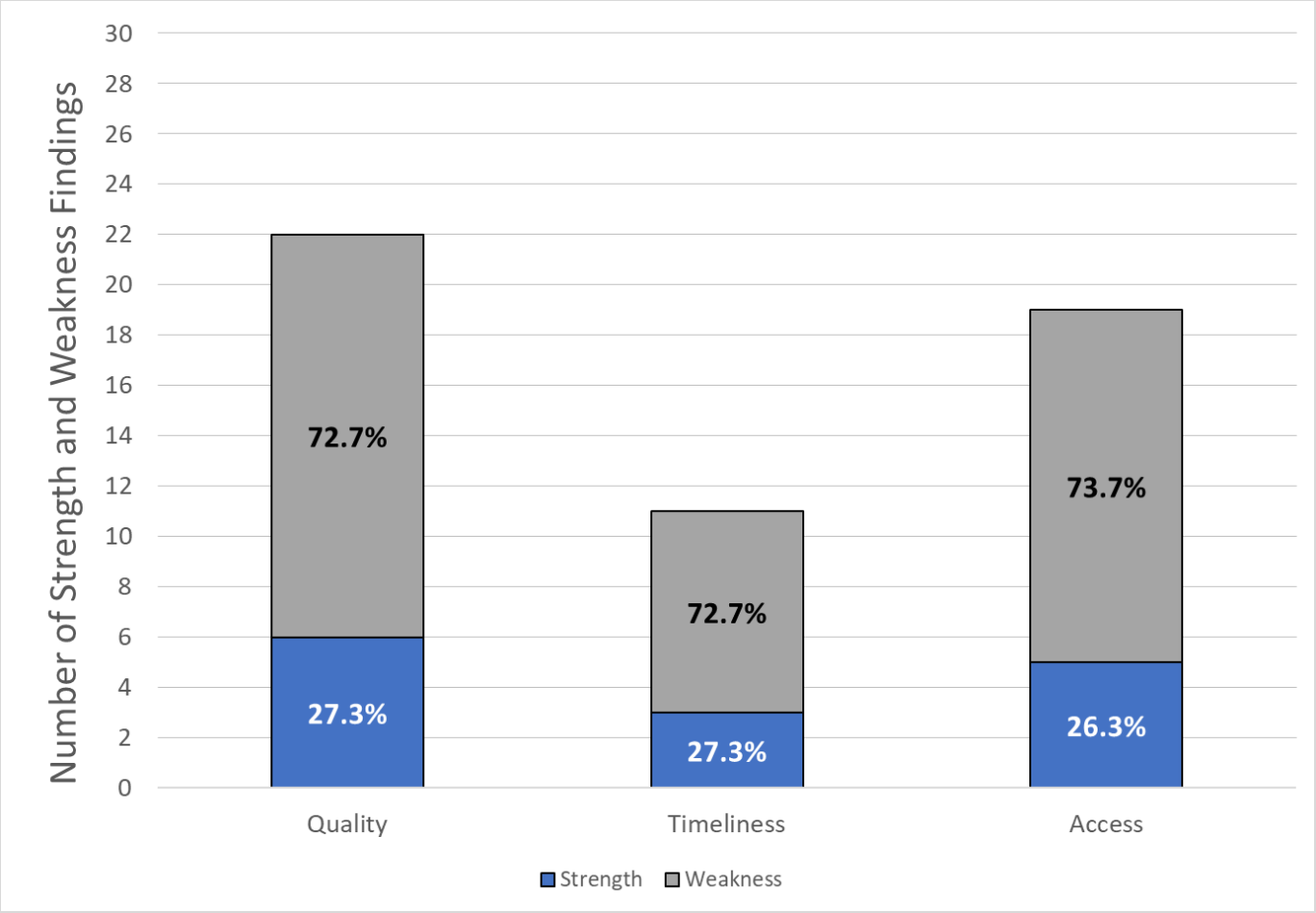
CY 2022 Recommendation	CY 2023 Assessment
CHA should investigate the root cause for the omissions and consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews would then be provided to providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.	**CHA did not provide a response or supporting documentation to address the recommendation.**
Mental Health Parity Evaluation	
CHA should update its administrative systems, or work with delegate Rx benefit managers, to capture the necessary data elements to allow the reporting of Rx PA data by benefit type. CHA must implement these changes in order to support future MHP reporting requirements.	**CHA did not provide a response or supporting documentation to address the recommendation.**

Columbia Pacific CCO, LLC

Results and Conclusions

HSAG assessed the strengths and weaknesses of each CCO with respect to the quality, timeliness, and accessibility of health care services. Figure 5-7 illustrates the number of strengths exhibited by CPCCO relative to the number of weaknesses identified during the CY 2023 EQR activities across the three domains. The greater the proportion of weaknesses, the greater opportunities for improvement.

Figure 5-7—CPCCO Overall Number of Findings (Strengths and Weaknesses) by Domain



Detailed results from the EQR's substantive findings are summarized in Table 5-7 for each activity. This table highlights the extent to which CPCCO furnishes high quality, timely, and appropriate access to health care services, and recommendations for how CPCCO can best address issues identified for each activity.[5-7]

[5-7] See Section 4—Comparative Statewide Results for detailed, CCO-specific scores associated with EQR activity.

Table 5-7—CPCCO Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)[5-8]
Compliance Monitoring Review		
−	**Weakness:** CPCCO received a score of 88.9 percent in Standard III—Coordination and Continuity of Care due to a lack of operational structure. **Why the weakness exists:** CPCCO's policies and procedures did not align with federal and State requirements. **Recommendations:** CPCCO must revise its policies and procedures to align with federal and State requirements.	
−	**Weakness:** CPCCO received a score of 69.4 percent in Standard IV—Coverage and Authorization of Services due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting CPCCO's ability to adhere to federal and State requirements for authorizing services and to ensure proper and timely notification of adverse benefit determinations. **Why the weakness exists:** CPCCO's policies and procedures did not align with federal and State requirements. Additionally, CPCCO demonstrated reversing service authorization decisions outside the appeal process. CPCCO also failed to demonstrate mechanisms for ensuring its UM activities are not structured to incentivize the individual to deny, limit, or discontinue medically necessary services, and consistent application of medical necessity criteria. Finally, CPCCO failed to adhere to requirements for appropriate decision-makers, and provision and required content of NOABDs. **Recommendations:** CPCCO must revise its policies and procedures to align with federal and State requirements. CPCCO must demonstrate adherence to federal and State requirements for authorization of services, and required content and time frames for notification of adverse benefit determinations.	
−	**Weakness:** CPCCO received a score of 50.0 percent in Standard VII—Member Rights and Protections due to a lack of operational structure and failure to demonstrate implementation of an established process, impacting CPCCO's ability to ensure that member rights are respected and allowed to be exercised freely without affecting the treatment of members, advance directive requirements are met, and members are notified of their rights as required by federal and State requirements.	

[5-8] = Quality, = Timeliness, = Access

Strength/ Weakness	Description	Domain(s)[5-8]
	Why the weakness exists: CPCCO's policies and procedures and member- and provider-facing materials did not align with federal and State requirements. **Recommendations:** CPCCO must revise its policies and procedures and member- and provider-facing materials to align with federal and State requirements.	
−	**Weakness:** CPCCO received a score of 87.0 percent in Standard X—Grievance and Appeal Systems due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting CPCCO's ability to ensure member grievances and appeals are addressed and responded to appropriately. **Why the weakness exists:** CPCCO's policies and procedures did not align with federal and State requirements. Additionally, CPCCO failed to adhere to requirements for time frames for acknowledging and responding to grievances and/or appeals and readability of notices. CPCCO also failed to communicate grievance and/or appeal requirements to members, providers, and subcontractors. CPCCO also failed to demonstrate maintaining one level of appeal. **Recommendations:** CPCCO must revise its policies and procedures to align with federal and State requirements. Additionally, CPCCO must demonstrate adherence to federal and State requirements for time frames for acknowledging and responding to grievances and appeals; readability of notices; and implementation of federal and State requirements within communications to members, providers, and subcontractors. CPCCO must also demonstrate maintaining one level of appeal.	
−	**Weakness:** CPCCO received a score of 68.2 percent in Standard XIV—Member Information due to a lack of operational structure and failure to demonstrate implementation of an established process, impacting CPCCO's ability to ensure timely and proper member communication. **Why the weakness exists:** CPCCO's policies and procedures and member-facing materials, including the member handbook, member notices, medication formulary, CCO website, and provider directory, did not align with federal and State requirements. Additionally, CPCCO failed to track and monitor the timely provision of required member information. **Recommendations:** CPCCO must revise its policies, procedures, and member-facing materials to align with federal and State requirements. Additionally, CPCCO must track and monitor the timely provision of required member information.	

Strength/ Weakness	Description	Domain(s)[5-8]
−	**Weakness:** CPCCO received a score of 83.3 percent in Standard XVI—Emergency and Poststabilization Services due to a lack of operational structure to ensure poststabilization services are covered appropriately. **Why the weakness exists:** CPCCO failed to demonstrate plan documents, such as policies and procedures, and the provider manual did not appropriately define "poststabilization services" and communicate the appropriate requirements. **Recommendations:** CPCCO must revise the applicable plan documents to define "poststabilization services" and communicate the appropriate requirements.	
Performance Improvement Projects		
Statewide Mental Health Service Access Monitoring PIP		
+	**Strength:** CPCCO's RY 1 performance indicator results demonstrated improvement in MH service access compared to baseline indicator results.	
−	**Weakness:** CPCCO's indicator results did not demonstrate statistically significant improvement over baseline performance. **Why the weakness exists:** The improvement in indicator results from baseline to RY 1 was not statistically significant. **Recommendations:** CPCCO should revisit root cause analyses identifying barriers to improving access to MH services to determine which barriers to improvement were not effectively addressed. CPCCO should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to further improve indicator results.	
−	**Weakness:** CPCCO did not demonstrate significant clinical or programmatic improvement in processes and outcomes. **Why the weakness exists:** CPCCO did not complete the Clinical and Programmatic Improvement Table; therefore, no evidence was provided to demonstrate significant clinical or programmatic improvement. **Recommendations:** CPCCO should complete the Clinical and Programmatic Improvement Table to demonstrate significant clinical or programmatic improvement in processes and outcomes.	
Statewide Substance Use Disorder PIP		
+	**Strength:** CPCCO successfully initiated the Implementation stage for the PIP, receiving a *Met* score for 100 percent of applicable evaluation elements in the PIP validation tool. In the Implementation stage, CPCCO accurately reported baseline performance indicator data; identified and analyzed barriers for initiation, engagement, and	

Strength/ Weakness	Description	Domain(s)[5-8]
	treatment of alcohol and other drug use disorders; and began to carry out interventions to address those barriers.	
Performance Measure Validation		
+	**Strength:** CPCCO's MY 2022 performance for members ages 6 to 14 years receiving preventive dental or oral health services improved by more than 5 percentage points compared to MY 2021 (8.0 percentage points). In addition, CPCCO's performance on the *Members Receiving Preventive Dental or Oral Health Services—Ages 1 to 5 Years* and *Ages 6 to 14 Years* measure indicators demonstrated ongoing improvement for members in both age groups since MY 2020.	
+	**Strength:** CPCCO'S performance on the *Oral Evaluation for Adults With Diabetes* measure demonstrated ongoing improvement since MY 2020.	
−	**Weakness:** CPCCO's MY 2022 rates on the *Initiation of SUD Treatment* and *Engagement of SUD Treatment* measure indicators for members ages 18 years and older fell below the 2020 HEDIS national Medicaid median benchmarks set by OHA for MY 2022. **Why the weakness exists:** In response to EQR recommendations, CPCCO noted several barriers to implementing performance improvement initiatives, including staffing shortages in its provider network and systemic barriers limiting access to care. **Recommendations:** In 2022, CPCCO monitored data on performance measures and conducted weekly internal meetings and monthly meetings with network providers to identify and address factors impacting performance. Additionally, CPCCO convened a monthly SUD expert group consisting of leaders from community mental health programs, public health, regional SUD programs, and Columbia Pacific to discuss best practices and address system barriers. CPCCO should continue implementing these efforts to raise its rates on this measure to the level of the benchmarks set by OHA.	
Validation of Network Adequacy		
Delivery System Network Evaluation		
+	**Strength:** CPCCO maintained and utilized frequently updated data dashboards of service utilization across multiple settings, subdivided by member demographics and risk cohorts, and available across divisions.	
−	**Weakness:** CPCCO demonstrated a moderate level of compliance with network monitoring requirements. **Why the weakness exists:** CPCCO did not demonstrate compliance with state-established specialty provider taxonomy data and reporting requirements. Additionally, CPCCO was not able to demonstrate how it collects and uses data on provider-to-member ratios, wait time to	

Strength/ Weakness	Description	Domain(s)[5-8]
	appointment availability, hours of operation, use of telehealth modalities, availability of culturally and linguistically appropriate care, or availability of physical accessibility accommodations to inform network adequacy monitoring and decision-making. **Recommendations:** CPCCO should ensure that all future reporting utilizes the state-established specialty provider taxonomies current to the review period, and should demonstrate how it collects and uses DSN data to inform network adequacy monitoring and decision-making.	
−	**Weakness:** CPCCO showed potential issues within its provider data, including but not limited to service area activity and status of accepting new patients. This issue was also identified during the CY 2021 and CY 2022 DSN Evaluations and was not addressed by CPCCO. **Why the weakness exists:** The percentage of providers operating within the service area was approximately 10 percent or less for most providers including PCPs. With the exception of PCPs, less than 1 percent of all provider types were accepting new patients. **Recommendations:** CPCCO should seek technical assistance with OHA to determine the nature of the provider capacity data issues and correct them.	
Secret Shopper Survey		
−	**Weakness:** The total secret shopper survey response rate was 71.9 percent across all PCP and PCD cases. Of the total responsive cases, only 89.9 percent of the offices offered the requested services, 73.6 percent accepted OHP, 40.3 percent accepted CPCCO, and 28.7 percent accepted new patients. Although 95.3 percent of the total cases confirmed the location, the rate for PCD cases was 87.0 percent. **Why the weakness exists:** In addition to limitations related to the secret shopper approach, the accuracy of CPCCO's provider data may have contributed to the low response rate and accuracy results. **Recommendations:** HSAG recommends that CPCCO use the case-level analytic data files to address the data deficiencies identified during the secret shopper survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
−	**Weakness:** Of the total secret shopper survey responsive cases, only 23.3 percent resulted in an appointment, and only 73.3 percent of those appointments offered were within the wait time compliance standard. **Why the weakness exists:** In addition to limitations related to the secret shopper approach, the accuracy of CPCCO's provider data may	

Strength/ Weakness	Description	Domain(s)[5-8]
	have contributed to the low appointment availability rate. Additionally, internal office procedures may have contributed to the long wait times. **Recommendations:** HSAG recommends that CPCCO confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. CPCCO should use the case-level analytic data files containing data deficiencies identified during the secret shopper survey calls.	
Revealed Telephone Survey		
−	**Weakness:** Overall, 67.7 percent of the revealed telephone survey total sampled cases were reached, of which three, or 2.4 percent, refused to participate in the survey. Of the total responsive cases, 64.3 percent of the offices offered the requested specialty, 61.9 percent accepted OHP, 37.3 percent accepted CPCCO, and 27.8 percent accepted new patients. **Why the weakness exists:** In addition to limitations related to the revealed telephone approach, the accuracy of CPCCO's provider data may have contributed to the low response rate and accuracy results. **Recommendations:** HSAG recommends that CPCCO use the case-level analytic data files to address the data deficiencies identified during the revealed telephone survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, program information, and translation/interpreter services offered).	
−	**Weakness:** Of the sampled cases, only 9.1 percent of the revealed telephone survey respondents offered a new patient appointment, while only 11.8 percent of survey respondents offered an appointment for an existing patient. Of the total cases that offered an appointment, 38.5 percent of routine appointments and 34.4 percent of urgent appointments were within the wait time compliance standard. **Why the weakness exists:** In addition to limitations related to the revealed telephone approach, the accuracy of CPCCO's provider data may have contributed to the low appointment availability rate. Additionally, internal office staffing structures and procedures may have contributed to the long wait times. **Recommendations:** HSAG recommends that CPCCO confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. CPCCO should use the case-level analytic data files containing data deficiencies identified during the revealed telephone survey calls and work with BH outpatient offices to identify the root cause for delays in appointment availability.	

Strength/ Weakness	Description	Domain(s)[5-8]
Encounter Data Validation		
+	**Strength:** Among records that could be matched between the two data sources, a high level of element accuracy (i.e., data elements from both sources had the same values when populated) was exhibited for nearly all evaluated key data elements.	
+	**Strength:** The CPCCO-submitted data had high all-element accuracy, indicating that the values (missing or non-missing) in both data sources (CPCCO and OHA) were the same for almost all records.	
−	**Weakness:** There were a high number and percentage of records present in the files submitted by OHA but not found in the files submitted by CPCCO's subcontractor(s) (i.e., record surplus). **Why the weakness exists:** Based on the data discrepancy report response from CPCCO, the surplus records were primarily associated with its subcontractor, WDG. A high number of WDG records were excluded from analysis due to missing the required variable, *Adjudication Date*. **Recommendations:** HSAG recommends that CPCCO proactively inform HSAG about special scenarios like the one observed with WDG, where the *Adjudication Date* was not populated due to WDG's capitated nature, that it does not receive, process, or adjudicate claims.	
−	**Weakness:** The *Rendering Provider NPI* showed that information was present in the OHA-submitted data but not in the CPCCO-submitted data. **Why the weakness exists:** More than 99.9 percent of the *Rendering Provider NPI* values in the OHA-submitted data, not found in the CPCCO-submitted data, had the same values as the *Billing Provider NPI*. This discrepancy is likely a result of the data processing approach in OHA's MMIS. In OHA's MMIS, if the *Rendering Provider NPI* value is not submitted, the system populates the value with the *Billing Provider NPI* value. Consequently, when comparing this data element across the two sources, the *Rendering Provider NPI* is present in the OHA-submitted data but not in the CPCCO-submitted data. **Recommendations:** While encounter submission to OHA did not require the inclusion of the *Rendering Provider NPI* value if it matched the *Billing Provider NPI* value, the data request for the EDV comparative analysis had different requirements. To address this, HSAG recommends that CPCCO and its subcontractor(s) ensure that values for both *Billing Provider NPI* and *Rendering Provider NPI* are included in the data submission, irrespective of their equivalence. This adjustment will enhance the accuracy and completeness of the comparative analysis data. Additionally, it will provide HSAG with the	

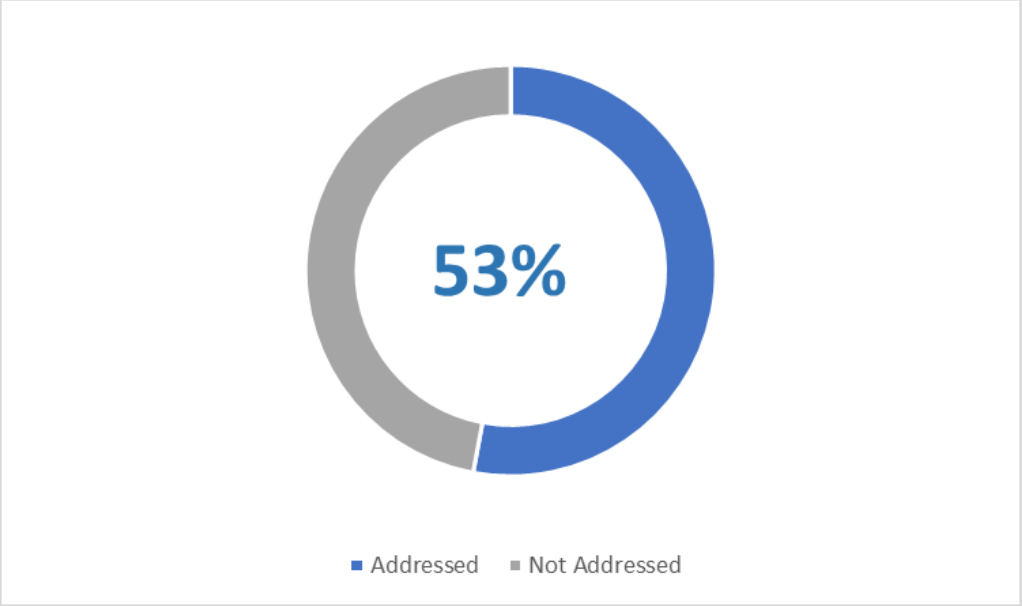
Strength/ Weakness	Description	Domain(s)[5-8]
	means to verify and ensure the accuracy of the MMIS' process of populating the *Rendering Provider NPI* with the *Billing Provider NPI*.	
Mental Health Parity Evaluation		
⊕	**Strength:** CPCCO achieved full compliance with parity requirements for NQTLs applied to MH/SUD and M/S benefits.	🔑

Follow-Up on Prior Year Recommendations

HSAG evaluated CPCCO's approach to addressing the recommendations and/or findings issued during CY 2022 and unresolved findings from CY 2020 and CY 2021 while conducting the CY 2023 EQR activities. The CCOs not addressing findings and recommendations are at risk of being out of compliance with their contracts.

Figure 5-8 illustrates the degree in which the CCO sufficiently addressed the recommendations for QI made by HSAG during the CY 2022 EQR.

Figure 5-8—Percentage of CY 2022 EQR Recommendations Addressed by CPCCO



CPCCO-specific CY 2022 recommendations and follow-up CY 2023 assessments are summarized in Table 5-8.

Table 5-8—Assessment of CPCCO's Approach to Addressing Previous Annual Recommendations

CY 2022 Recommendation	CY 2023 Assessment
Compliance Monitoring Review	
Standard I—Availability of Services	
This recommendation was initially given during the CY 2021 EQR. CPCCO should develop thorough documented processes that address all required elements of network evaluation. Policies as well as provider and member communications should be updated to reflect accurate information on network access.	**CPCCO did not sufficiently address the recommendation.** CPCCO's policies and procedures did not include the CCO's process for monitoring its provider network. CPCCO also did not demonstrate evidence of monitoring its provider network for appointment availability nor monitoring its provider network based upon the characteristics and needs of its membership. The CCO also did not demonstrate that it uses the mechanisms available to monitor that its provider network includes sufficient family planning providers to ensure timely access to covered services. CPCCO should develop thorough, documented processes that address all required elements of network evaluation. The CCO should be able to demonstrate evidence of monitoring its provider network and corrective action when providers fail to meet the standards.
Standard II—Assurances of Adequate Capacity and Services	
This recommendation was initially given during the CY 2021 EQR. CPCCO should develop a documented process for monitoring provider capacity that includes monitoring specialty providers individually by specialty type and ensure its network evaluation incorporates key data collected from its monitoring processes.	**CPCCO did not sufficiently address the recommendation.** CPCCO did not develop a documented or demonstrate implementing a process for monitoring provider capacity that includes monitoring specialty providers individually by specialty type. CPCCO should develop a documented process for monitoring provider capacity that includes monitoring specialty providers individually by specialty type and ensuring its network evaluation incorporates key data collected from its monitoring processes.
Standard III—Coordination and Continuity of Care	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard IV—Coverage and Authorization of Services	
This standard was not assessed during the 2022 CMR.	Not applicable.

CY 2022 Recommendation	CY 2023 Assessment
Standard V—Provider Selection	
This recommendation was initially given during the CY 2021 EQR. CPCCO should develop and conduct state-required training and document completion of provider and CCO staff training.	**CPCCO did not sufficiently address the recommendation.** CPCCO did not demonstrate a streamlined system of providing the state-established required training to CCO staff and participating providers and their staff. CPCCO should develop and conduct state-required training and document completion of provider and CCO staff training.
Standard VI—Subcontractual Relationships and Delegation	
This recommendation was initially given during the CY 2021 EQR. CPCCO should execute revised subcontracts that include all required contract provisions.	**CPCCO sufficiently addressed the recommendation.** Documentation reviewed during the CY 2023 CMR activity demonstrated compliance with the standard.
Standard VII—Member Rights and Protections	
This recommendation was initially given during the CY 2020 EQR. CPCCO should revise its policies to address the health care interpretation services available and the inclusion of American sign language (ASL), oral interpretation for any language, and written translation in prevalent languages.	**CPCCO sufficiently addressed the recommendation.** Documentation reviewed during the CY 2023 CMR activity demonstrated compliance with the standard.
Standard VIII—Confidentiality	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard IX—Enrollment and Disenrollment	
CPCCO should revise its policies and procedures and member-facing documents to align with federal and State requirements. CPCCO should also demonstrate oversight and monitoring of disenrollment reasons to ensure compliance with the regulatory requirements.	**CPCCO did not sufficiently address the recommendation.** CPCCO did not include one of the reasons why members can disenroll without cause within its member handbook. CPCCO should ensure that it communicates to members all the reasons why members can disenroll from the CCO. Utilizing the model member handbook would ensure the CCO captures the requirements.
Standard X—Grievance and Appeal Systems	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard XI—Practice Guidelines	
This recommendation was initially given during the CY 2021 EQR. CPCCO should	**CPCCO sufficiently addressed the recommendation.** Documentation reviewed

CY 2022 Recommendation	CY 2023 Assessment
maintain a cycle for reviewing and updating practice guidelines that is consistent with its policies and update its Clinical Practice Guidelines policy. Member education should be addressed in the policy, and the CCO should provide evidence of ensuring member education as well as coverage and utilization decisions are consistent with its practice guidelines.	during the CY 2023 CMR activity demonstrated compliance with the standard.
Standard XII—Quality Assessment and Performance Improvement	
CPCCO should revise its QAPI program structure to align with federal and State requirements for a QAPI program. CPCCO should also demonstrate appropriate oversight of its QAPI program.	**CPCCO did not sufficiently address the recommendation.** CPCCO did not demonstrate that its QAPI program structure included the federal and State requirements for a QAPI program, including mechanisms to assess the quality and appropriateness of the care furnished to members with SHCN and members receiving LTSS, and an annual written evaluation of its QAPI program. CPCCO also did not demonstrate appropriate oversight of its QAPI program, including implementing a QI committee that meets the State's requirements. CPCCO should ensure appropriate oversight of its QAPI program, including implementing a QI committee that meets the State's requirements.
Standard XIII—Health Information Systems, including ISCA	
CPCCO should amend its policies, procedures, and information systems to capture all required data elements and make them available for reporting to align with CCO contract requirements. CPCCO should also update its policies and procedures to include oversight processes for monitoring MOTS data submissions from its BH providers. CPCCO should ensure its staff are trained in, knowledgeable of, and implement those defined processes, including the documentation of all oversight activities and follow-up actions taken when issues are identified.	**CPCCO did not sufficiently address the recommendation.** CPCCO did not demonstrate mechanisms for ensuring BH provider compliance with MOTS reporting requirements. CPCCO should develop and implement processes to monitor its BH providers' compliance with MOTS reporting requirements.
Standard XIV—Member Information	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.

CY 2022 Recommendation	CY 2023 Assessment
Performance Improvement Projects	
Statewide Mental Health Service Access Monitoring PIP	
For each completed measurement period, CPCCO should include a statement in the narrative interpretation of results that addresses whether any factors were identified that may impact the validity or comparability of results.	**CPCCO did not sufficiently address the recommendation**. The CCO did not discuss whether factors were identified that may impact the validity of comparability of RY 1 indicator results in this year's PIP submission. CPCCO should include a statement in the narrative interpretation of RY 1 results that addresses whether any factors were identified that may impact the validity or comparability of RY 1 results to the baseline results. The CCO should state if no factors were identified. If factors were identified, the CCO should describe resolutions of those factors in the narrative interpretation of results.
Statewide Substance Use Disorder PIP	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Performance Measure Validation	
This recommendation was initially given during the CY 2021 EQR. CPCCO should continue to monitor key performance measure rates in alignment with its QAPI goals and objectives. For all key measures that fall below established performance or improvement thresholds, CPCCO should conduct root cause analyses to identify specific factors affecting performance. Once identified, targeted interventions should be developed, implemented, and evaluated to ensure effective improvement strategies are adopted to increase performance over time. Additionally, CPCCO should continue to monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches to ensuring the quality, timeliness, and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	**CPCCO sufficiently addressed the recommendation.** CPCCO reported that it monitored performance measure data and conducted meetings with internal staff and network providers to identify and address factors impacting performance. CPCCO held weekly metrics meetings to review gaps in the network and identify priority populations, and held monthly meetings to solicit feedback from network providers. CPCCO should continue implementing these efforts to raise its rates on this measure to the level of the benchmarks set by OHA.
CPCCO should continue to monitor performance of the *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—*	**CPCCO sufficiently addressed the recommendation.** CPCCO reported that it convened a monthly SUD expert group consisting

CY 2022 Recommendation	CY 2023 Assessment
Ages 18 Years and Older measure. CPCCO should conduct root cause analyses to identify specific factors affecting performance and develop, implement, and evaluate targeted interventions to ensure improvement strategies are adopted to increase performance over time. Additionally, CPCCO should continue to monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches to ensuring the quality, timeliness, and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	of leaders from community mental health programs, public health, regional SUD programs, and Columbia Pacific to discuss best practices and address system barriers. CPCCO developed and implemented several interventions to increase the prescribing of medication to treat opioid use disorder and alcohol use disorder, improve follow-up with members discharged from the ED or the hospital with a SUD diagnosis, and increase access to Naloxone for members at risk of overdose.
Validation of Network Adequacy	
This recommendation was initially given during the CY 2021 EQR. CPCCO should work with OHA to determine the root cause of the low count for in-network providers and work to correct any deficiency.	**CPCCO did not sufficiently address the recommendation.** The CCO provided responses that did not address the recommended actions. The root concern was that the CCO had a likely data quality issue showing that an overwhelming majority of the CCO's individual practitioners (not particular specialties or facility types) were cited as being outside of the CCO's network. The CCO did not describe coordinating with OHA to determine the nature of this issue. The CCO must work with OHA directly to determine the root cause of the low count for in-network providers and work to correct any deficiency.
This recommendation was initially given during the CY 2020 EQR. CPCCO should ensure that it reports DSN Provider Capacity Reporting data values for all required data fields and seek technical assistance from OHA as needed.	**CPCCO sufficiently addressed the recommendation.** CPCCO's reported data quality results for Q1 2023 showed a high degree of confidence in data fields that were present, complete, and in a valid format.
Encounter Data Validation	
This recommendation was initially given during the CY 2021 EQR. HSAG recommends that CPCCO implement standard quality controls to ensure accurate data extracts. Through the development of standard data extraction procedures and quality control, the number of errors associated with extracted data could be reduced. CPCCO had noted that the data extract issues will be corrected in the future. Additionally, HSAG recommends that CPCCO	**CPCCO sufficiently addressed the recommendation.** Based on the response, it appears that CPCCO has implemented initiatives to address the recommendation. CPCCO runs reports to scrub encounter data before and after submission, works on correcting diagnosis code issues, and reviews and reprocesses claims that hit pend reasons instituted by OHA. Additionally, CPCCO plans to enhance QA testing for applications and data extracts, addressing

CY 2022 Recommendation	CY 2023 Assessment
continually monitor its encounter submissions to OHA to ensure complete, accurate, and timely encounter data submissions.	potential barriers through education for new staff and the hiring of a dedicated resource for process documentation. CPCCO's identified strategy for continued improvement involves educating new resources, peer review testing sessions, and maintaining subject matter expertise. Overall, CPCCO's efforts demonstrated progress in addressing the recommendation, particularly in terms of diagnosis code-related issues and QA. CPCCO's planned enhancements to testing and documentation suggest a commitment to ongoing improvement.
CPCCO should investigate and follow up with its providers to determine why encounters were submitted to OHA; however, no medical records/documentation were available for the requested dates of service.	**CPCCO sufficiently addressed the recommendation.** CPCCO's response suggested that the CCO has taken initiatives to address the recommendation. CPCCO noted that its payment integrity department has expanded and brought in new leadership. CPCCO conducts per-payment audits, itemized bill reviews, and post-pay audits on facility charges, resulting in significant cost avoidance and recoveries. CPCCO noted that provider education efforts have been made to address potential issues with code usage. However, CPCCO noted that there are identified barriers related to the limited skill set for chart audits, impacting the number of audits that can be completed. To overcome this, CPCCO plans to expand and train the payment integrity team and has partnered with external vendors to enhance specialty expertise for additional MRR. Overall, while CPCCO has made progress in payment integrity, ongoing efforts are focused on expanding capabilities and addressing specific challenges related to chart audits.
CPCCO should investigate the root cause for the omissions and consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews would then be provided to providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.	**CPCCO sufficiently addressed the recommendation.** CPCCO addressed the recommendation by implementing various initiatives within the payment integrity realm, which included expanding the department, conducting different types of audits, providing education to providers, and collaborating with external vendors. CPCCO's response highlighted positive outcomes, such as cost avoidance through audits, but acknowledged challenges related to the specific skill set required for chart audits.

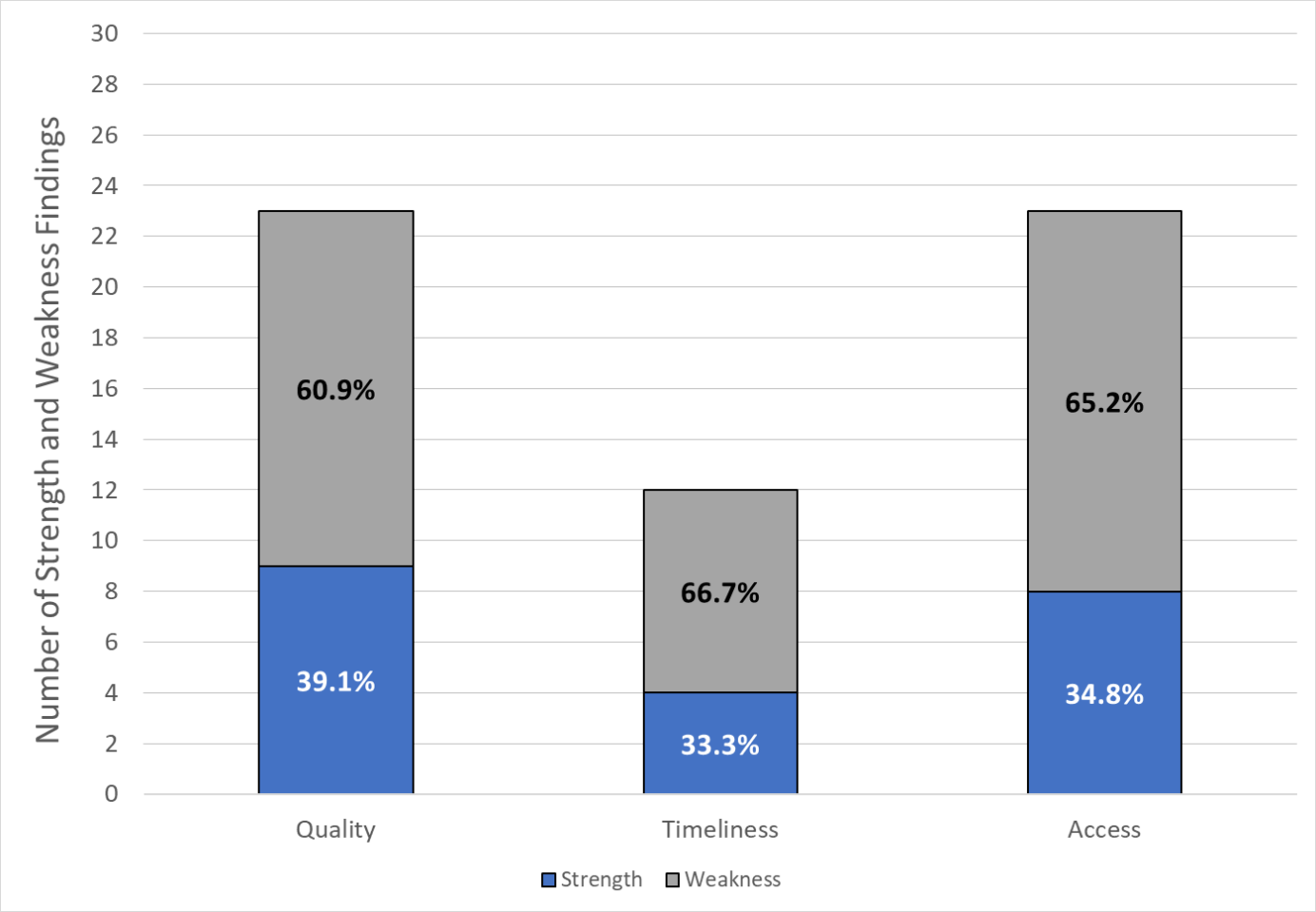
CY 2022 Recommendation	CY 2023 Assessment
	CPCCO's strategy for continued improvement involves expanding and training the payment integrity team and partnering with external vendors to enhance expertise in MRR. Overall, CPCCO's response indicates a proactive and multifaceted approach to addressing the recommendation.
Mental Health Parity Evaluation	
CPCCO met performance expectations. No significant strengths or weaknesses were noted during the review.	Not applicable.

Eastern Oregon CCO, LLC

Results and Conclusions

HSAG assessed the strengths and weaknesses of each CCO with respect to the quality, timeliness, and accessibility of health care services. Figure 5-9 illustrates the number of strengths exhibited by EOCCO relative to the number of weaknesses identified during the CY 2023 EQR activities across the three domains. The greater the proportion of weaknesses, the greater opportunities for improvement.

Figure 5-9—EOCCO Overall Number of Findings (Strengths and Weaknesses) by Domain



Detailed results from the EQR's substantive findings are summarized in Table 5-9 for each activity. This table highlights the extent to which EOCCO furnishes high quality, timely, and appropriate access to health care services, and recommendations for how EOCCO can best address issues identified for each activity.[5-9]

[5-9] See Section 4—Comparative Statewide Results for detailed, CCO-specific scores associated with EQR activity.

Table 5-9—EOCCO Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)[5-10]
Compliance Monitoring Review		
−	**Weakness:** EOCCO received a score of 83.3 percent in Standard III—Coordination and Continuity of Care due to a lack of operational structure, impacting EOCCO's ability to appropriately assess/reassess members for care coordination services, develop treatment plans with member involvement, and ensure health records are maintained in accordance with professional standards. **Why the weakness exists:** EOCCO's policies and procedures did not align with State requirements. Additionally, EOCCO failed to demonstrate a streamlined method of assessing and reassessing members and updating the member's care plan with the member's involvement within the appropriate time frames. EOCCO also failed to implement mechanisms to ensure the appropriate maintenance of medical records in accordance with professional standards. **Recommendations:** EOCCO must revise its policies and procedures to align with State requirements. EOCCO must also demonstrate implementation of appropriate assessments, reassessments, and revision of treatment plans according to federal and State requirements. EOCCO must also implement mechanisms to ensure the appropriate maintenance of medical records in accordance with professional standards.	
−	**Weakness:** EOCCO received a score of 77.8 percent in Standard IV—Coverage and Authorization of Services due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting EOCCO's ability to adhere to federal and State requirements for authorizing services and to ensure proper and timely notification of adverse benefit determinations. **Why the weakness exists:** EOCCO's policies and procedures did not align with federal and State requirements. Additionally, EOCCO demonstrated reversing service authorization decisions outside of the appeal process. EOCCO also failed to adhere to requirements for appropriate decision-makers; proper outreach to obtain information needed to process authorization requests; and required content, readability, and time frames for notification of adverse benefit determinations. **Recommendations:** EOCCO must revise its policies and procedures to align with federal and State requirements. EOCCO must demonstrate adherence to federal and State requirements for authorization requests	

[5-10] = Quality, = Timeliness, = Access

Strength/ Weakness	Description	Domain(s)[5-10]
	and required content, readability, and time frames for notification of adverse benefit determinations. EOCCO must also demonstrate proper outreach to retrieve the information needed to process service authorization requests.	
–	**Weakness:** EOCCO received a score of 70.0 percent in Standard VII—Member Rights and Protections due to a lack of operational structure and failure to demonstrate implementation of an established process, impacting EOCCO's ability to ensure that member rights are respected and allowed to be exercised freely without affecting the treatment of members and that advance directive requirements are met. **Why the weakness exists:** EOCCO's policies and procedures and provider-facing materials did not align with federal and State requirements. **Recommendations:** EOCCO must revise its policies and procedures and provider-facing materials to align with federal and State requirements.	
–	**Weakness:** EOCCO received a score of 85.2 percent in Standard X—Grievance and Appeal Systems due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting EOCCO's ability to ensure member grievances and appeals are addressed and responded to appropriately. **Why the weakness exists:** EOCCO's policies and procedures did not align with federal and State requirements. EOCCO also failed to adhere to requirements for the required content for grievance resolution notices, maintenance of an expedited process, time frames for acknowledging appeals, and extension requirements. EOCCO also failed to communicate grievance and/or appeal requirements to providers and subcontractors. **Recommendations:** EOCCO must revise its policies and procedures to align with federal and State requirements. EOCCO must also adhere to federal and State requirements for the required content for grievance resolution notices, maintenance of an expedited process, time frames for acknowledging appeals, and extension requirements. EOCCO must also demonstrate implementation of federal and State requirements within communications to providers and subcontractors.	
–	**Weakness:** EOCCO received a score of 79.5 percent in Standard XIV—Member Information due to a lack of operational structure and failure to demonstrate implementation of an established process, impacting EOCCO's ability to ensure timely and proper member communication. **Why the weakness exists:** EOCCO's policies and procedures and member-facing materials (i.e., the member handbook, member notices, medication formulary, and provider directory) did not align with federal	

Strength/ Weakness	Description	Domain(s)[5-10]
	and State requirements. Additionally, EOCCO failed to track and monitor the timely provision of required member information. **Recommendations:** EOCCO must revise its policies, procedures, and member-facing materials to align with federal and State requirements. EOCCO must also notify members of the availability of member information. Additionally, EOCCO must track and monitor the timely provision of required member information.	
−	**Weakness:** EOCCO received a score of 83.3 percent in Standard XVI—Emergency and Poststabilization Services due to failure to demonstrate implementation of appropriate processes and workflows, impacting EOCCO's ability to ensure that emergency and poststabilization services are covered appropriately. **Why the weakness exists:** EOCCO's policies and procedures did not align with federal and State requirements. EOCCO also failed to ensure provider materials communicated the appropriate requirements. **Recommendations:** EOCCO must revise its policies and procedures to align with federal and State requirements. EOCCO must also revise its provider materials to define "emergency and poststabilization services" and communicate the appropriate requirements.	
Performance Improvement Projects		
Statewide Mental Health Service Access Monitoring PIP		
−	**Weakness:** EOCCO's indicator results did not demonstrate any improvement over the baseline across all performance indicators. **Why the weakness exists:** The indicator results demonstrated a decline in performance from baseline to RY 1. **Recommendations:** EOCCO should revisit root cause analyses identifying barriers to improving access to MH services to determine which barriers to improvement were not effectively addressed. EOCCO should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to improve indicator results.	
Statewide Substance Use Disorder PIP		
+	**Strength:** EOCCO successfully initiated the Implementation stage for the PIP, receiving a *Met* score for 100 percent of applicable evaluation elements in the PIP validation tool. In the Implementation stage, EOCCO accurately reported baseline performance indicator data; identified and analyzed barriers for initiation, engagement, and treatment of alcohol and other drug use disorders; and began to carry out interventions to address those barriers.	

Strength/ Weakness	Description	Domain(s)[5-10]
Performance Measure Validation		
⊕	**Strength:** EOCCO's MY 2022 performance for members ages 6 to 14 years receiving preventive dental or oral health services improved by more than 5 percentage points compared to MY 2021 (6.3 percentage points). EOCCO's performance on the *Members Receiving Preventive Dental or Oral Health Services—Ages 1 to 5 Years* and *Ages 6 to 14 Years* measure indicators demonstrated ongoing improvement for members in both age groups since MY 2020. In addition, EOCCO's MY 2022 rates in both age groups exceeded the statewide aggregate and the 2020 CCO 75th percentile benchmark set by OHA for MY 2022 by 5 percentage points or more.	
⊕	**Strength:** EOCCO's performance on the *Child and Adolescent Well-Care Visits—Ages 3 to 6 Years* measure indicator demonstrated ongoing improvement since MY 2020.	
⊕	**Strength:** EOCCO's performance on the *Oral Evaluation for Adults With Diabetes* measure demonstrated ongoing improvement since MY 2020.	
⊖	**Weakness:** EOCCO's MY 2022 rate on the *Initiation of SUD Treatment* measure indicator for members ages 18 years and older fell below the 2020 HEDIS national Medicaid median benchmark set by OHA for MY 2022. **Why the weakness exists:** In response to EQR recommendations, EOCCO noted ongoing challenges with the availability of SUD treatment providers in rural and frontier service areas. **Recommendations:** EOCCO took several steps in 2022 to improve performance on this measure. EOCCO administered a Youth SUD Services Survey to understand available treatment options with CMHPs. EOCCO identified members with a qualifying SUD episode and worked with CMHPs and integrated clinics to engage these members in ongoing treatment services. Lastly, EOCCO monitored out-of-network claims for SUD treatment services and worked to establish contracts with providers to address members' SUD treatment needs. EOCCO should continue implementing these efforts to raise its rate on this measure indicator to the level of the benchmarks set by OHA.	

Strength/ Weakness	Description	Domain(s)[5-10]
Validation of Network Adequacy		
Delivery System Network Evaluation		
+	**Strength:** EOCCO demonstrated frequent and sophisticated monitoring of member service utilization as part of committee and staff network adequacy activities.	
−	**Weakness:** EOCCO scored below 90 percent and below the CCO aggregate score in two DSN Provider Narrative domains. **Why the weakness exists:** EOCCO did not demonstrate how it uses collected information on members with physical and mental disabilities, SHCN, and the availability of physical accessibility accommodations to inform its network adequacy monitoring and decision-making. EOCCO did not provide a complete plan for assessing the efficacy of planned interventions, nor did it address all findings identified in the CY 2022 DSN Evaluation. **Recommendations:** EOCCO should ensure that it describes or demonstrates how collected information is used to inform network adequacy monitoring and decision-making. EOCCO should ensure that all network adequacy interventions include plans for assessing their efficacy. EOCCO should address all findings from prior DSN Evaluations.	
−	**Weakness:** EOCCO's provider data results suggested potential data issues regarding adult and pediatric populations served, service area, and accepting new patients status. **Why the weakness exists:** EOCCO reported nearly all its providers as serving strictly either adult or pediatric populations, with few providers documented as serving both. It was unclear from the analysis whether these practice characteristics were accurately reported in EOCCO's quarterly provider capacity data files. Additionally, EOCCO reported very low rates of providers operating within the service area or accepting new patients, with most providers accepting no new patients. **Recommendations:** EOCCO should seek technical assistance with OHA to determine the nature of the provider capacity data issues and correct them.	
Secret Shopper Survey		
+	**Strength:** Of the secret shopper survey total responsive cases, 97.7 percent of PCD offices and 93.8 percent of PCP offices confirmed the location.	
+	**Strength:** Of the secret shopper survey responsive PCD cases, 90.7 percent of the offices offered the requested services.	

Strength/ Weakness	Description	Domain(s)[5-10]
−	**Weakness:** The total secret shopper survey response rate was 81.0 percent across all PCP and PCD cases. Of the total responsive cases, 67.6 percent of the offices offered the requested services, 49.5 percent accepted OHP, 46.3 percent accepted EOCCO, and 37.2 percent accepted new patients. **Why the weakness exists:** In addition to limitations related to the secret shopper approach, the accuracy of EOCCO's provider data may have contributed to the low accuracy results. **Recommendations:** HSAG recommends that EOCCO use the case-level analytic data files to address the data deficiencies identified during the secret shopper survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
−	**Weakness:** Of the total secret shopper survey responsive cases, only 25.5 percent resulted in an appointment. Although the appointment wait time compliance rate for PCDs was 100 percent, the overall rate for PCDs and PCPs combined was 68.8 percent. **Why the weakness exists:** In addition to limitations related to the secret shopper approach, the accuracy of EOCCO's provider data may have contributed to the low appointment availability rate. Additionally, internal office procedures may have contributed to the long wait times. **Recommendations:** HSAG recommends that EOCCO confirm appointment availability with providers, including panel capacity to accept new patients. EOCCO should use the case-level analytic data files containing data deficiencies identified during the secret shopper survey calls.	
Revealed Telephone Survey		
+	**Strength:** Of the revealed telephone survey respondents with verified locations that offered the requested services, and accepted OHP and EOCCO, 97.2 percent of the offices offered translation or interpreter services to members.	
−	**Weakness:** Overall, 62.3 percent of the revealed telephone survey total sampled cases were reached, of which 13, or 13.1 percent, refused to participate in the survey. Of the total responsive cases, 77.8 percent of the offices confirmed the location, 62.6 percent offered the requested specialty, 57.6 percent accepted OHP, 36.4 percent accepted EOCCO, and 35.4 percent accepted new patients. **Why the weakness exists:** In addition to limitations related to the revealed telephone approach, the accuracy of EOCCO's provider data may have contributed to the low response rate and accuracy results.	

Strength/ Weakness	Description	Domain(s)[5-10]
	Recommendations: HSAG recommends that EOCCO use the case-level analytic data files to address the data deficiencies identified during the revealed telephone survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
−	**Weakness:** Of the sampled cases, only 21.4 percent of the revealed telephone survey respondents offered a new patient appointment, while only 22.0 percent of survey respondents offered an appointment for an existing patient. Of the total cases that offered an appointment, 72.5 percent of routine appointments and 47.8 percent of urgent appointments were within the wait time compliance standard. **Why the weakness exists:** In addition to limitations related to the revealed telephone approach, the accuracy of EOCCO's provider data may have contributed to the low appointment availability rate. Additionally, internal office staffing structures and procedures may have contributed to the long wait times. **Recommendations:** HSAG recommends that EOCCO confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. EOCCO should use the case-level analytic data files containing data deficiencies identified during the revealed telephone survey calls and work with BH outpatient offices to identify the root cause for delays in appointment availability.	
Encounter Data Validation		
+	**Strength:** The EOCCO-submitted data exhibited high record-level data completeness, with low record omission and surplus rates.	
+	**Strength:** Among records that could be matched between the two data sources, a high level of element accuracy (i.e., data elements from both sources had the same values when populated) was exhibited across all evaluated key data elements.	
+	**Strength:** The EOCCO-submitted data had high all-element accuracy for all evaluated key data elements, indicating that the values (missing or non-missing) in both data sources (EOCCO and OHA) were the same for almost all records.	
−	**Weakness:** The *Rendering Provider NPI* showed that information was present in the OHA-submitted data but not in the EOCCO-submitted data. **Why the weakness exists:** More than 99.9 percent of the *Rendering Provider NPI* values in the OHA-submitted data, not found in the EOCCO-submitted data, had the same values as the *Billing Provider NPI*. This discrepancy is likely a result of the data processing approach in OHA's MMIS. In OHA's MMIS, if the *Rendering Provider NPI*	

Strength/ Weakness	Description	Domain(s)[5-10]
	value is not submitted, the system populates the value with the *Billing Provider NPI* value. Consequently, when comparing this data element across the two sources, the *Rendering Provider NPI* is present in the OHA-submitted data but not in the EOCCO-submitted data. **Recommendations:** While encounter submission to OHA did not require the inclusion of the *Rendering Provider NPI* value if it matched the *Billing Provider NPI* value, the data request for the EDV comparative analysis had different requirements. To address this, HSAG recommends that EOCCO and its subcontractor(s) ensure that values for both *Billing Provider NPI* and *Rendering Provider NPI* are included in the data submission, irrespective of their equivalence. This adjustment will enhance the accuracy and completeness of the comparative analysis data. Additionally, it will provide HSAG with the means to verify and ensure the accuracy of the MMIS' process of populating the *Rendering Provider NPI* with the *Billing Provider NPI*.	
Mental Health Parity Evaluation		
–	**Weakness:** EOCCO was partially compliant with the Medical Management—Concurrent Review NQTL requirement. **Why the weakness exists:** EOCCO did not provide its rationale for the assignment of the NQTL to both the IP and OP classifications for MH/SUD benefits and only to the IP classification for the M/S benefits. **Recommendations:** EOCCO should review its implementation of for OP MH/SUD services to ensure that the additional limitation based on the benefit does not impede the member's ability to access OP care more so than M/S.	🔑
–	**Weakness:** EOCCO was partially compliant with the Medical Management—Fail-First Requirements or Step Therapy NQTL requirement. **Why the weakness exists:** EOCCO did not provide its rationale for the assignment of the NQTL (i.e., lower cost options), procedures related to step therapy (e.g., individuals involved, factors used, professional guidelines used), or how frequently or strictly the NQTL is applied (e.g., decision-making process). **Recommendations:** EOCCO should identify processes, strategies, evidentiary standards, and other factors used in step therapy assignment for prescription drugs.	🔑
–	**Weakness:** EOCCO was partially compliant with the Pharmacy Management—Prescription Drug Benefit Tiers NQTL requirement. **Why the weakness exists:** EOCCO did not provide its rationale for the assignment of the NQTL (i.e., formulary drug tiering), procedures related to formulary tiering (e.g., individuals involved, factors used to determine tier placement, professional guidelines used), or how	🔑

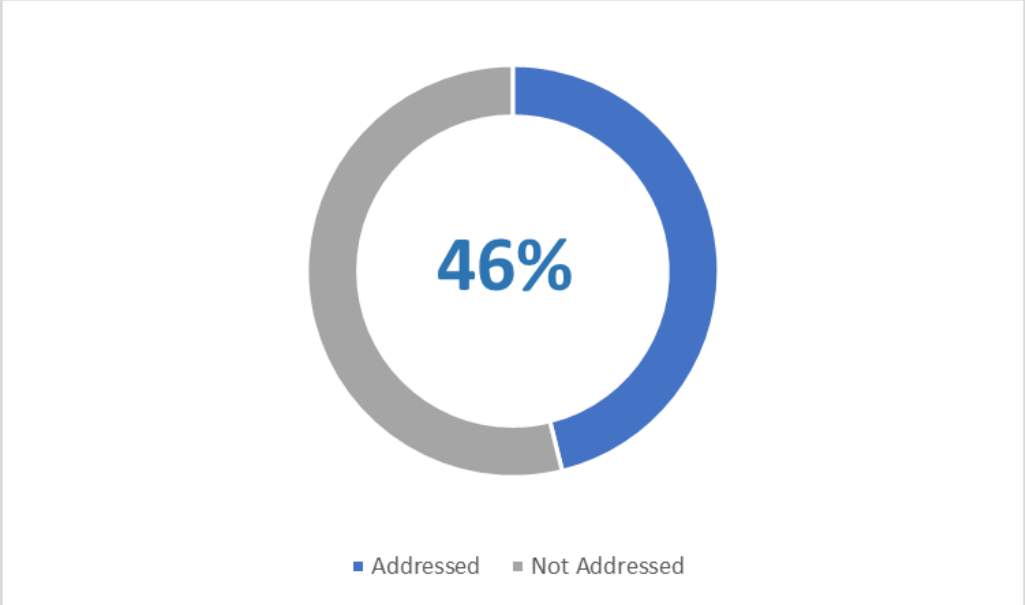
Strength/ Weakness	Description	Domain(s)[5-10]
	frequently or strictly the NQTL is applied (e.g., decision-making process). **Recommendations:** EOCCO should identify processes, strategies, evidentiary standards, and other factors used in formulary tiering.	

Follow-Up on Prior Year Recommendations

HSAG evaluated EOCCO's approach to addressing the recommendations and/or findings issued during CY 2022 and unresolved findings from CY 2020 and CY 2021 while conducting the CY 2023 EQR activities. The CCOs not addressing findings and recommendations are at risk of being out of compliance with their contracts.

Figure 5-10 illustrates the degree in which the CCO sufficiently addressed the recommendations for QI made by HSAG during the CY 2022 EQR.

Figure 5-10—Percentage of CY 2022 EQR Recommendations Addressed by EOCCO



EOCCO-specific CY 2022 recommendations and follow-up CY 2023 assessments are summarized in Table 5-10.

Table 5-10—Assessment of EOCCO's Approach to Addressing Previous Annual Recommendations

CY 2022 Recommendation	CY 2023 Assessment
Compliance Monitoring Review	
Standard I—Availability of Services	
This recommendation was initially given during the CY 2021 EQR. EOCCO should revise its provider communications to include complete and accurate network access information.	**EOCCO sufficiently addressed the recommendation.** Documentation reviewed during the CY 2023 CMR activity demonstrated compliance with the standard.
Standard II—Assurances of Adequate Capacity and Services	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard III—Coordination and Continuity of Care	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard IV—Coverage and Authorization of Services	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard V—Provider Selection	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard VI—Subcontractual Relationships and Delegation	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard VII—Member Rights and Protections	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard VIII—Confidentiality	
EOCCO met performance expectations. No significant strengths or weaknesses were noted during the review.	Not applicable.
Standard IX—Enrollment and Disenrollment	
EOCCO should revise its policies and procedures, member-facing documents, and training provided to staff to align with federal and State requirements. EOCCO should also demonstrate oversight and monitoring of disenrollment reasons to ensure compliance with the regulatory requirements.	**EOCCO did not sufficiently address the recommendation.** Although EOCCO sufficiently revised its member-facing and training documents, the CCO's policies and procedures did not fully align with the state-established reasons that members may request disenrollment without cause. EOCCO should ensure its policies

CY 2022 Recommendation	CY 2023 Assessment
	and procedures align with federal and State requirements.
Standard X—Grievance and Appeal Systems	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard XI—Practice Guidelines	
This recommendation was initially given during the CY 2021 EQR. EOCCO should ensure its decisions for member education are consistent with its practice guidelines.	**EOCCO sufficiently addressed the recommendation.** Documentation reviewed during the CY 2023 CMR activity demonstrated compliance with the standard.
Standard XII—Quality Assessment and Performance Improvement	
EOCCO should revise its QAPI program structure to align with federal and State requirements for a QAPI program, including appropriate oversight of its QAPI program.	**EOCCO did not sufficiently address the recommendation.** EOCCO's QAPI program lacked defined processes or mechanisms to assess the quality and appropriateness of care provided to members using LTSS. EOCCO also failed to demonstrate a QI committee that met the State requirements, including approval of the annual quality strategy. EOCCO should revise its QAPI program structure to align with federal and State requirements for a QAPI program. EOCCO should identify a defined process or mechanism to evaluate the population and/or relevant subpopulations for the appropriate care. EOCCO should describe the data used and how these data will be used to assess the population. EOCCO should also demonstrate appropriate oversight of its QAPI program.
Standard XIII—Health Information Systems, including ISCA	
EOCCO met performance expectations. No significant strengths or weaknesses were noted during the review.	Not applicable.
Standard XIV—Member Information	
This recommendation was initially given during the CY 2020 EQR. EOCCO should ensure the provider directory includes the State and federal requirements for information listed for each provider.	**EOCCO did not sufficiently address the recommendation.** EOCCO's provider directory did not include all of the State and federal requirements for the information listed for each provider. EOCCO should ensure the provider directory includes the State and federal requirements for the information listed for each provider.

CY 2022 Recommendation	CY 2023 Assessment
Performance Improvement Projects	
Statewide Mental Health Service Access Monitoring PIP	
EOCCO should review the final baseline indicator data file distributed by OHA and seek technical assistance, if needed. The CCO should correct the baseline indicator data prior to next year's annual PIP validation.	**EOCCO sufficiently addressed the recommendation.** EOCCO correctly reported the baseline and RY 1 indicator data in this year's PIP submission.
For each completed measurement period, EOCCO should include a statement in the narrative interpretation of results that addresses whether any factors were identified that may impact the validity or comparability of results.	**EOCCO sufficiently addressed the recommendation.** EOCCO's narrative interpretation of indicator results addressed all required components, including whether factors were identified that may impact validity, in this year's PIP submission.
Statewide Substance Use Disorder PIP	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Performance Measure Validation	
EOCCO should continue to monitor its provider network to identify gaps in access to alcohol and other drug abuse and dependence care, and work with providers to identify alternative approaches to ensuring the quality, timeliness, and accessibility of treatment services (e.g., telehealth strategies, mobile clinics).	**EOCCO sufficiently addressed the recommendation.** EOCCO reported using a Youth SUD Services Survey to collect data on available SUD treatment options and identify gaps in treatment for young members. EOCCO reported working with CMHPs and integrated clinics to engage members with qualifying SUD episode in treatment services. EOCCO reported efforts to contract with SUD treatment providers and monitored out-of-network claims for SUD treatment services. Lastly, EOCCO plans to continue addressing SUD treatment gaps through out-of-network authorizations, network adequacy supports, and time and distance mapping. EOCCO should continue implementing these efforts to raise its rate on this measure indicator to the level of the benchmarks set by OHA.
Validation of Network Adequacy	
This recommendation was initially given during the CY 2021 EQR. EOCCO should ensure it addresses the accuracy of provider directory information as it addresses issues with member appointment access.	**EOCCO did not sufficiently address the recommendation.** While the CCO did initiate a process to collect additional information from its providers during an online survey, the CCO did not address actively addressing inaccuracies or appointment availability. The CY 2023 secret

CY 2022 Recommendation	CY 2023 Assessment
	shopper and revealed telephone survey activities conducted by HSAG demonstrated substantial data deficiencies, low appointment availability rates, and long wait times. EOCCO should reevaluate its current mechanisms to monitor provider directory accuracy and appointment availability, and implement processes to improve access to care for members.
EOCCO should assess its data and reporting systems to determine the nature of the inconsistencies between its DSN Provider Capacity Reporting data and DSN Provider Narrative submission and create an action plan to correct any issues.	**EOCCO sufficiently addressed the recommendation.** EOCCO's reported capacity data for Q1 2023 generally aligned with its narrative responses in terms of potential service gaps.
EOCCO should adhere to state-approved DSN data requirements and seek technical assistance from OHA, as needed.	**EOCCO did not sufficiently address the recommendation.** The OHA Q1 2023 DSN Provider Capacity Report showed that gaps remained in the CCO's *Credentialing Date* data field, which per the CCO's explanation were due to untimely recredentialing rather than data reporting errors. While the CCO was in the process of addressing this deficiency by hiring additional credentialing staff, this was not completed at the time of review.
Encounter Data Validation	
EOCCO should ensure its contracted providers' accountability in responding to medical record requests for the purposes of auditing, inspection, and oversight. HSAG recommends EOCCO consider strengthening and/or enforcing its contract requirements with its providers in providing the requested documentation. Additionally, EOCCO should investigate its provider information to determine the location in which services were provided and consequently encounters were submitted to OHA.	**EOCCO did not sufficiently address the recommendation.** While EOCCO's response mentioned engaging with network providers to ensure contractual requirements are met and conducting service verification audits throughout the year, the CCO's response did not explicitly detail any specific initiatives or strategies to strengthen or enforce contract requirements related to medical record requests. HSAG notes that it is essential to have clear measures in place to address non-responsive providers and ensure accountability. EOCCO should provide additional information on any enhanced measures, contractual amendments, or strategies implemented to strengthen provider accountability in responding to medical record requests. Additionally, outlining steps taken to address non-responsive providers and any improvements made

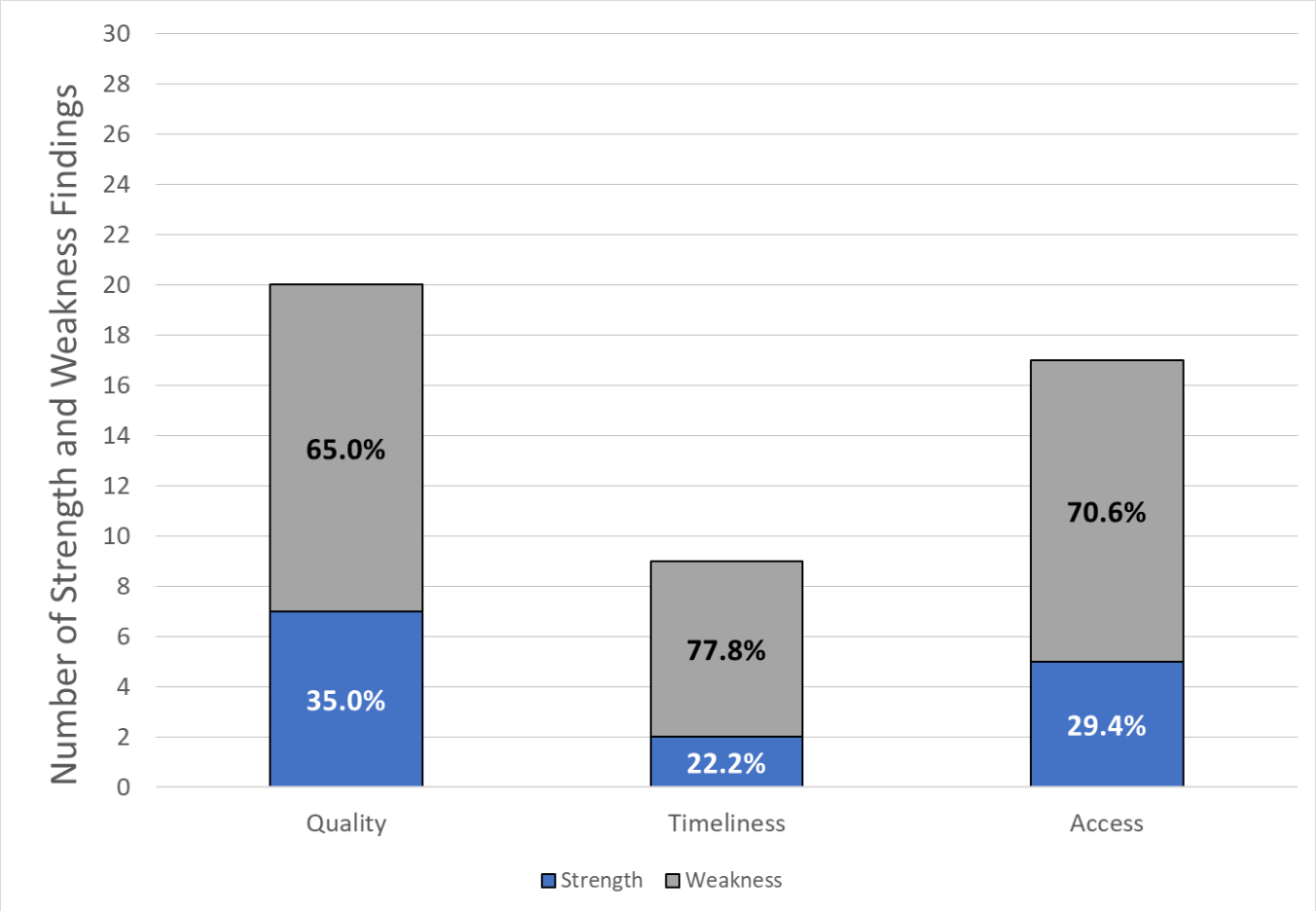
CY 2022 Recommendation	CY 2023 Assessment
	to the process would demonstrate a proactive approach to meeting the recommendation.
EOCCO should investigate the root cause for the omissions and consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews would then be provided to providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.	**EOCCO did not sufficiently address the recommendation.** EOCCO's response indicated ongoing efforts to communicate with network providers; conduct service verification and fraud, waste, and abuse (FWA) audits; and provide annual training. However, EOCCO provided no details regarding investigating the root cause for omissions or performing periodic MRRs of submitted claims to verify appropriate coding and data completeness. HSAG notes that EOCCO's focus was on communication, reminders, audits, and training rather than a specific emphasis on root cause investigation and periodic MRRs. Additionally, EOCCO provided no description of performance improvement or identified barriers with strategies for continued improvement. Therefore, HSAG's recommendation to investigate omissions and conduct periodic MRRs, along with provider education, appears only partially addressed.
Mental Health Parity Evaluation	
EOCCO met performance expectations. No significant strengths or weaknesses were noted during the review.	Not applicable.

Health Share of Oregon

Results and Conclusions

HSAG assessed the strengths and weaknesses of each CCO with respect to the quality, timeliness, and accessibility of health care services. Figure 5-11 illustrates the number of strengths exhibited by Health Share relative to the number of weaknesses identified during the CY 2023 EQR activities across the three domains. The greater the proportion of weaknesses, the greater opportunities for improvement.

Figure 5-11—Health Share Overall Number of Findings (Strengths and Weaknesses) by Domain



Detailed results from the EQR's substantive findings are summarized in Table 5-11 for each activity. This table highlights the extent to which Health Share furnishes high quality, timely, and appropriate access to health care services, and recommendations for how Health Share can best address issues identified for each activity.[5-11]

[5-11] See Section 4—Comparative Statewide Results for detailed, CCO-specific scores associated with EQR activity.

Table 5-11—Health Share Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)[5-12]
Compliance Monitoring Review		
−	**Weakness:** Health Share received a score of 44.4 percent in Standard III—Coordination and Continuity of Care due to a lack of operational structure and failure to appropriately screen and assess/reassess members for care management and ICC services. **Why the weakness exists:** Health Share failed to demonstrate appropriate oversight of its subcontractors and their processes and materials. Health Share's and/or its subcontractors' policies and procedures did not align with federal and State requirements. Additionally, Health Share failed to notify members of the person formally designated as primarily responsible for coordinating the services accessed by the member. Health Share also did not demonstrate mechanisms to ensure completion of the health risk screening. Health Share failed to demonstrate a streamlined method of assessing and reassessing members and updating the member's care plan within the appropriate time frame for members enrolled in case management. Finally, Health Share failed to share the required information to prevent duplication, coordinate between settings of care, ensure maintenance of professional standards, implement privacy procedures in the process of care coordination, and ensure direct access to specialists for members with SHCN. **Recommendations:** Health Share must revise its policies and procedures to align with federal and State requirements and demonstrate that its subcontractors have and implement the appropriate processes to ensure compliance with the requirements.	
−	**Weakness:** Health Share received a score of 44.4 percent in Standard IV—Coverage and Authorization of Services due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting Health Share's ability to adhere to federal and State requirements for ensuring the appropriate authorization of services and to ensure proper and timely notification of adverse benefit determinations. **Why the weakness exists:** Health Share failed to demonstrate appropriate oversight of its subcontractors and their processes and materials. Health Share's and/or its subcontractors' policies and procedures did not align with federal and State requirements. Additionally, Health Share demonstrated reversing service authorization decisions outside the appeal process. Health Share also	

[5-12] = Quality, = Timeliness, = Access

Strength/ Weakness	Description	Domain(s)[5-12]
	failed to demonstrate mechanisms for the appropriate scope of services offered to members and consistent application of medical necessity criteria. Health Share failed to adhere to requirements for the appropriate decision-makers and provision, required content, and readability of NOABDs. Finally, Health Share failed to ensure the proper response is provided for outpatient pharmacy requests. **Recommendations:** Health Share must revise its policies and procedures to align with federal and State requirements. Health Share must demonstrate adherence to federal and State requirements for coverage and authorization of services and required content and time frames for notification of adverse benefit determinations.	
−	**Weakness:** Health Share received a score of 60.0 percent in Standard VII—Member Rights and Protections due to a lack of operational structure and failure to demonstrate implementation of an established process, impacting Health Share's ability to ensure that member rights are respected and allowed to be exercised freely without affecting the treatment of members, advance directive requirements are met, and members are notified of their rights as required by federal and State requirements. **Why the weakness exists:** Health Share's/subcontractors' policies and procedures and member- and provider-facing materials did not align with federal and State requirements. **Recommendations:** Health Share and/or its subcontractors must revise their policies and procedures and member- and provider-facing materials to align with federal and State requirements.	
−	**Weakness:** Health Share received a score of 77.8 percent in Standard X—Grievance and Appeal Systems due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting Health Share's ability to ensure member grievances and appeals are addressed and responded to appropriately. **Why the weakness exists:** Health Share failed to demonstrate appropriate oversight of its subcontractors and their processes and materials. Health Share's and/or its subcontractors' policies and procedures did not align with federal and State requirements. Additionally, Health Share failed to adhere to requirements and/or time frames for acknowledging and responding to grievances and/or appeals and readability of notices. Health Share also failed to communicate grievance and/or appeal requirements to providers and subcontractors. Health Share also failed to demonstrate using the appropriate decision-makers on appeal adjudication and maintaining one level of appeal. **Recommendations:** Health Share must revise its policies and procedures to align with federal and State requirements. Additionally,	

Strength/ Weakness	Description	Domain(s)[5-12]
	Health Share must demonstrate adherence to federal and State requirements for grievances and appeals.	
−	**Weakness:** Health Share received a score of 68.2 percent in Standard XIV—Member Information due to a lack of operational structure and failure to demonstrate implementation of an established process, impacting Health Share's ability to ensure timely and proper member communication **Why the weakness exists:** Health Share failed to demonstrate appropriate oversight of its subcontractors and member-facing materials. Health Share's policies and procedures and member-facing materials, including the member handbook, member notices, medication formulary, CCO website, and provider directory, did not align with federal and State requirements. **Recommendations:** Health Share must revise its policies, procedures, and member-facing materials to align with federal and State requirements. Additionally, Health Share must track and monitor the timely provision of required member information.	
−	**Weakness:** Health Share received a score of 62.5 percent in Standard XVI—Emergency and Poststabilization Services due to a lack of operational structure to ensure emergency and poststabilization services are covered appropriately. **Why the weakness exists:** Health Share failed to demonstrate that plan documents, such as policies and procedures, and the member handbook appropriately define "emergency and poststabilization services." Health Share also failed to demonstrate the appropriate mechanisms (e.g., oversight of its subcontractors, processes, and workflows) are in place to ensure the appropriate coverage of emergency and poststabilization services. **Recommendations:** Health Share must revise the applicable plan documents to define "emergency and poststabilization services" and communicate the appropriate requirements. Health Share must also ensure that its internal and subcontractors' policies and procedures align with State and federal requirements and demonstrate implementation.	
Performance Improvement Projects		
Statewide Mental Health Service Access Monitoring PIP		
+	**Strength:** Health Share successfully continued the Implementation stage for the PIP, receiving a *Met* score for 100 percent of applicable evaluation elements in the PIP validation tool. In the Implementation stage, Health Share accurately reported baseline and RY 1 performance indicator data, identified and analyzed barriers to improving MH service access, carried out interventions to address those barriers, and refined interventions based on intervention evaluation results.	

Strength/ Weakness	Description	Domain(s)[5-12]
+	**Strength:** Health Share's RY 1 performance indicator results demonstrated statistically significant improvement in MH service access compared to baseline indicator results.	
Statewide Substance Use Disorder PIP		
+	**Strength:** Health Share successfully initiated the Implementation stage for the PIP, receiving a *Met* score for 100 percent of applicable evaluation elements in the PIP validation tool. In the Implementation stage, Health Share accurately reported baseline performance indicator data; identified and analyzed barriers for initiation, engagement, and treatment of alcohol and other drug use disorders; and began to carry out interventions to address those barriers.	
Performance Measure Validation		
+	**Strength:** Health Share's performance on the *Members Receiving Preventive Dental or Oral Health Services—Ages 1 to 5 Years* and *Ages 6 to 14 Years* measure indicators demonstrated ongoing improvement for members in both age groups since MY 2020. In addition, the CCO's MY 2022 rate for the *Ages 1 to 5 Years* measure indicator exceeded the 2020 CCO 75th percentile benchmark set by OHA for MY 2022 by 5 percentage points or more.	
Validation of Network Adequacy		
Delivery System Network Evaluation		
+	**Strength:** Health Share demonstrated a broad, data-driven population-level disease monitoring approach across physical, dental, and BH services. Health Share's data included subdivision by demographics, risk cohorts, and other factors including SDOH and climate change vulnerability. This monitoring directly informed network adequacy decision-making and strategic planning.	
−	**Weakness:** Health Share scored below 90 percent and below the CCO aggregate score in the *DSN Monitoring and Analysis* domain of the DSN Provider Narrative. **Why the weakness exists:** Health Share did not demonstrate compliance with state-established specialty provider taxonomy data and reporting requirements, monitor hours of operation, and demonstrate how it uses collected information on telehealth utilization to inform network adequacy monitoring and decision-making. **Recommendations:** Health Share should ensure that all future reporting utilizes the state-established specialty provider taxonomies current to the review period, and should demonstrate how it collects and uses DSN data to inform network adequacy monitoring and decision-making.	

Strength/ Weakness	Description	Domain(s)[5-12]
−	**Weakness:** Health Share showed potential issues within its provider data, including but not limited to service area activity and status of accepting new patients. **Why the weakness exists:** Health Share reported moderate rates of providers operating within its service area and moderate to very low rates (i.e., SUD providers at 3.4 percent) of providers accepting new patients. **Recommendations:** Health Share should seek technical assistance with OHA to determine the nature of the provider capacity data issues and correct them.	
Secret Shopper Survey		
+	**Strength:** Of the total secret shopper survey responsive cases, 94.9 percent of PCD offices and 94.3 percent of PCP offices confirmed the location.	
−	**Weakness:** The total secret shopper survey response rate was 86.0 percent across all PCP and PCD cases. Of the total responsive cases, 52.9 percent of the offices offered the requested services, 40.2 percent accepted OHP, 22.8 percent accepted Health Share, and 15.2 percent accepted new patients. **Why the weakness exists:** In addition to limitations related to the secret shopper approach, the accuracy of Health Share's provider data may have contributed to the low accuracy results. **Recommendations:** HSAG recommends that Health Share use the case-level analytic data files to address the data deficiencies identified during the secret shopper survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
−	**Weakness:** Of the total secret shopper survey responsive cases, only 13.8 percent resulted in an appointment. Although the appointment wait time compliance rate for PCPs was 100 percent, the overall rate for PCDs and PCPs combined was 78.9 percent. **Why the weakness exists:** In addition to limitations related to the secret shopper approach, the accuracy of Health Share's provider data may have contributed to the low appointment availability rate. Additionally, internal office procedures may have contributed to the long wait times. **Recommendations:** HSAG recommends that Health Share confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. Health Share should use the case-level analytic data files containing data deficiencies identified during the secret shopper survey calls.	

Strength/ Weakness	Description	Domain(s)[5-12]
Revealed Telephone Survey		
–	**Weakness:** Overall, 40.3 percent of the revealed telephone survey total sampled cases were reached, of which nine, or 6.7 percent, refused to participate in the survey. Of the total responsive cases, 71.9 percent of the offices confirmed the location, 37.0 percent offered the requested specialty, 36.3 percent accepted OHP, 22.2 percent accepted Health Share, 16.3 percent accepted new patients, and 70.0 percent offered translation or interpreter services. **Why the weakness exists:** In addition to limitations related to the revealed telephone approach, the accuracy of Health Share's provider data may have contributed to the low response rate and accuracy results. **Recommendations:** HSAG recommends that Health Share use the case-level analytic data files to address the data deficiencies identified during the revealed telephone survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, program information, and translation/interpreter services offered).	
–	**Weakness:** Of the sampled cases, only 4.2 percent of the revealed telephone survey respondents offered a new patient appointment, while only 6.3 percent of survey respondents offered an appointment for an existing patient. Of the total cases that offered an appointment, 85.3 percent of routine appointments and 45.7 percent of urgent appointments were within the wait time compliance standard. **Why the weakness exists:** In addition to limitations related to the revealed telephone approach, the accuracy of Health Share's provider data may have contributed to the low appointment availability rate. Additionally, internal office staffing structures and procedures may have contributed to the long wait times. **Recommendations:** HSAG recommends that Health Share confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. Health Share should use the case-level analytic data files containing data deficiencies identified during the revealed telephone survey calls and work with BH outpatient offices to identify the root cause for delays in appointment availability.	

Strength/ Weakness	Description	Domain(s)[5-12]
Encounter Data Validation		
+	**Strength:** Among records that could be matched between the two data sources, a high level of element accuracy (i.e., data elements from both sources had the same values when populated) was exhibited across all evaluated key data elements.	
+	**Strength:** The Health Share-submitted data had high all-element accuracy for all evaluated key data elements, indicating that the values (missing or non-missing) in both data sources (Health Share and OHA) were the same for almost all records.	
−	**Weakness:** There were a high number and percentage of records present in the files submitted by OHA but not found in the files submitted by Health Share's subcontractor(s) (i.e., record surplus). **Why the weakness exists:** Based on the data discrepancy report response from Health Share, some of the surplus records were associated with its subcontractor, WDG. A high number of WDG records were excluded from analysis due to missing the required variable, *Adjudication Date*. Furthermore, Health Share noted a portion of the surplus records were D3 encounters that were inadvertently omitted from the data extract sent to HSAG. **Recommendations:** HSAG recommends that Health Share proactively inform HSAG about special scenarios like the one observed with WDG, where the *Adjudication Date* was not populated due to WDG's capitated nature, that it does not receive, process, or adjudicate claims.	
−	**Weakness:** The *Rendering Provider NPI* showed that information was present in the OHA-submitted data but not in the Health Share-submitted data. **Why the weakness exists:** More than 99.9 percent of the *Rendering Provider NPI* values in the OHA-submitted data, not found in the Health Share-submitted data, had the same values as the *Billing Provider NPI*. This discrepancy is likely a result of the data processing approach in OHA's MMIS. In OHA's MMIS, if the *Rendering Provider NPI* value is not submitted, the system populates the value with the *Billing Provider NPI* value. Consequently, when comparing this data element across the two sources, the *Rendering Provider NPI* is present in the OHA-submitted data but not in the Health Share-submitted data. **Recommendations:** While encounter submission to OHA did not require the inclusion of the *Rendering Provider NPI* value if it matched the *Billing Provider NPI* value, the data request for the EDV comparative analysis had different requirements. To address this, HSAG recommends that Health Share and its subcontractor(s) ensure that values for both *Billing Provider NPI* and *Rendering Provider NPI* are included in the data submission, irrespective of their equivalence.	

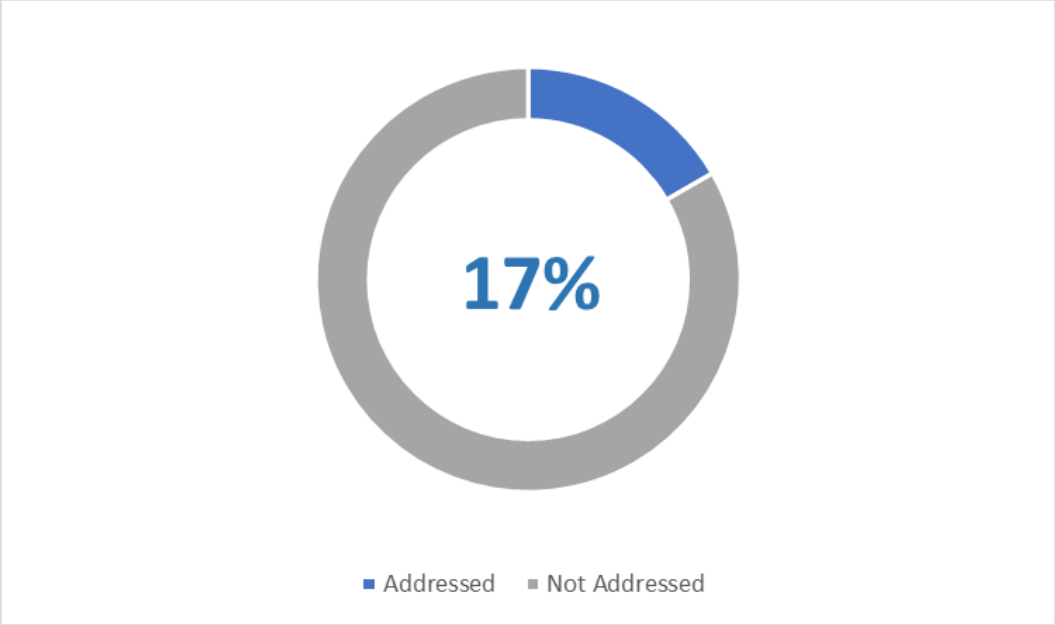
Strength/ Weakness	Description	Domain(s)[5-12]
	This adjustment will enhance the accuracy and completeness of the comparative analysis data. Additionally, it will provide HSAG with the means to verify and ensure the accuracy of the MMIS' process of populating the *Rendering Provider NPI* with the *Billing Provider NPI*.	
Mental Health Parity Evaluation		
−	**Weakness:** Many of the NQTLs reported by Health Share were unable to be fully evaluated for parity with MHP requirements. **Why the weakness exists:** Health Share did not provide sufficient information and/or supporting documentation to explain how each subcontractor applies the treatment limitations, including the rationale for the NQTL; procedures, processes, and requirements used to apply the NQTL; frequency and strictness of the NQTL; and evidentiary standards to support the rationale for how frequently and strictly the NQTL is applied. **Recommendations:** Health Share should describe or provide supporting documentation for the reported NQTLs for each subcontractor.	

Follow-Up on Prior Year Recommendations

HSAG evaluated Health Share's approach to addressing the recommendations and/or findings issued during CY 2022 and unresolved findings from CY 2020 and CY 2021 while conducting the CY 2023 EQR activities. The CCOs not addressing findings and recommendations are at risk of being out of compliance with their contracts.

Figure 5-12 illustrates the degree in which the CCO sufficiently addressed the recommendations for QI made by HSAG during the CY 2022 EQR.

Figure 5-12—Percentage of CY 2022 EQR Recommendations Addressed by Health Share



Health Share-specific CY 2022 recommendations and follow-up CY 2023 assessments are summarized in Table 5-12.

Table 5-12—Assessment of Health Share's Approach to Addressing Previous Annual Recommendations

CY 2022 Recommendation	CY 2023 Assessment
Compliance Monitoring Review	
Standard I—Availability of Services	
This recommendation was initially given during the CY 2021 EQR. Health Share should revise policies and procedures as well as member and provider communications to include complete and accurate network access information. In addition, the CCO should ensure processes include ongoing monitoring of provider network compliance and corrective actions when providers fail to meet network access requirements. Audits of subcontractors should include review of evidence of implementation.	**Health Share did not sufficiently address the recommendation.** Health Share and its subcontractors' policies and procedures, member- and provider-facing materials, and other monitoring documentation remained out of compliance and did not appropriately address the network availability requirements, including appointment availability time frames, evidence of monitoring network provider's compliance with state-established standards and corrective action when appropriate, out-of-network service availability requirements, family planning services requirements, and women specialist requirements. Health Share should ensure its subcontractors and its own policies and procedures, member- and provider-facing materials, and other monitoring documentation

CY 2022 Recommendation	CY 2023 Assessment
	appropriately address the network availability requirements.
Standard II—Assurances of Adequate Capacity and Services	
This recommendation was initially given during the CY 2021 EQR. Health Share should develop a documented process for monitoring provider capacity that includes monitoring specialty providers individually by specialty type and ensure its network evaluation incorporates key data collected from its monitoring processes.	**Health Share did not sufficiently address the recommendation.** Health Share and its subcontractors' policies and procedures, member- and provider-facing materials, and other monitoring documentation remained out of compliance and did not appropriately address the network availability requirements, including appointment availability time frames, evidence of monitoring network provider's compliance with state-established standards and corrective action when appropriate, out-of-network service availability requirements, family planning services requirements, and women specialist requirements. Health Share should ensure its subcontractors and its own policies and procedures, member- and provider-facing materials, and other monitoring documentation appropriately address the network availability requirements.
Standard III—Coordination and Continuity of Care	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard IV—Coverage and Authorization of Services	
This recommendation was initially given during the CY 2020 EQR. Health Share should revise its policies to specify the procedures and time frames for processing PAs. The CCO should also ensure oversight and monitoring of its subcontractors to ensure the subcontractor's policies align with the State and federal requirements.	**Health Share did not sufficiently address the recommendation.** Health Share did not demonstrate oversight of its subcontractors and whether the subcontractors met the requirements. Health Share's subcontractors did not follow the appropriate policies and procedures to consult with the requesting provider for medical services when appropriate. Additionally, the CCO and its subcontractors lacked policies and procedures that included the time frames for processing PAs. Health Share should ensure oversight and monitoring of its subcontractors to ensure the subcontractor's policies and processes align with the State and federal requirements. The CCO should also ensure that its policies specify the procedures and time frames for processing PAs and that its subcontractors consult with the

CY 2022 Recommendation	CY 2023 Assessment
	requesting provider for medical services when appropriate.
Standard V—Provider Selection	
This recommendation was initially given during the CY 2021 EQR. Health Share should implement an effective credentialing program that includes oversight of subcontractors' compliance with State credentialing requirements. In addition, Health Share should ensure subcontractor completion of state-required training for subcontractor staff members and network providers.	**Health Share did not sufficiently address the recommendation.** Health Share's credentialing program did not address State credentialing requirements, specifically, credentialing requirements for THWs. Additionally, Health Share did not demonstrate providing the state-required training for subcontractor staff members and network providers. Health Share should ensure that its credentialing program meets minimum State requirements. The CCO should also demonstrate completing the appropriate training for subcontractor staff members and network providers.
Standard VI—Subcontractual Relationships and Delegation	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard VII—Member Rights and Protections	
This recommendation was initially given during the CY 2020 EQR. Health Share should address limitations on implementing advance directives as a matter of conscience and ensure its subcontractors' policies comply with regulatory requirements.	**Health Share did not sufficiently address the recommendation.** Health Share did not demonstrate addressing limitations on implementing advance directives as a matter of conscience. The CCO's policies and procedures did not describe the range of medical conditions or procedures affected by the conscientious objection, clarify whether the limitations were institution wide or those raised by individual physicians, identify the State legal authority permitting the specific limitations or provide an affirmative statement that the CCO does not impose any limitations on the implementation of members' advance directives. Health Share should ensure its policies and procedures and other member- and provider-facing materials align with federal and State requirements for advance directives.
Standard VIII—Confidentiality	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.

CY 2022 Recommendation	CY 2023 Assessment
Standard IX—Enrollment and Disenrollment	
Health Share should revise its policies and procedures, member-facing documents, and training provided to staff to align with federal and State requirements. Health Share should also demonstrate oversight and monitoring of disenrollment reasons to ensure compliance with the regulatory requirements.	**Health Share did not sufficiently address the recommendation.** Health Share's policies and procedures did not fully address the federal and State requirements for disenrollment, including, CCO-initiated and member-initiated disenrollment requirements. Health Share should ensure its policies and procedures fully address the federal and State requirements for the disenrollment of members.
Standard X—Grievance and Appeal Systems	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard XI—Practice Guidelines	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard XII—Quality Assessment and Performance Improvement	
Health Share should revise its QAPI program structure to align with federal and State requirements for a QAPI program. Health Share should also demonstrate implementation and appropriate oversight of its QAPI program.	**Health Share did not sufficiently address the recommendation.** Health Share's QAPI program did not fully meet federal and State requirements for a QAPI program. The CCO did not demonstrate specific measures to monitor its LTSS population or a written evaluation of its QAPI program that met the State's minimum requirements. The CCO also did not demonstrate a QI program that met State requirements, including maintaining oversight and accountability of any delegated functions or quality efforts and activities performed by other CCO committees and reviewing results, progress, and effectiveness of corrective actions recommended at previous meetings. Health Share should revise its QAPI program structure to align with federal and State requirements for a QAPI program. Health Share should also demonstrate implementation and appropriate oversight of its QAPI program.
Standard XIII—Health Information Systems, including ISCA	
Health Share should amend its policies, procedures, and information systems to capture all required data elements and make them available for reporting to align with CCO contract	**Health Share did not sufficiently address the recommendation.** Health Share did not develop or implement processes to monitor its BH providers' compliance with MOTS reporting

CY 2022 Recommendation	CY 2023 Assessment
requirements. The CCO should also update its policies and procedures to include oversight processes for monitoring MOTS data submissions from its BH providers. Health Share should ensure that its staff are trained in, knowledgeable of, and implement those defined processes, including the documentation of all oversight activities and follow-up actions taken when issues are identified.	requirements. Health Share should develop or implement processes to monitor its BH providers' compliance with MOTS reporting requirements.
Standard XIV—Member Information	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Performance Improvement Projects	
Statewide Mental Health Service Access Monitoring PIP	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Statewide Substance Use Disorder PIP	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Performance Measure Validation	
This recommendation was initially given during the CY 2021 EQR. Health Share should continue to monitor key performance measure rates in alignment with its QAPI goals and objectives. For all key measures that fall below established performance or improvement thresholds, Health Share should conduct root cause analyses to identify specific factors affecting performance. Once identified, targeted interventions should be developed, implemented, and evaluated to ensure effective improvement strategies are adopted to increase performance over time. Additionally, Health Share should continue to monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches to ensuring the quality, timeliness, and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	**Health Share sufficiently addressed the recommendation.** Health Share reported that it defined objectives, projects, goals, activities, and staff leadership for 11 QAPI components. Health Share also reported that it continues to monitor its provider network to identify gaps in access to care and works with clinical partners to identify alternative approaches. Lastly, Health Share reported that it developed a quality committee to oversee performance on measures connected to QAPI goals and identify improvement interventions when performance on a measure falls below thresholds.

CY 2022 Recommendation	CY 2023 Assessment
Validation of Network Adequacy	
This recommendation was initially given during the CY 2021 EQR. Health Share should ensure that it reports DSN Provider Capacity Reporting data values for all required data fields and seek technical assistance from OHA as needed.	**Health Share sufficiently addressed the recommendation.** Results from OHA's Q1 2023 DSN Provider Capacity Report demonstrated sufficient improvements in the completeness of data fields critical to monitoring primary care.
Encounter Data Validation	
This recommendation was initially given during the CY 2021 EQR. Health Share should address the recommendation to implement standardized data extraction procedures to reduce the number of errors associated with data extraction.	**Health Share did not sufficiently address the recommendation.** Health Share's response indicated that the CCO has worked with partners to obtain encounter data directly, implemented an automated process for data validation, and successfully tested the process across various submission types. HSAG noted that while these initiatives demonstrate efforts to enhance data extraction procedures, there was no explicit mention of standardized data extraction procedures being implemented. Health Share's response also identified potential barriers related to coordination and acknowledged the need for more focused encounter data studies in the future. Health Share's strategy for continued improvement included ongoing review and enhancement of the automated process, as well as the development of a QA dashboard. Overall, HSAG's recommendation to implement standardized data extraction procedures appears to have only been partially addressed.
Health Share should investigate the root cause for the omissions and consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews would then be provided to providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.	**Health Share did not sufficiently address the recommendation.** Health Share's response mentioned initiatives implemented to use encounter files for quality checks, including encounter validation and reporting. Health Share noted that encounter reconciliation is conducted weekly. However, Health Share's response did not mention an investigation into the root cause of omissions or the implementation of periodic MRRs to verify coding and data completeness, as recommended. Additionally, Health Share's response noted that MRRs and sharing findings with providers are held by Health Share of Oregon plan partners, without providing specific details on the education and training efforts regarding

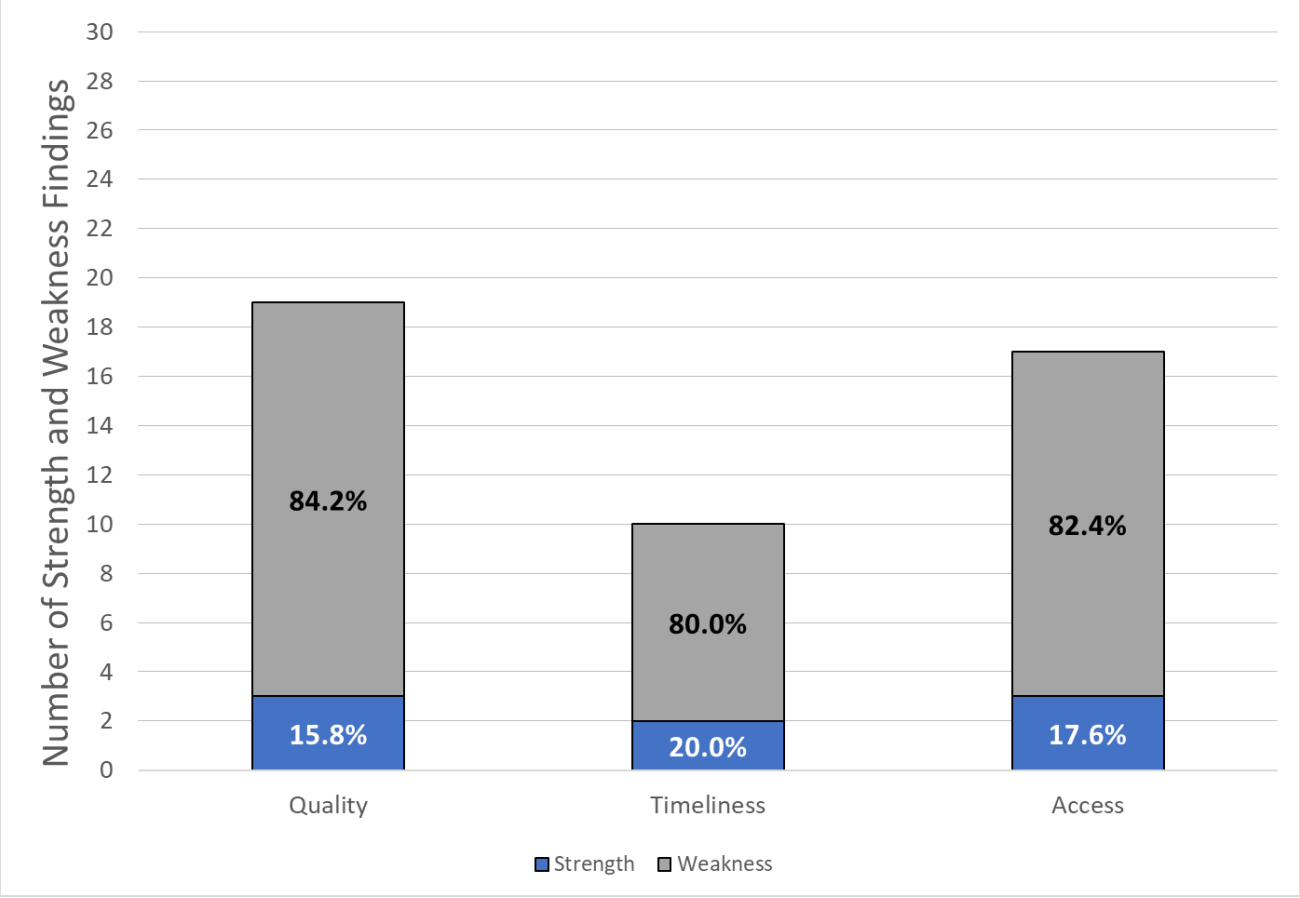
CY 2022 Recommendation	CY 2023 Assessment
	encounter data submissions, medical record documentation, and coding practices. Based on the information provided, it appears that Health Share did not fully address the recommendation, as there is limited information on the root cause investigation and periodic MRRs, as well as the education and training components.
Mental Health Parity Evaluation	
Health Share met performance expectations. No significant strengths or weaknesses were noted during the review.	Not applicable.

InterCommunity Health Network

Results and Conclusions

HSAG assessed the strengths and weaknesses of each CCO with respect to the quality, timeliness, and accessibility of health care services. Figure 5-13 illustrates the number of strengths exhibited by IHN relative to the number of weaknesses identified during the CY 2023 EQR activities across the three domains. The greater the proportion of weaknesses, the greater opportunities for improvement.

Figure 5-13—IHN Overall Number of Findings (Strengths and Weaknesses) by Domain



Detailed results from the EQR's substantive findings are summarized in Table 5-13 for each activity. This table highlights the extent to which IHN furnishes high quality, timely, and appropriate access to health care services, and recommendations for how IHN can best address issues identified for each activity.[5-13]

[5-13] See Section 4—Comparative Statewide Results for detailed, CCO-specific scores associated with EQR activity.

Table 5-13—IHN Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)[5-14]
Compliance Monitoring Review		
−	**Weakness:** IHN received a score of 88.9 percent in Standard III—Coordination and Continuity of Care due to failure to appropriately screen members for care coordination services and ensure health records are maintained in accordance with professional standards. **Why the weakness exists:** IHN failed to demonstrate the implementation of health risk screenings according to State requirements. IHN also failed to implement mechanisms to ensure the appropriate maintenance of medical records in accordance with professional standards. **Recommendations:** IHN must demonstrate implementation of appropriate initial health risk screenings according to federal and State requirements. IHN must also implement mechanisms to ensure the appropriate maintenance of medical records in accordance with professional standards.	
−	**Weakness:** IHN received a score of 61.1 percent in Standard IV—Coverage and Authorization of Services due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting IHN's ability to adhere to federal and State requirements for authorizing services and to ensure proper and timely notification of adverse benefit determinations. **Why the weakness exists:** IHN's policies and procedures did not align with federal and State requirements. Additionally, IHN demonstrated reversing service authorization decisions outside the appeal process. IHN also failed to adhere to requirements for appropriate decision-makers, monitoring for consistency of application of review criteria, proper outreach to obtain information needed to process authorization requests, readability, required content, and administering authorization decisions. **Recommendations:** IHN must revise its policies and procedures to align with federal and State requirements. IHN must demonstrate adherence to federal and State requirements for authorization of services and required content for notification of adverse benefit determinations.	
−	**Weakness:** IHN received a score of 70.0 percent in Standard VII—Member Rights and Protections due to a lack of operational structure and failure to demonstrate implementation of an established process, impacting IHN's ability to ensure that member rights are respected and	

[5-14] = Quality, = Timeliness, = Access

Strength/ Weakness	Description	Domain(s)[5-14]
	allowed to be exercised freely without affecting the treatment of members. **Why the weakness exists:** IHN's policies and procedures and provider-facing materials did not align with federal and State requirements. **Recommendations:** IHN must revise its policies and procedures and provider-facing materials to align with federal and State requirements.	
−	**Weakness:** IHN received a score of 85.2 percent in Standard X—Grievance and Appeal Systems due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting IHN's ability to ensure member grievances and appeals are addressed and responded to appropriately. **Why the weakness exists:** IHN's policies and procedures did not align with federal and State requirements. Additionally, IHN failed to adhere to requirements for time frames for acknowledging and responding to grievances and/or appeals and readability of notices. IHN also failed to communicate grievance and/or appeal requirements to providers and subcontractors. **Recommendations:** IHN must revise its policies and procedures to align with federal and State requirements. IHN must demonstrate adherence to federal and State requirements for time frames for acknowledging and responding to grievances and appeals and readability of notices. IHN must also demonstrate implementation of federal and State requirements within communications to providers and subcontractors.	
−	**Weakness:** IHN received a score of 86.4 percent in Standard XIV—Member Information due to a lack of operational structure and failure to demonstrate implementation of an established process, impacting IHN's ability to ensure proper member communication. **Why the weakness exists:** IHN's member-facing materials (i.e., member notices, medication formulary, and provider directory) did not align with federal and State requirements. **Recommendations:** IHN must ensure that all member-facing materials align with federal and State requirements.	
−	**Weakness:** IHN received a score of 66.7 percent in Standard XVI—Emergency and Poststabilization Services due to failure to demonstrate implementation of appropriate processes and workflows, impacting IHN's ability to ensure emergency and poststabilization services are covered appropriately. **Why the weakness exists:** IHN failed to demonstrate evidence of processes to ensure payment of emergency and poststabilization services.	

Strength/ Weakness	Description	Domain(s)[5-14]
	Recommendations: IHN must demonstrate evidence of processes to ensure payment of emergency and poststabilization services.	
Performance Improvement Projects		
Statewide Mental Health Service Access Monitoring PIP		
−	**Weakness:** IHN's narrative interpretation of indicator results included inaccuracies. **Why the weakness exists:** IHN did not align with the corrected baseline indicator in the narrative interpretation of results and report the correct decrease from baseline to RY 1. **Recommendations:** IHN should ensure that all performance indicator data and interpretation of results are accurately and consistently reported throughout the PIP documentation.	
−	**Weakness:** IHN's reported indicator results did not demonstrate any improvement over baseline performance. **Why the weakness exists:** The indicator results demonstrated a decline in performance from baseline to RY 1. **Recommendations:** IHN should revisit root cause analyses identifying barriers to improving access to MH services to determine which barriers to improvement were not effectively addressed. IHN should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to improve indicator results.	
Statewide Substance Use Disorder PIP		
+	**Strength:** IHN successfully initiated the Implementation stage for the PIP, receiving a *Met* score for 100 percent of applicable evaluation elements in the PIP validation tool. In the Implementation stage, IHN accurately reported baseline performance indicator data; identified and analyzed barriers for initiation, engagement, and treatment of alcohol and other drug use disorders; and began to carry out interventions to address those barriers.	
Performance Measure Validation		
+	**Strength:** IHN's performance on the *Members Receiving Preventive Dental or Oral Health Services—Ages 1 to 5 Years* and *Ages 6 to 14 Years* measure indicators demonstrated ongoing improvement for members in both age groups since MY 2020. In addition, IHN's MY 2022 rate for the *Ages 1 to 5 Years* measure indicator exceeded the 2020 CCO 75th percentile benchmark set by OHA for MY 2022 by 5 percentage points or more.	
−	**Weakness:** IHN's MY 2022 rate on the *Initiation of SUD Treatment* measure indicator for members ages 18 years and older fell below the	

Strength/ Weakness	Description	Domain(s)[5-14]
	2020 HEDIS national Medicaid median benchmark set by OHA for MY 2022. **Why the weakness exists:** IHN's MY 2022 performance on this measure indicator was not at the level of CCOs statewide (i.e., IHN's rate was below the statewide aggregate rate) and did not meet the performance threshold set by OHA. **Recommendations:** IHN should conduct root cause analyses to identify specific factors affecting performance on this measure and develop, implement, and evaluate targeted interventions to ensure improvement strategies are adopted. Additionally, IHN should monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches for ensuring the timeliness and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	
Validation of Network Adequacy		
Delivery System Network Evaluation		
−	**Weakness:** IHN scored below 90 percent and below the CCO aggregate score overall and in three domains of the DSN Provider Narrative. **Why the weakness exists:** IHN failed to demonstrate compliance with state-established specialty provider taxonomy data and reporting requirements. IHN did not sufficiently describe or demonstrate how it uses collected information on member needs and populations or provider networks to inform network adequacy monitoring and decision-making. IHN did not resolve all findings from the CY 2022 DSN Evaluation. **Recommendations:** IHN should ensure that all future reporting utilizes the state-established specialty provider taxonomies current to the review period, and should demonstrate how it collects and uses member and DSN data to inform network adequacy monitoring and decision-making. IHN should ensure that all network adequacy interventions include plans for assessing their efficacy. IHN should address all findings from prior DSN Evaluations.	
−	**Weakness:** IHN showed potential data and/or access issues within its provider and facility data, including active status, service area, and status of accepting new patients. **Why the weakness exists:** IHN reported moderate rates of providers active within its network, moderate to low rates of providers and facilities operating within its service area, and very high rates (i.e., at or close to 100 percent) of providers accepting new patients.	

Strength/ Weakness	Description	Domain(s)[5-14]
	Recommendations: IHN should seek technical assistance with OHA to determine the nature of the provider capacity data issues and correct them.	
Secret Shopper Survey		
–	**Weakness:** The total secret shopper survey response rate was 58.9 percent across all PCP and PCD cases. Of the total responsive cases, 77.3 percent of the offices confirmed the location, 29.1 percent offered the requested services, 23.3 percent accepted OHP, 18.6 percent accepted IHN, and 14.0 percent accepted new patients. **Why the weakness exists:** In addition to limitations related to the secret shopper approach, the accuracy of IHN's provider data may have contributed to the low response rate and accuracy results. **Recommendations:** HSAG recommends that IHN use the case-level analytic data files to address the data deficiencies identified during the secret shopper survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
–	**Weakness:** Of the total secret shopper survey responsive cases, only 7.6 percent resulted in an appointment. Of the cases that offered an appointment, 61.5 percent were within the wait time compliance standard. **Why the weakness exists:** In addition to limitations related to the secret shopper approach, the accuracy of IHN's provider data may have contributed to the low appointment availability rate. Additionally, internal office procedures may have contributed to the long wait times. **Recommendations:** HSAG recommends that IHN confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. IHN should use the case-level analytic data files containing data deficiencies identified during the secret shopper survey calls.	
Revealed Telephone Survey		
–	**Weakness:** Overall, 29.6 percent of the revealed telephone survey total sampled cases were reached, of which none refused to participate in the survey. Of the total responsive cases, 79.7 percent of the offices confirmed the location, 66.7 percent offered the requested specialty, 59.4 percent accepted OHP, 53.6 percent accepted IHN, and 50.7 percent accepted new patients. **Why the weakness exists:** In addition to limitations related to the revealed telephone approach, the accuracy of IHN's provider data may have contributed to the low response rate and accuracy results.	

Strength/ Weakness	Description	Domain(s)[5-14]
	Recommendations: HSAG recommends that IHN use the case-level analytic data files to address the data deficiencies identified during the revealed telephone survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
−	**Weakness:** Of the sampled cases, only 9.0 percent of the revealed telephone survey respondents offered a new patient appointment, while only 14.2 percent of survey respondents offered an appointment for an existing patient. Of the total cases that offered an appointment, 80.9 percent of routine appointments and 69.8 percent of urgent appointments were within the wait time compliance standard. **Why the weakness exists:** In addition to limitations related to the revealed telephone approach, the accuracy of IHN's provider data may have contributed to the low appointment availability rate. Additionally, internal office staffing structures and procedures may have contributed to the long wait times. **Recommendations:** HSAG recommends that IHN confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. IHN should use the case-level analytic data files containing data deficiencies identified during the revealed telephone survey calls and work with BH outpatient offices to identify the root cause for delays in appointment availability.	
Encounter Data Validation		
+	**Strength:** Encounters that could be matched between data extracted from OHA's data warehouse and data extracted from IHN's or the subcontractor's data system exhibited a high level of element completeness (i.e., low element omission and surplus rates) for nearly all evaluated key data elements.	
+	**Strength:** Among records that could be matched between the two data sources, a high level of element accuracy (i.e., data elements from both sources had the same values when populated) was exhibited across all evaluated key data elements.	
−	**Weakness:** There were a high number and percentage of records present in the files submitted by OHA but not found in the files submitted by IHN's subcontractor(s) (i.e., record surplus). **Why the weakness exists:** Based on the data discrepancy report response from IHN, the surplus records were primarily associated with its subcontractors, Capitol Dental and WDG. Issues in Capitol Dental's data were attributed to a naming convention change during 2022. A high number of WDG records were excluded from analysis due to missing the required variable, *Adjudication Date*.	

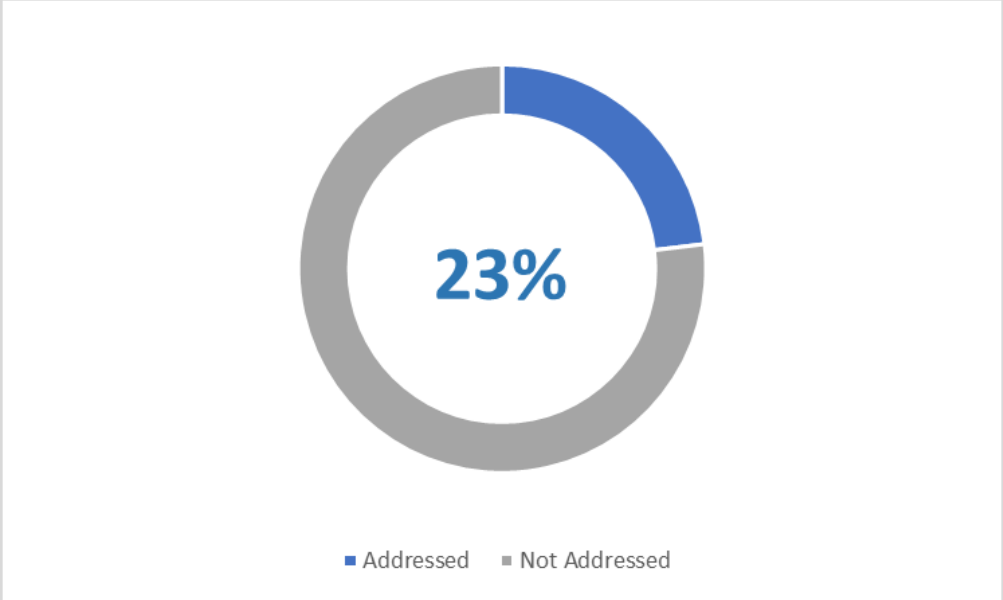
Strength/ Weakness	Description	Domain(s)[5-14]
	Recommendations: HSAG recommends that IHN proactively inform HSAG about special scenarios like the one observed with WDG, where the *Adjudication Date* was not populated due to WDG's capitated nature, that it does not receive, process, or adjudicate claims.	
−	**Weakness:** The all-element accuracy rate was low, indicating about 13 percent of records that are in both data sources do not have the same values (either missing or non-missing) for all key data elements. This issue is directly related to the high element surplus rate for *Tooth Number*, which is identified as another weakness. **Why the weakness exists:** The *Tooth Number* information that was captured in OHA's data, but not in IHN's data, suggests a potential loss in information after encounter submission to OHA. **Recommendations:** Since all *Tooth Number* surplus records were associated with Advantage Dental, HSAG recommends IHN to collaborate with Advantage Dental to actively address and resolve the issue. This may involve refining data entry processes, enhancing validation protocols, and conducting regular audits to ensure accurate and complete data for *Tooth Number* information.	
Mental Health Parity Evaluation		
+	**Strength:** IHN achieved full compliance with parity requirements for NQTLs applied to MH/SUD and M/S benefits.	

Follow-Up on Prior Year Recommendations

HSAG evaluated IHN's approach to addressing the recommendations and/or findings issued during CY 2022 and unresolved findings from CY 2020 and CY 2021 while conducting the CY 2023 EQR activities. The CCOs not addressing findings and recommendations are at risk of being out of compliance with their contracts.

Figure 5-14 illustrates the degree in which the CCO sufficiently addressed the recommendations for QI made by HSAG during the CY 2022 EQR.

Figure 5-14—Percentage of CY 2022 EQR Recommendations Addressed by IHN



IHN-specific CY 2022 recommendations and follow-up CY 2023 assessments are summarized in Table 5-14.

Table 5-14—Assessment of IHN's Approach to Addressing Previous Annual Recommendations

CY 2022 Recommendation	CY 2023 Assessment
Compliance Monitoring Review	
Standard I—Availability of Services	
This recommendation was initially given during the CY 2021 EQR. IHN should update its policies as well as its member and provider communications to include access standards and essential information on scheduling standards and out-of-network services.	**IHN sufficiently addressed the recommendation.** Documentation reviewed during the CY 2023 CMR activity demonstrated compliance with the standard.
Standard II—Assurances of Adequate Capacity and Services	
This recommendation was initially given during the CY 2021 EQR. IHN should develop an effective network monitoring process that encompasses all elements of the standards and contract requirements. In addition, the CCO should monitor the provider network to ensure the geographic location and distribution of providers are adequate for the population enrolled or expected to be enrolled in the service area.	**IHN sufficiently addressed the recommendation.** Documentation reviewed during the CY 2023 CMR activity demonstrated compliance with the standard.

CY 2022 Recommendation	CY 2023 Assessment
Standard III—Coordination and Continuity of Care	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard IV—Coverage and Authorization of Services	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard V—Provider Selection	
This recommendation was initially given during the CY 2021 EQR. IHN should conduct training of its staff members and document oversight of subcontractor training on delivery of covered services and applicable administrative rules.	**IHN did not sufficiently address the recommendation.** IHN did not demonstrate providing the required training to its staff and participating providers. IHN should ensure it has a system to provide the required training to its staff and that participating providers provide clear direction to their subcontractors regarding their delegated responsibilities (i.e., frequency of training, training content, and required participants—dental subcontractor staff and/or dental providers). In addition, participating providers should demonstrate oversight of subcontractors to ensure the training provided on behalf of the CCO is conducted in regulatory alignment.
Standard VI—Subcontractual Relationships and Delegation	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard VII—Member Rights and Protections	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard VIII—Confidentiality	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard IX—Enrollment and Disenrollment	
IHN should revise its policies and procedures and member-facing documents to align with federal and State requirements. IHN should also demonstrate oversight and monitoring of disenrollment reasons to ensure compliance with the regulatory requirements.	**IHN did not sufficiently address the recommendation.** Although IHN revised its policies and procedures and demonstrated monitoring of disenrollment reasons to ensure compliance with requirements, the CCO's member-facing documents and website included statements and documentation that did not align with the enrollment nondiscrimination

CY 2022 Recommendation	CY 2023 Assessment
	requirements. IHN should ensure all documentation communicates the appropriate enrollment nondiscrimination requirements.
Standard X—Grievance and Appeal Systems	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard XI—Practice Guidelines	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard XII—Quality Assessment and Performance Improvement	
IHN should demonstrate appropriate oversight of its QAPI program.	**IHN did not sufficiently address the recommendation.** IHN did not demonstrate a QI committee that met State requirements, including the review of the effectiveness of corrective actions recommended at previous meetings. IHN should demonstrate appropriate oversight of its QAPI program, including implementing a QI committee that meets State requirements.
Standard XIII—Health Information Systems, including ISCA	
IHN should amend, or develop, policies and procedures that describe the collection and reporting of required data, as well as oversight processes for monitoring data submissions from its BH providers. IHN should ensure its staff are trained in, knowledgeable of, and implement those defined processes, including the documentation of all oversight activities and follow-up actions taken when issues are identified.	**IHN did not sufficiently address the recommendation.** IHN reported that it does not currently have mechanisms to monitor BH provider compliance with MOTS reporting requirements. IHN should amend or develop policies and procedures that describe the collection and reporting of required data, as well as oversight processes for monitoring data submissions from its BH providers. IHN should ensure its staff are trained in, knowledgeable of, and implement those defined processes, including the documentation of all oversight activities and follow-up actions taken when issues are identified.
Standard XIV—Member Information	
This recommendation was initially given during the CY 2020 EQR. This element has remained out of compliance since the CY 2020 CMR activity. IHN did not include all required elements in its provider directory, including website uniform resource locators (URLs), office accommodations for people with physical	**IHN did not sufficiently address the recommendation.** IHN's provider directory did not include all of the State and federal requirements for the information listed for each provider. IHN should ensure the provider directory includes the State and federal

CY 2022 Recommendation	CY 2023 Assessment
disabilities, or cultural and linguistic capabilities. IHN should ensure the provider directory includes the State and federal requirements for information listed for each provider.	requirements for the information listed for each provider.
Performance Improvement Projects	
Statewide Mental Health Service Access Monitoring PIP	
IHN should review the final baseline indicator data file distributed by OHA and seek technical assistance, if needed. The CCO should correct the baseline indicator data prior to next year's annual PIP validation.	**IHN sufficiently addressed the recommendation.** IHN correctly reported the baseline and RY 1 indicator data in this year's PIP submission.
Statewide Substance Use Disorder PIP	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Performance Measure Validation	
IHN should continue implementing creative approaches and incentives to support alcohol and other drug treatment clinics. Additionally, IHN should continue to monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches to ensuring the quality, timeliness, and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	**IHN did not provide a response or supporting documentation to address the recommendation.**
Validation of Network Adequacy	
This recommendation was initially given during the CY 2020 EQR. IHN should ensure that it reports DSN Provider Capacity Reporting data values for all required data fields and seek technical assistance from OHA as needed.	**IHN did sufficiently address the recommendation.** OHA's Q1 2023 DSN Provider Capacity Report did not show sufficient improvement in the quality of the *Credentialing Date* data field.
This recommendation was initially given during the CY 2021 EQR. IHN stated that it is working on interventions to improve provider data management as it relates to the provider directory; however, specific planned interventions were not provided.	**IHN did not provide a response or supporting documentation to address the recommendation.**
Encounter Data Validation	
IHN should investigate and follow up with its providers to determine why encounters were submitted to OHA; however, no medical	**IHN did not provide a response or supporting documentation to address the recommendation.**

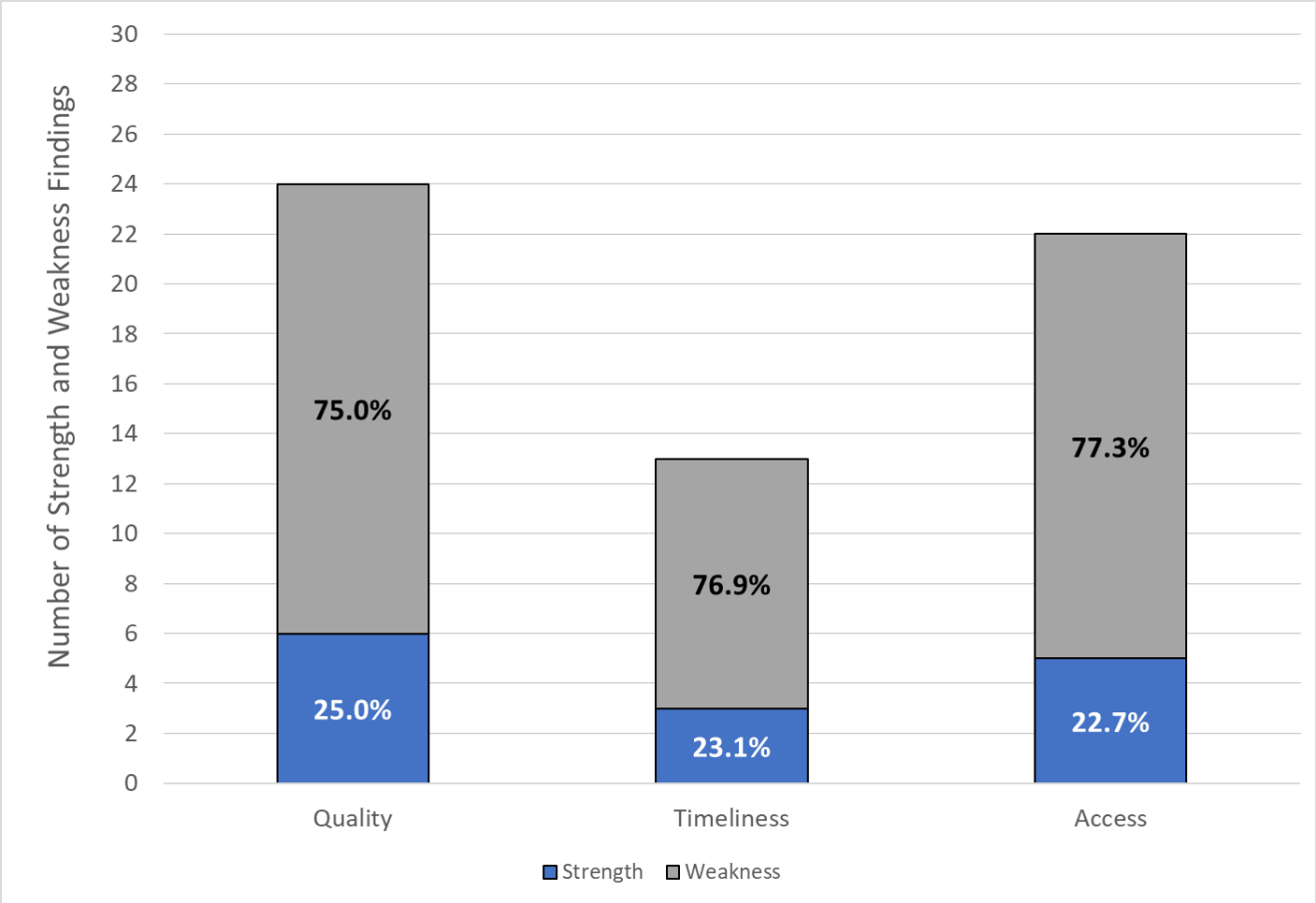
CY 2022 Recommendation	CY 2023 Assessment
records/documentation were available for the requested dates of service.	
IHN should investigate the root cause for the omissions and consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews would then be provided to providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.	**IHN did not provide a response or supporting documentation to address the recommendation.**
Mental Health Parity Evaluation	
IHN met performance expectations. No significant strengths or weaknesses were noted during the review.	Not applicable.

Jackson Care Connect

Results and Conclusions

HSAG assessed the strengths and weaknesses of each CCO with respect to the quality, timeliness, and accessibility of health care services. Figure 5-15 illustrates the number of strengths exhibited by JCC relative to the number of weaknesses identified during the CY 2023 EQR activities across the three domains. The greater the proportion of weaknesses, the greater opportunities for improvement.

Figure 5-15—JCC Overall Number of Findings (Strengths and Weaknesses) by Domain



Detailed results from the EQR's substantive findings are summarized in Table 5-15 for each activity. This table highlights the extent to which JCC furnishes high quality, timely, and appropriate access to health care services, and recommendations for how JCC can best address issues identified for each activity.[5-15]

[5-15] See Section 4—Comparative Statewide Results for detailed, CCO-specific scores associated with EQR activity.

Table 5-15—JCC Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)[5-16]
Compliance Monitoring Review		
−	**Weakness:** JCC received a score of 88.9 percent in Standard III—Coordination and Continuity of Care due to a lack of operational structure. **Why the weakness exists:** JCC's policies and procedures did not align with federal and State requirements. **Recommendations:** JCC must revise its policies and procedures to align with federal and State requirements.	
−	**Weakness:** JCC received a score of 69.4 percent in Standard IV—Coverage and Authorization of Services due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting JCC's ability to adhere to federal and State requirements for authorizing services and to ensure proper and timely notification of adverse benefit determinations. **Why the weakness exists:** JCC's policies and procedures did not align with federal and State requirements. Additionally, JCC demonstrated reversing service authorization decisions outside the appeal process. JCC also failed to demonstrate mechanisms for ensuring its UM activities are not structured to incentivize the individual to deny, limit, or discontinue medically necessary services, and consistent application of medical necessity criteria. Finally, JCC failed to adhere to requirements for appropriate decision-makers, and provision and required content of NOABDs. **Recommendations:** JCC must revise its policies and procedures to align with federal and State requirements. JCC must demonstrate adherence to federal and State requirements for authorization of services, and required content and time frames for notification of adverse benefit determinations.	
−	**Weakness:** JCC received a score of 50.0 percent in Standard VII—Member Rights and Protections due to a lack of operational structure and failure to demonstrate implementation of an established process, impacting JCC's ability to ensure that member rights are respected and allowed to be exercised freely without affecting the treatment of members, advance directive requirements are met, and members are notified of their rights as required by federal and State requirements.	

[5-16] = Quality, = Timeliness, = Access

Strength/ Weakness	Description	Domain(s)[5-16]
	Why the weakness exists: JCC's policies and procedures and member- and provider-facing materials did not align with federal and State requirements. **Recommendations:** JCC must revise its policies and procedures and member- and provider-facing materials to align with federal and State requirements.	
−	**Weakness:** JCC received a score of 87.0 percent in Standard X—Grievance and Appeal Systems due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting JCC's ability to ensure member grievances and appeals are addressed and responded to appropriately. **Why the weakness exists:** JCC's policies and procedures did not align with federal and State requirements. Additionally, JCC failed to adhere to requirements for time frames for acknowledging and responding to grievances and/or appeals, and readability and required content of notices. JCC also failed to communicate grievance and/or appeal requirements to members, providers, and subcontractors. JCC also failed to demonstrate maintaining one level of appeal. **Recommendations:** JCC must revise its policies and procedures to align with federal and State requirements. Additionally, JCC must demonstrate adherence to federal and State requirements for time frames for acknowledging and responding to grievances and appeals; readability and required content of notices; and implementation of federal and State requirements within communications to members, providers, and subcontractors. JCC must also demonstrate maintaining one level of appeal.	
−	**Weakness:** The CCO received a score of 68.2 percent in Standard XIV—Member Information due to a lack of operational structure and failure to demonstrate implementation of an established process, impacting JCC's ability to ensure timely and proper member communication. **Why the weakness exists:** JCC's policies and procedures and member-facing materials, including the member handbook, member notices, medication formulary, CCO website, and provider directory, did not align with federal and State requirements. Additionally, JCC failed to track and monitor the timely provision of required member information. **Recommendations:** JCC must revise its policies, procedures, and member-facing materials to align with federal and State requirements. Additionally, JCC must track and monitor the timely provision of required member information.	
−	**Weakness:** JCC received a score of 83.3 percent in Standard XVI—Emergency and Poststabilization Services due to a lack of operational structure to ensure poststabilization services are covered appropriately.	

Strength/ Weakness	Description	Domain(s)[5-16]
	Why the weakness exists: JCC failed to demonstrate plan documents, such as policies and procedures, and the provider manual did not appropriately define "poststabilization services" and communicate the appropriate requirements. **Recommendations:** JCC must revise the applicable plan documents to define "poststabilization services" and communicate the appropriate requirements.	
Performance Improvement Projects		
Statewide Mental Health Service Access Monitoring PIP		
–	**Weakness:** JCC did not address factors that threatened the validity of the data reported and compare the initial measurement with the remeasurement. **Why the weakness exists:** JCC did not discuss whether any factors were identified that threatened the validity of the RY 1 results or the comparability of the RY 1 results to the baseline results. **Recommendations:** JCC should revise the narrative interpretation to address the documentation requirement.	
–	**Weakness:** JCC's reported indicator results did not demonstrate any improvement over baseline performance. **Why the weakness exists:** The indicator results demonstrated a decline in performance from baseline to RY 1. **Recommendations:** JCC should revisit root cause analyses identifying barriers to improving access to MH services to determine which barriers to improvement were not effectively addressed. JCC should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to improve indicator results.	
–	**Weakness:** JCC's documentation did not demonstrate significant clinical or programmatic improvement in processes and outcomes. **Why the weakness exists:** JCC did not complete the Clinical and Programmatic Improvement Table; therefore, no evidence was provided to demonstrate significant clinical or programmatic improvement. **Recommendations:** JCC should complete the Clinical and Programmatic Improvement Table to demonstrate significant clinical or programmatic improvement in processes and outcomes.	
Statewide Substance Use Disorder PIP		
–	**Weakness:** JCC did not include accurate information in the data table in Step 7 and must update the baseline narrative section after obtaining the correct data.	

Strength/ Weakness	Description	Domain(s)[5-16]
	Why the weakness exists: JCC revised the baseline indicator results in the Step 7 Indicator Results table and narrative; however, the data differed from the OHA data file. **Recommendations:** JCC should correct the baseline indicator results in the Step 7 Indicator Results table and baseline narrative prior to submission for next year's validation in 2024.	
Performance Measure Validation		
⊕	**Strength:** JCC's MY 2022 performance on the *Members Receiving Preventive Dental or Oral Health Services—Ages 1 to 5 Years* and *Ages 6 to 14 Years* measure indicators improved by more than 5 percentage points compared to MY 2021; 6.1 percentage points for members ages 1 to 5 years and 6.5 percentage points for members ages 6 to 14 years. JCC's performance on this measure demonstrated ongoing improvement for members in both age groups since MY 2020. In addition, the CCO's MY 2022 rates in both age groups exceeded the 2020 CCO 75th percentile benchmark set by OHA for MY 2022 by 5 percentage points or more.	
⊕	**Strength:** JCC's performance on the *Oral Evaluation for Adults With Diabetes* measure demonstrated ongoing improvement since MY 2020.	
⊖	**Weakness:** JCC's MY 2022 performance on the *Child and Adolescent Well-Care Visits—Ages 3 to 6 Years* measure indicator declined by more than 5 percentage points compared to MY 2021 (-5.7 percentage points). In addition, JCC's MY 2022 rate for this measure fell below the statewide aggregate and the 2020 CCO 75th percentile benchmark set by OHA for MY 2022 by 5 percentage points or more. **Why the weakness exists:** Although JCC's eligible population for this measure increased from MY 2021 to MY 2022, fewer children ages 3 to 6 years had a comprehensive well-care visit with their PCP in MY 2022 compared to MY 2021. OHA's 2022 CCO Performance Metrics Annual Report showed statewide performance for the *Child and Adolescent Well-Care Visits—Ages 3 to 6 Years* measure indicator declined slightly (0.6 percent) from MY 2021. **Recommendations:** JCC should conduct root cause analyses to identify specific factors affecting performance on this measure and develop, implement, and evaluate targeted interventions to ensure improvement strategies are adopted. Additionally, JCC should monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches for ensuring the timeliness and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	
⊖	**Weakness:** JCC's MY 2022 rate on the *Initiation of SUD Treatment* measure indicator for members ages 18 years and older fell below the	

Strength/ Weakness	Description	Domain(s)[5-16]
	2020 HEDIS national Medicaid median benchmark set by OHA for MY 2022. **Why the weakness exists:** In response to EQR recommendations, JCC noted several barriers to implementing performance improvement initiatives, including staffing shortages in its provider network and systemic barriers limiting access to care. **Recommendations:** In 2022, JCC monitored data on performance measures and conducted weekly internal meetings and monthly meetings with network providers to identify and address factors impacting performance. JCC should continue implementing these efforts to raise its rate on this measure indicator to the level of the benchmarks set by OHA.	
Validation of Network Adequacy		
Delivery System Network Evaluation		
+	**Strength:** JCC maintained and utilized frequently updated data dashboards of service utilization across multiple settings, subdivided by member demographics and risk cohorts, and available across divisions.	
−	**Weakness:** JCC demonstrated a moderate level of compliance with network monitoring requirements. **Why the weakness exists:** JCC did not demonstrate compliance with state-established specialty provider taxonomy data and reporting requirements. Additionally, JCC was not able to demonstrate how it collects and uses data on provider-to-member ratios, wait time to appointment availability, hours of operation, use of telehealth modalities, availability of culturally and linguistically appropriate care, or availability of physical accessibility accommodations to inform network adequacy monitoring and decision-making. **Recommendations:** JCC should ensure that all future reporting utilizes the state-established specialty provider taxonomies current to the review period, and should demonstrate how it collects and uses DSN data to inform network adequacy monitoring and decision-making.	
−	**Weakness:** JCC showed potential issues within its provider data, including but not limited to service area activity and status of accepting new patients. This issue was also identified during the CY 2021 and CY 2022 DSN Evaluations and was not addressed by JCC. **Why the weakness exists:** The percentage of providers operating within the service area was approximately 10 percent or less for most providers including PCPs. With the exception of PCPs, less than 1 percent of all provider types were accepting new patients. **Recommendations:** JCC should seek technical assistance with OHA to determine the nature of the provider capacity data issues and correct them.	

Strength/ Weakness	Description	Domain(s)[5-16]
Secret Shopper Survey		
⊕	**Strength:** Of the total secret shopper survey responsive cases, 90.5 percent of PCD offices and 97.3 percent of PCP offices confirmed the location, and 93.3 percent offered the requested services.	
⊖	**Weakness:** The total secret shopper survey response rate was 89.3 percent across all PCP and PCD cases. Of the total responsive cases, 70.1 percent of the offices accepted OHP, 47.0 percent accepted JCC, and 37.3 percent accepted new patients. Although 95.6 percent of the PCP offices offered the requested services, the PCD rate was only 81.0 percent. **Why the weakness exists:** In addition to limitations related to the secret shopper approach, the accuracy of JCC's provider data may have contributed to the low accuracy results. **Recommendations:** HSAG recommends that JCC use the case-level analytic data files to address the data deficiencies identified during the secret shopper survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
⊖	**Weakness:** Of the secret shopper survey responsive cases, only 2.7 percent of the PCP cases and 0.0 percent of the PCD cases resulted in an appointment. **Why the weakness exists:** In addition to limitations related to the secret shopper approach, the accuracy of JCC's provider data may have contributed to the low appointment availability rate. **Recommendations:** HSAG recommends that JCC confirm appointment availability with providers, including panel capacity to accept new patients. JCC should use the case-level analytic data files containing data deficiencies identified during the secret shopper survey calls.	
Revealed Telephone Survey		
⊕	**Strength:** Of the revealed telephone survey respondents with verified locations that offered the requested services, and accepted OHP and JCC, 92.3 percent of the offices offered translation or interpreter services.	
⊖	**Weakness:** Overall, 59.2 percent of the revealed telephone survey total sampled cases were reached, of which seven, or 5.9 percent, refused to participate in the survey. Of the total responsive cases, 79.8 percent of the offices confirmed the location, 62.2 percent offered the requested specialty, 58.0 percent accepted OHP, 21.8 percent accepted JCC, and 21.0 percent accepted new patients.	

Strength/ Weakness	Description	Domain(s)[5-16]
	Why the weakness exists: In addition to limitations related to the revealed telephone approach, the accuracy of JCC's provider data may have contributed to the low response rate and accuracy results. **Recommendations:** HSAG recommends that JCC use the case-level analytic data files to address the data deficiencies identified during the revealed telephone survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
−	**Weakness:** Of the sampled cases, only 8.5 percent of the revealed telephone survey respondents offered a new patient appointment, while only 9.0 percent of survey respondents offered an appointment for an existing patient. Of the total cases that offered an appointment, 60.0 percent of routine appointments and 44.1 percent of urgent appointments were within the wait time compliance standard. **Why the weakness exists:** In addition to limitations related to the revealed telephone approach, the accuracy of JCC's provider data may have contributed to the low appointment availability rate. Additionally, internal office staffing structures and procedures may have contributed to the long wait times. **Recommendations:** HSAG recommends that JCC confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. JCC should use the case-level analytic data files containing data deficiencies identified during the revealed telephone survey calls and work with BH outpatient offices to identify the root cause for delays in appointment availability.	
Encounter Data Validation		
+	**Strength:** Among records that could be matched between the two data sources, a high level of element accuracy (i.e., data elements from both sources had the same values when populated) was exhibited across all evaluated key data elements.	
+	**Strength:** The JCC-submitted data had high all-element accuracy for all evaluated key data elements, indicating that the values (missing or non-missing) in both data sources (JCC and OHA) were the same for almost all records.	
−	**Weakness:** There were a moderately high number and percentage of records present in the files submitted by OHA but not found in the files submitted by JCC's subcontractor(s) (i.e., record surplus). **Why the weakness exists:** Based on the data discrepancy report response from JCC, the surplus records were associated with its subcontractor, WDG. A high number of WDG records were excluded from analysis due to missing the required variable, *Adjudication Date*.	

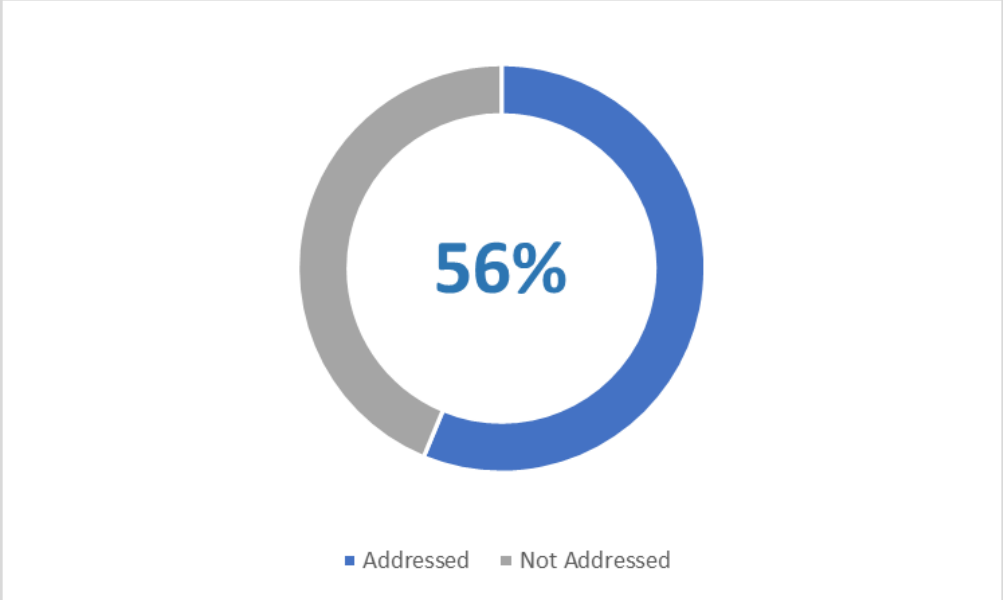
Strength/ Weakness	Description	Domain(s)[5-16]
	Recommendations: HSAG recommends that JCC proactively inform HSAG about special scenarios like the one observed with WDG, where the *Adjudication Date* was not populated due to WDG's capitated nature, that it does not receive, process, or adjudicate claims.	
	**Weakness:** The *Rendering Provider NPI* showed that information was present in the OHA-submitted data but not in the JCC-submitted data. **Why the weakness exists:** More than 99.9 percent of the *Rendering Provider NPI* values in the OHA-submitted data, not found in the JCC-submitted data, had the same values as the *Billing Provider NPI*. This discrepancy is likely a result of the data processing approach in OHA's MMIS. In OHA's MMIS, if the *Rendering Provider NPI* value is not submitted, the system populates the value with the *Billing Provider NPI* value. Consequently, when comparing this data element across the two sources, the *Rendering Provider NPI* is present in the OHA-submitted data but not in the JCC-submitted data. **Recommendations:** While encounter submission to OHA did not require the inclusion of the *Rendering Provider NPI* value if it matched the *Billing Provider NPI* value, the data request for the EDV comparative analysis had different requirements. To address this, HSAG recommends that JCC and its subcontractor(s) ensure that values for both *Billing Provider NPI* and *Rendering Provider NPI* are included in the data submission, irrespective of their equivalence. This adjustment will enhance the accuracy and completeness of the comparative analysis data. Additionally, it will provide HSAG with the means to verify and ensure the accuracy of the MMIS' process of populating the *Rendering Provider NPI* with the *Billing Provider NPI*.	
Mental Health Parity Evaluation		
	**Strength:** JCC achieved full compliance with parity requirements for application of NQTLs applied to MH/SUD and M/S benefits.	

Follow-Up on Prior Year Recommendations

HSAG evaluated JCC's approach to addressing the recommendations and/or findings issued during CY 2022 and unresolved findings from CY 2020 and CY 2021 while conducting the CY 2023 EQR activities. The CCOs not addressing findings and recommendations are at risk of being out of compliance with their contracts.

Figure 5-16 illustrates the degree in which the CCO sufficiently addressed the recommendations for QI made by HSAG during the CY 2022 EQR.

Figure 5-16—Percentage of CY 2022 EQR Recommendations Addressed by JCC



JCC-specific CY 2022 recommendations and follow-up CY 2023 assessments are summarized in Table 5-16.

Table 5-16—Assessment of JCC's Approach to Addressing Previous Annual Recommendations

CY 2022 Recommendation	CY 2023 Assessment
Compliance Monitoring Review	
Standard I—Availability of Services	
This recommendation was initially given during the CY 2021 EQR. JCC should develop thorough documented processes that address all required elements of network evaluation. Policies as well as provider and member communications should be updated to reflect accurate information on network access.	**JCC did not sufficiently address the recommendation.** JCC's policies and procedures did not include the CCO's process for monitoring its provider network. JCC also did not demonstrate evidence of monitoring its provider network for appointment availability nor monitoring its provider network based on the characteristics and needs of its membership. The CCO also did not demonstrate that it uses the mechanisms available to monitor that its provider network includes sufficient family planning providers to ensure timely access to covered services. JCC should develop thorough, documented processes that address all required elements of network evaluation. The CCO should be able to demonstrate evidence of monitoring its provider network and corrective action when providers fail to meet the standards.

CY 2022 Recommendation	CY 2023 Assessment
Standard II—Assurances of Adequate Capacity and Services	
This recommendation was initially given during the CY 2021 EQR. JCC should develop a documented process for monitoring provider capacity that includes monitoring specialty providers individually by specialty type and ensure its network evaluation incorporates key data collected from its monitoring processes.	**JCC did not sufficiently address the recommendation.** JCC did not develop a documented or demonstrate implementing a process for monitoring provider capacity that includes monitoring specialty providers individually by specialty type. JCC should develop a documented process for monitoring provider capacity that includes monitoring specialty providers individually by specialty type and ensuring its network evaluation incorporates key data collected from its monitoring processes.
Standard III—Coordination and Continuity of Care	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard IV—Coverage and Authorization of Services	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard V—Provider Selection	
This recommendation was initially given during the CY 2021 EQR. JCC should develop and conduct state-required training and document completion of provider and CCO staff training.	**JCC did not sufficiently address the recommendation.** JCC did not demonstrate a streamlined system of providing the state-established required training to CCO staff and participating providers and their staff. JCC should develop and conduct state-required training and document the completion of provider and CCO staff training.
Standard VI—Subcontractual Relationships and Delegation	
This recommendation was initially given during the CY 2021 EQR. JCC should execute revised subcontracts that include all required contract provisions.	**JCC sufficiently addressed the recommendation.** Documentation reviewed during the CY 2023 CMR activity demonstrated compliance with the standard.
Standard VII—Member Rights and Protections	
This recommendation was initially given during the CY 2020 EQR. JCC should revise its policies to address the health care interpretation services available and the inclusion of ASL, oral interpretation for any language, and written translation in prevalent languages.	**JCC sufficiently addressed the recommendation.** Documentation reviewed during the CY 2023 CMR activity demonstrated compliance with the standard.

CY 2022 Recommendation	CY 2023 Assessment
Standard VIII—Confidentiality	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard IX—Enrollment and Disenrollment	
JCC should revise its policies and procedures and member-facing documents to align with federal and State requirements. JCC should also demonstrate oversight and monitoring of disenrollment reasons to ensure compliance with the regulatory requirements.	**JCC did not sufficiently address the recommendation.** JCC did not include one of the reasons why members can disenroll without cause within its member handbook. JCC should ensure that it communicates to members all the reasons why members can disenroll from the CCO. Utilizing the model member handbook would ensure the CCO captures the requirements.
Standard X—Grievance and Appeal Systems	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard XI—Practice Guidelines	
This recommendation was initially given during the CY 2021 EQR. JCC should maintain a cycle for reviewing and updating practice guidelines that is consistent with its policies and update its *Clinical Practice Guidelines* policy. Member education should be addressed in the policy, and the CCO should provide evidence of ensuring member education as well as coverage and utilization decisions are consistent with its practice guidelines.	**JCC sufficiently addressed the recommendation.** Documentation reviewed during the CY 2023 CMR activity demonstrated compliance with the standard.
Standard XII—Quality Assessment and Performance Improvement	
JCC should revise its QAPI program structure to align with federal and State requirements for a QAPI program. JCC should also demonstrate appropriate oversight of its QAPI program.	**JCC did not sufficiently address the recommendation.** JCC did not demonstrate that its QAPI program structure included the federal and State requirements for a QAPI program, including mechanisms to assess the quality and appropriateness of the care furnished to members with SHCN and members receiving LTSS, and an annual written evaluation of its QAPI program. JCC also did not demonstrate appropriate oversight of its QAPI program, including implementing a QI committee that meets the State's requirements. JCC should ensure appropriate oversight of its QAPI program,

CY 2022 Recommendation	CY 2023 Assessment
	including implementing a QI committee that meets the State's requirements.
Standard XIII—Health Information Systems, including ISCA	
JCC should amend its policies, procedures, and information systems to capture all required data elements and make them available for reporting to align with CCO contract requirements. JCC must also update its policies and procedures to include oversight processes for monitoring MOTS data submissions from its BH providers. JCC should ensure its staff are trained in, knowledgeable of, and implement those defined processes, including the documentation of all oversight activities and follow-up actions taken when issues are identified.	**JCC did not sufficiently address the recommendation.** JCC did not demonstrate mechanisms for ensuring BH provider compliance with MOTS reporting requirements. JCC should develop and implement processes to monitor its BH providers' compliance with MOTS reporting requirements.
Standard XIV—Member Information	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Performance Improvement Projects	
Statewide Mental Health Service Access Monitoring PIP	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Statewide Substance Use Disorder PIP	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Performance Measure Validation	
This recommendation was initially given during the CY 2021 EQR. JCC should continue to monitor key performance measure rates in alignment with its QAPI goals and objectives. For all key measures that fall below established performance or improvement thresholds, JCC should conduct root cause analyses to identify specific factors affecting performance. Once identified, targeted interventions should be developed, implemented, and evaluated to ensure effective improvement strategies are adopted to increase performance over time. Additionally, JCC should continue to monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches to	**JCC sufficiently addressed the recommendation.** JCC reported that it monitored performance measure data and conducted meetings with internal staff and network providers to identify and address factors impacting performance. JCC held weekly metrics meetings to review gaps in the network and identify priority populations, and held monthly meetings to solicit feedback from network providers. JCC should continue implementing these efforts to raise its rate on this measure indicator to the level of the benchmarks set by OHA.

CY 2022 Recommendation	CY 2023 Assessment
ensuring the quality, timeliness, and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	
Validation of Network Adequacy	
This recommendation was initially given during the CY 2021 EQR. JCC should work with OHA to determine the root cause of the low count for in-network providers and work to correct any deficiency.	**JCC did not sufficiently address the recommendation.** The CCO provided responses that did not address the recommended actions. The root concern was that the CCO had a likely data quality issue showing that an overwhelming majority of the CCO's individual practitioners (not particular specialties or facility types) were cited as being outside of the CCO's network. The CCO did not describe coordinating with OHA to determine the nature of this issue. The CCO must work with OHA directly to determine the root cause of the low count for in-network providers and work to correct any deficiency.
This recommendation was initially given during the CY 2020 EQR. JCC should ensure that it reports DSN Provider Capacity Reporting data values for all required data fields and seek technical assistance from OHA as needed.	**JCC sufficiently addressed the recommendation.** JCC's reported data quality results for Q1 2023 showed a high degree of confidence in data fields that were present, complete, and in a valid format.
JCC should ensure that provider data for time and distance are reported accurately and address any miscommunication between JCC and OHA.	**JCC sufficiently addressed the recommendation.** JCC identified and corrected the data discrepancies, as well as described the use of internal quality control checks by data analysts. JCC's reported data for Q1 2023 provided evidence of implementation of the corrective action.
Encounter Data Validation	
This recommendation was initially given during the CY 2021 EQR. HSAG recommends that JCC implement standard quality controls to ensure accurate data extracts. Through the development of standard data extraction procedures and quality control, the number of errors associated with extracted data could be reduced. JCC had noted that the data extract issues will be corrected in the future. Additionally, HSAG recommends that JCC continually monitor its encounter submissions to OHA to ensure complete, accurate, and timely encounter data submissions.	**JCC sufficiently addressed the recommendation.** Based on the response, it appears that JCC has implemented initiatives to address the recommendation. JCC runs reports to scrub encounter data before and after submission, works on correcting diagnosis code issues, and reviews and reprocesses claims that hit pend reasons instituted by OHA. Additionally, JCC plans to enhance QA testing for applications and data extracts, addressing potential barriers through education for new staff and the hiring of a dedicated resource for process documentation. JCC's identified strategy for continued

CY 2022 Recommendation	CY 2023 Assessment
	improvement involves educating new resources, peer review testing sessions, and maintaining subject matter expertise. Overall, JCC's efforts demonstrate progress in addressing the recommendation, particularly in terms of diagnosis code-related issues and QA. JCC's planned enhancements to testing and documentation suggest a commitment to ongoing improvement.
JCC should investigate the root cause for the omissions and consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews would then be provided to providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.	**JCC sufficiently addressed the recommendation.** JCC addressed the recommendation by implementing various initiatives within the payment integrity realm, which included expanding the department, conducting different types of audits, providing education to providers, and collaborating with external vendors. JCC's response highlighted positive outcomes, such as cost avoidance through audits, but acknowledged challenges related to the specific skill set required for chart audits. JCC's strategy for continued improvement involves expanding and training the payment integrity team and partnering with external vendors to enhance expertise in MRR. Overall, JCC's summary indicates a proactive and multifaceted approach to addressing the recommendation.
Mental Health Parity Evaluation	
This recommendation was initially given during the CY 2021 EQR. JCC should conduct more thorough oversight of its MH/SUD subcontractor and implement corrective actions, as necessary.	**JCC sufficiently addressed the recommendation.** JCC's BH UM team supervisors developed a checklist and reviewed each denial prior to sending to members. The Clinical Operations trainer developed a readability/health literacy training, which was reportedly attended by all staff. The BH team participated in a readability workgroup and created a BH clause library to update OARs in plain language. The team also participated in the committee that updated the new templates in alignment with OHA requirements. The CCO reported having two supervisors on extended leave, creating barriers to fully implementing initiatives. However, the CCO also reported continued supervisory oversight and consideration of peer reviews to ensure ongoing reviews of denial notices. While the action plan appeared to

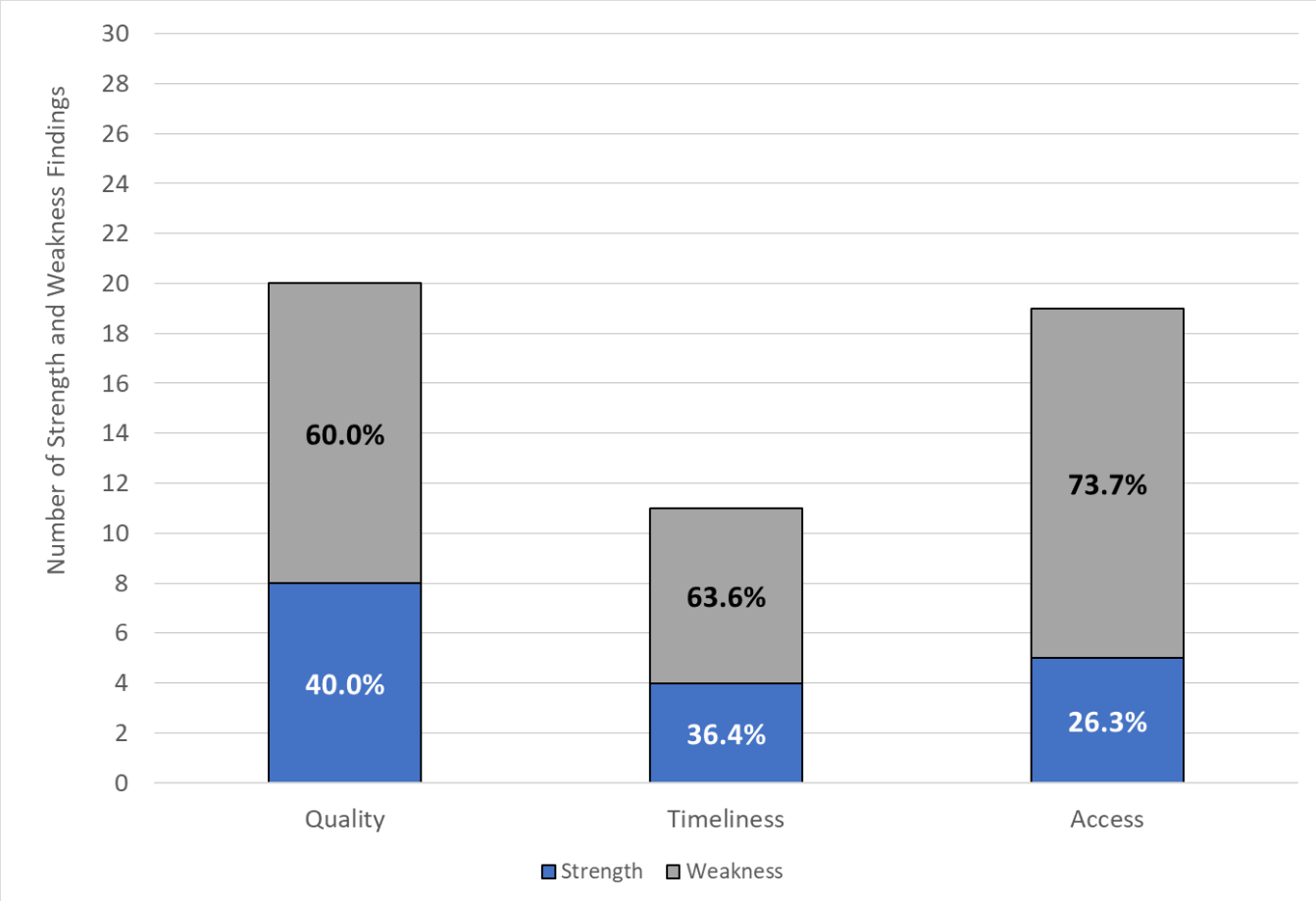
CY 2022 Recommendation	CY 2023 Assessment
	sufficiently address the recommendation, HSAG recommends the CCO ensure ongoing oversight of subcontractor performance to comply with both MHP and CMR requirements related to language and the format of NOABDs.

PacificSource Community Solutions–Central Oregon

Results and Conclusions

HSAG assessed the strengths and weaknesses of each CCO with respect to the quality, timeliness, and accessibility of health care services. Figure 5-17 illustrates the number of strengths exhibited by PCS-CO relative to the number of weaknesses identified during the CY 2023 EQR activities across the three domains. The greater the proportion of weaknesses, the greater opportunities for improvement.

Figure 5-17—PCS-CO Overall Number of Findings (Strengths and Weaknesses) by Domain



Detailed results from the EQR's substantive findings are summarized in Table 5-17 for each activity. This table highlights the extent to which PCS-CO furnishes high quality, timely, and appropriate access to health care services, and recommendations for how PCS-CO can best address issues identified for each activity.[5-17]

[5-17] See Section 4—Comparative Statewide Results for detailed, CCO-specific scores associated with EQR activity.

Table 5-17—PCS-CO Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)[5-18]
Compliance Monitoring Review		
−	**Weakness:** PCS-CO received a score of 94.4 percent in Standard III—Coordination and Continuity of Care due to a lack of operational structure and failure to appropriately assess/reassess members of prioritized populations and members for care coordination services. **Why the weakness exists:** PCS-CO's policies and procedures did not align with State requirements. Additionally, PCS-CO failed to demonstrate a streamlined method of assessing and reassessing members and updating the care plan within the appropriate time frame for members enrolled in ICC. **Recommendations:** PCS-CO must revise its policies and procedures to align with State requirements. PCS-CO must also demonstrate implementation of appropriate assessments, reassessments, and revision of treatment plans according to federal and State requirements.	
−	**Weakness:** PCS-CO received a score of 75.0 percent in Standard IV—Coverage and Authorization of Services due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting PCS-CO's ability to ensure the appropriate services and coverage are offered to members. **Why the weakness exists:** PCS-CO's policies and procedures did not align with federal and State requirements. Additionally, PCS-CO failed to demonstrate mechanisms for ensuring the services offered by the CCO are appropriate. PCS-CO also failed to adhere to requirements for the appropriate decision-makers, proper outreach to obtain information needed to process authorization requests, and time frames for notification of adverse benefit determinations. **Recommendations:** PCS-CO must revise its policies and procedures to align with federal and State requirements. PCS-CO must also demonstrate the implementation of appropriate service offerings. PCS-CO must also demonstrate proper outreach to retrieve the information needed to process service authorization requests and adhere to federal and State required time frames for notification of adverse benefit determinations.	
−	**Weakness:** PCS-CO received a score of 70.0 percent in Standard VII—Member Rights and Protections due to a lack of operational structure and failure to demonstrate implementation of an established process, impacting PCS-CO's ability to ensure that member rights are respected	

[5-18] = Quality, = Timeliness, = Access

Strength/ Weakness	Description	Domain(s)[5-18]
	and allowed to be exercised freely without affecting the treatment of members and that members are notified of their rights as required by federal and State requirements. **Why the weakness exists:** PCS-CO's policies and procedures and member- and provider-facing materials did not align with federal and State requirements. **Recommendations:** PCS-CO must revise its policies and procedures and member- and provider-facing materials to align with federal and State requirements.	
−	**Weakness:** PCS-CO received a score of 88.9 percent in Standard X—Grievance and Appeal Systems due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting PCS-CO's ability to ensure member grievances and appeals are addressed and responded to appropriately. **Why the weakness exists:** PCS-CO's policies and procedures did not align with federal and State requirements. PCS-CO also failed to adhere to requirements for the appropriate decision-makers on grievances and appeals, maintenance of an expedited process, and time frames for acknowledging and resolving grievances and/or appeals. PCS-CO also failed to communicate grievance and/or appeal requirements to providers and subcontractors. **Recommendations:** PCS-CO must revise its policies and procedures to align with federal and State requirements. PCS-CO must also adhere to federal and State requirements for the appropriate decision-makers on grievances and appeals, maintenance of an expedited process for appeals, and time frames for acknowledging and resolving grievances and appeals. PCS-CO must also demonstrate implementation of federal and State requirements within communications to providers and subcontractors.	
−	**Weakness:** PCS-CO received a score of 90.9 percent in Standard XIV—Member Information due to deficiencies in its operational structure and failure to demonstrate implementation of an established process, impacting PCS-CO's ability to ensure timely and proper member communication. **Why the weakness exists:** PCS-CO's policies and procedures and member-facing materials, including the member handbook and provider directory, did not align with federal and State requirements. Additionally, PCS-CO did not provide proper notification to members of the availability of member information. **Recommendations:** PCS-CO must revise its policies, procedures, and member-facing materials to align with federal and State requirements. PCS-CO must also notify members of the availability of member information.	

Strength/ Weakness	Description	Domain(s)[5-18]
−	**Weakness:** PCS-CO received a score of 87.5 percent in Standard XVI—Emergency and Poststabilization Services due to failure to demonstrate implementation of appropriate processes and workflows, impacting PCS-CO's ability to ensure emergency and poststabilization services are covered appropriately. **Why the weakness exists:** PCS-CO failed to demonstrate evidence of processes to ensure payment of emergency and poststabilization services. **Recommendations:** PCS-CO must demonstrate evidence of processes to ensure payment of emergency and poststabilization services.	
Performance Improvement Projects		
Statewide Mental Health Service Access Monitoring PIP		
−	**Weakness:** PCS-CO's reported indicator results did not demonstrate any improvement over the baseline across all performance indicators. **Why the weakness exists:** The indicator results demonstrated a decline in performance from baseline to RY 1. **Recommendations:** PCS-CO should revisit root cause analyses identifying barriers to improving access to MH services to determine which barriers to improvement were not effectively addressed. PCS-CO should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to improve indicator results.	
Statewide Substance Use Disorder PIP		
+	**Strength:** PCS-CO successfully initiated the Implementation stage for the PIP, receiving a *Met* score for 100 percent of applicable evaluation elements in the PIP validation tool. In the Implementation stage, PCS-CO accurately reported baseline performance indicator data; identified and analyzed barriers for initiation, engagement, and treatment of alcohol and other drug use disorders; and began to carry out interventions to address those barriers.	
Performance Measure Validation		
+	**Strength:** PCS-CO's MY 2022 performance for members ages 6 to 14 years receiving preventive dental or oral health services improved by more than 5 percentage points compared to MY 2021 (5.7 percentage points). The CCO's performance on the *Members Receiving Preventive Dental or Oral Health Services—Ages 1 to 5 Years* and *Ages 6 to 14 Years* measure indicators demonstrated ongoing improvement for members in both age groups since MY 2020. In addition, the CCO's MY 2022 rate for the *Ages 6 to 14 Years* measure indicator exceeded the 2020 CCO 75th percentile benchmark set by OHA for MY 2022 by 5 percentage points or more.	

Strength/ Weakness	Description	Domain(s)[5-18]
⊕	**Strength:** PCS-CO's performance on the *Oral Evaluation for Adults With Diabetes* measure demonstrated ongoing improvement since MY 2020.	
⊕	**Strength:** PCS-CO's performance on the *Child and Adolescent Well-Care Visits—Ages 3 to 6 Years* measure indicator demonstrated ongoing improvement since MY 2020. In addition, the CCO's MY 2022 rate exceeded the statewide aggregate and the 2020 CCO 75th percentile benchmark set by OHA for MY 2022 by 5 percentage points or more.	
Validation of Network Adequacy		
Delivery System Network Evaluation		
⊕	**Strength:** PCS-CO demonstrated full compliance with all elements of the DSN Provider Narrative, showing a high degree of competency in its network adequacy processes, narrative responses, documentation, and overall organization of the deliverable submission.	
⊕	**Strength:** PCS-CO described and demonstrated sophisticated collection and use of member and provider information to support network adequacy monitoring and decision-making by both strategic bodies and smaller "front line" teams.	
⊖	**Weakness:** PCS-CO's global reporting of nearly all provider data did not allow for a full assessment of the network available to members within specific CCOs. **Why the weakness exists:** With the exception of PCPs, all providers and their statuses were reported globally and were identical for all PCS CCOs, including but not limited to active status and accepting new patients status. Most providers were shown as operating outside of PCS-CO's service area. **Recommendations:** PCS-CO should seek technical assistance with OHA to determine the nature of the provider capacity data issues and take corrective action, as necessary.	
Secret Shopper Survey		
⊕	**Strength:** Of the total secret shopper survey responsive cases, 100 percent of PCD offices and 91.1 percent of PCP offices confirmed the location.	
⊖	**Weakness:** The total secret shopper survey response rate was 69.8 percent across all PCP and PCD cases. Of the total responsive cases, 47.1 percent of the offices offered the requested services, 38.5 percent accepted OHP, 36.5 percent accepted PCS-CO, and 32.7 percent accepted new patients.	

Strength/ Weakness	Description	Domain(s)[5-18]
	Why the weakness exists: In addition to limitations related to the secret shopper approach, the accuracy of PCS-CO's provider data may have contributed to the low response rate and accuracy results. **Recommendations:** HSAG recommends that PCS-CO use the case-level analytic data files to address the data deficiencies identified during the secret shopper survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
–	**Weakness:** Of the secret shopper survey responsive cases, only 16.7 percent of the PCP cases and 0.0 percent of the PCD cases resulted in an appointment. Of the PCP cases that offered an appointment, 40.0 percent were within the wait time compliance standard. **Why the weakness exists:** In addition to limitations related to the secret shopper approach, the accuracy of PCS-CO's provider data may have contributed to the low appointment availability rate. Additionally, internal office procedures may have contributed to the long wait times. **Recommendations:** HSAG recommends that PCS-CO confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. PCS-CO should use the case-level analytic data files containing data deficiencies identified during the secret shopper survey calls.	
Revealed Telephone Survey		
–	**Weakness:** Overall, 42.2 percent of the revealed telephone survey total sampled cases were reached, of which 22, or 24.7 percent, refused to participate in the survey. Of the total responsive cases, 73.0 percent of the offices confirmed the location, 69.7 percent offered the requested specialty, 52.8 percent accepted OHP, 42.7 percent accepted PCS-CO, and 41.6 percent accepted new patients. **Why the weakness exists:** In addition to limitations related to the revealed telephone approach, the accuracy of PCS-CO's provider data may have contributed to the low response rate and accuracy results. **Recommendations:** HSAG recommends that PCS-CO use the case-level analytic data files to address the data deficiencies identified during the revealed telephone survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
–	**Weakness:** Of the sampled cases, only 8.5 percent of the revealed telephone survey respondents offered a new patient appointment, while only 9.5 percent of survey respondents offered an appointment for an existing patient. Of the total cases that offered an appointment,	

Strength/ Weakness	Description	Domain(s)[5-18]
	81.6 percent of routine appointments and 29.7 percent of urgent appointments were within the wait time compliance standard. **Why the weakness exists:** In addition to limitations related to the revealed telephone approach, the accuracy of PCS-CO's provider data may have contributed to the low appointment availability rate. Additionally, internal office staffing structures and procedures may have contributed to the long wait times. **Recommendations:** HSAG recommends that PCS-CO confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. PCS-CO should use the case-level analytic data files containing data deficiencies identified during the revealed telephone survey calls and work with BH outpatient offices to identify the root cause for delays in appointment availability.	
Encounter Data Validation		
+	**Strength:** PCS-CO-submitted data exhibited high record-level data completeness, with low record omission and surplus rates.	
+	**Strength:** Among records that could be matched between the two data sources, a high level of element accuracy (i.e., data elements from both sources had the same values when populated) was exhibited across all evaluated key data elements.	
+	**Strength:** PCS-CO-submitted data had high all-element accuracy for all evaluated key data elements, indicating that the values (missing or non-missing) in both data sources (PCS-CO and OHA) were the same for almost all records.	
−	**Weakness:** The *Rendering Provider NPI* showed that information was present in the OHA-submitted data but not in the PCS-CO-submitted data. **Why the weakness exists:** More than 99.9 percent of the *Rendering Provider NPI* values in the OHA-submitted data, not found in the PCS-CO-submitted data, had the same values as the *Billing Provider NPI*. This discrepancy is likely a result of the data processing approach in OHA's MMIS. In OHA's MMIS, if the *Rendering Provider NPI* value is not submitted, the system populates the value with the *Billing Provider NPI* value. Consequently, when comparing this data element across the two sources, the *Rendering Provider NPI* is present in the OHA-submitted data but not in the PCS-CO-submitted data. **Recommendations:** While encounter submission to OHA did not require the inclusion of the *Rendering Provider NPI* value if it matched the *Billing Provider NPI* value, the data request for the EDV comparative analysis had different requirements. To address this, HSAG recommends that PCS-CO and its subcontractor(s) ensure that values for both *Billing Provider NPI* and *Rendering Provider NPI* are	

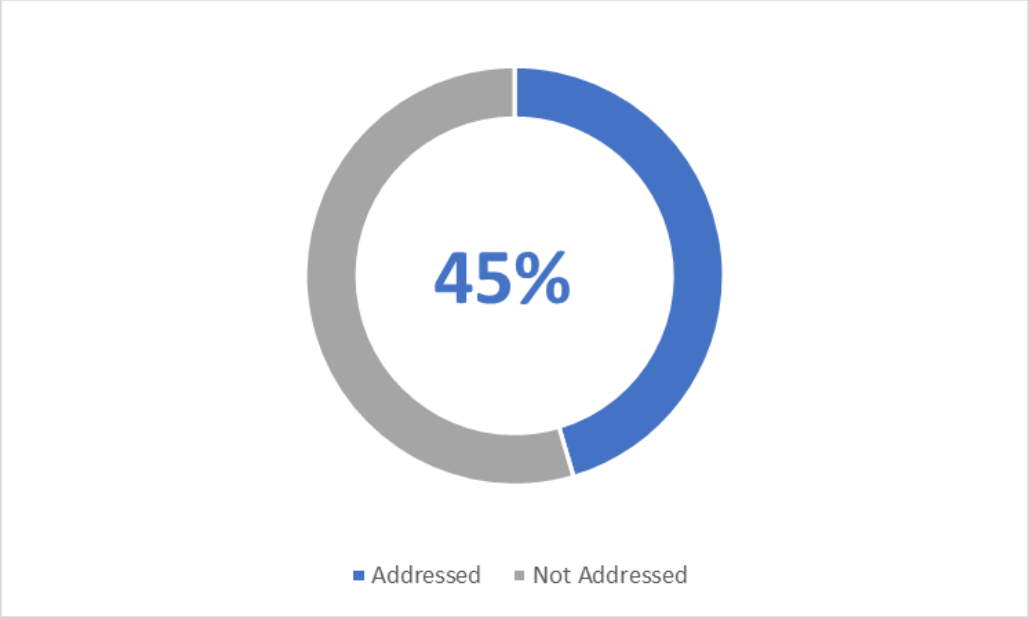
Strength/ Weakness	Description	Domain(s)[5-18]
	included in the data submission, irrespective of their equivalence. This adjustment will enhance the accuracy and completeness of the comparative analysis data. Additionally, it will provide HSAG with the means to verify and ensure the accuracy of the MMIS' process of populating the *Rendering Provider NPI* with the *Billing Provider NPI*.	
Mental Health Parity Evaluation		
–	**Weakness:** PCS-CO was partially compliant with the Pharmacy Management—Formulary Design NQTL requirement. **Why the weakness exists:** PCS-CO did not provide its rationale for the assignment of the NQTL (i.e., prescription drug formulary), procedures used for the development of the formulary (e.g., individuals involved in formulary development, professional guidelines used, and how often the formulary is reviewed and updated or by whom), or how frequently or strictly the NQTL is applied (e.g., ability of the provider to request an exception). **Recommendations:** PCS-CO should identify processes, strategies, evidentiary standards, and other factors that are used in formulary design and the application for prescription drugs.	🔑
–	**Weakness:** PCS-CO was partially compliant with the Pharmacy Management—Prescription Drug Benefit Tiers NQTL requirement. **Why the weakness exists:** PCS-CO did not provide its rationale for the assignment of the NQTL (i.e., formulary drug tiering), procedures related to formulary tiering (e.g., individuals involved, factors used to determine tier placement, or professional guidelines used), or how frequently or strictly the NQTL is applied (e.g., decision-making process). **Recommendations:** PCS-CO should identify processes, strategies, evidentiary standards, and other factors that are used in formulary tiering.	🔑

Follow-Up on Prior Year Recommendations

HSAG evaluated PCS-CO's approach to addressing the recommendations and/or findings issued during CY 2022 and unresolved findings from CY 2020 and CY 2021 while conducting the CY 2023 EQR activities. The CCOs not addressing findings and recommendations are at risk of being out of compliance with their contracts.

Figure 5-18 illustrates the degree in which the CCO sufficiently addressed the recommendations for QI made by HSAG during the CY 2022 EQR.

Figure 5-18—Percentage of CY 2022 EQR Recommendations Addressed by PCS-CO



PCS-CO-specific CY 2022 recommendations and follow-up CY 2023 assessments are summarized in Table 5-18.

Table 5-18—Assessment of PCS-CO's Approach to Addressing Previous Annual Recommendations

CY 2022 Recommendation	CY 2023 Assessment
Compliance Monitoring Review	
Standard I—Availability of Services	
This recommendation was initially given during the CY 2021 EQR. PCS-CO should ensure policies as well as provider and member facing materials include accurate information related to information related to direct access for female members to a women's health specialist and access to out-of-network services when the CCO is unable to provide the services. The CCO should also ensure its member handbook and provider manual include correct specialty BH care time frames. Finally, the CCO should ensure monitoring mechanisms include monitoring of BH and oral health access and fully comply with all State requirements for appointment availability, including oversight of subcontractors.	**PCS-CO did not sufficiently address the recommendation.** PCS-CO implemented processes to monitor its provider network and take corrective actions when providers failed to meet network access standards. The CCO also revised policies as well as provider- and member-facing materials to include correct appointment time frames and access to out-of-network services. However, PCS-CO's provider manual continued to include language that limited access to a women's health specialist to an annual gynecological exam. PCS-CO should ensure its provider manual includes accurate information related to female access to a women's health specialist.

CY 2022 Recommendation	CY 2023 Assessment
Standard II—Assurances of Adequate Capacity and Services	
This recommendation was initially given during the CY 2021 EQR. PCS-CO should revise its policies to include the CCO's methodology for monitoring based on the expected utilization of services.	**PCS-CO sufficiently addressed the recommendation.** Documentation reviewed during the CY 2023 CMR activity demonstrated compliance with the standard.
Standard III—Coordination and Continuity of Care	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard IV—Coverage and Authorization of Services	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard V—Provider Selection	
This recommendation was initially given during the CY 2021 EQR. PCS-CO should implement an effective credentialing program that includes recredentialing of providers no less than every three years and oversight of its subcontractors.	**PCS-CO sufficiently addressed the recommendation.** Documentation reviewed during the CY 2023 CMR activity demonstrated compliance with the standard.
Standard VI—Subcontractual Relationships and Delegation	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard VII—Member Rights and Protections	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard VIII—Confidentiality	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard IX—Enrollment and Disenrollment	
PCS-CO should revise its policies and procedures, member-facing documents, and training provided to staff to align with federal and State requirements. PCS-CO should also demonstrate oversight and monitoring of disenrollment reasons to ensure compliance with the regulatory requirements.	**PCS-CO sufficiently addressed the recommendation.** Documentation reviewed during the CY 2023 CMR activity demonstrated compliance with the standard.

CY 2022 Recommendation	CY 2023 Assessment
Standard X—Grievance and Appeal Systems	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard XI—Practice Guidelines	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard XII—Quality Assessment and Performance Improvement	
PCS-CO should revise its QAPI program structure to align with federal and State requirements for a QAPI program, including an annual written evaluation of the QAPI program and member care.	**PCS-CO sufficiently addressed the recommendation.** Documentation reviewed during the CY 2023 CMR activity demonstrated compliance with the standard.
Standard XIII—Health Information Systems, including ISCA	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard XIV—Member Information	
This standard was not assessed during the 2022 CMR.	Not applicable.
Performance Improvement Projects	
Statewide Mental Health Service Access Monitoring PIP	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Statewide Substance Use Disorder PIP	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Performance Measure Validation	
This recommendation was initially given during the CY 2021 EQR. PCS-CO should continue to monitor key performance measure rates in alignment with its QAPI goals and objectives. For all key measures that fall below established performance or improvement thresholds, PCS-CO should conduct root cause analyses to identify specific factors affecting performance. Once identified, targeted interventions should be developed, implemented, and evaluated to ensure effective improvement strategies are adopted to increase performance over time. Additionally,	**PCS-CO did not provide a response or supporting documentation to address the recommendation.**

CY 2022 Recommendation	CY 2023 Assessment
PCS-CO should continue to monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches to ensuring the quality, timeliness, and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	
Validation of Network Adequacy	
This recommendation was initially given during the CY 2021 EQR. PCS-CO should implement mechanisms to monitor provider directory accuracy and appointment availability.	**PCS-CO did not provide a response or supporting documentation to address the recommendation.**
This recommendation was initially given during the CY 2021 EQR. PCS-CO should identify the nature of the acute psychiatric care hospital (HPSY) data error, correct it, and assess the rest of its provider data for similar incorrect categorizations.	**PCS-CO sufficiently addressed the recommendation.** PCS-CO conducted an audit across its Business Intelligence, Provider Network Analytics, and Provider Operations teams to reclassify providers that were incorrectly coded, and data submitted for Q1 2023 provided evidence of implementation.
Encounter Data Validation	
This recommendation was initially given during the CY 2021 EQR. PCS-CO should continually work with its vendor to monitor its encounter submissions to OHA to ensure complete, accurate, and timely encounter data submissions.	**PCS-CO did not provide a response or supporting documentation to address the recommendation.**
This recommendation was initially given during the CY 2021 EQR. PCS-CO should implement standard quality controls to ensure accurate data extracts. Through the development of standard data extraction procedures and quality control, the number of errors associated with extracted data could be reduced. Additionally, HSAG recommends that PCS-CO continually work to monitor its encounter submissions to OHA to ensure complete, accurate, and timely encounter data submissions.	**PCS-CO did not provide a response or supporting documentation to address the recommendation.**
PCS-CO should investigate the root cause for the omissions and consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews would then be provided to providers through periodic education and training regarding encounter data	**PCS-CO did not provide a response or supporting documentation to address the recommendation.**

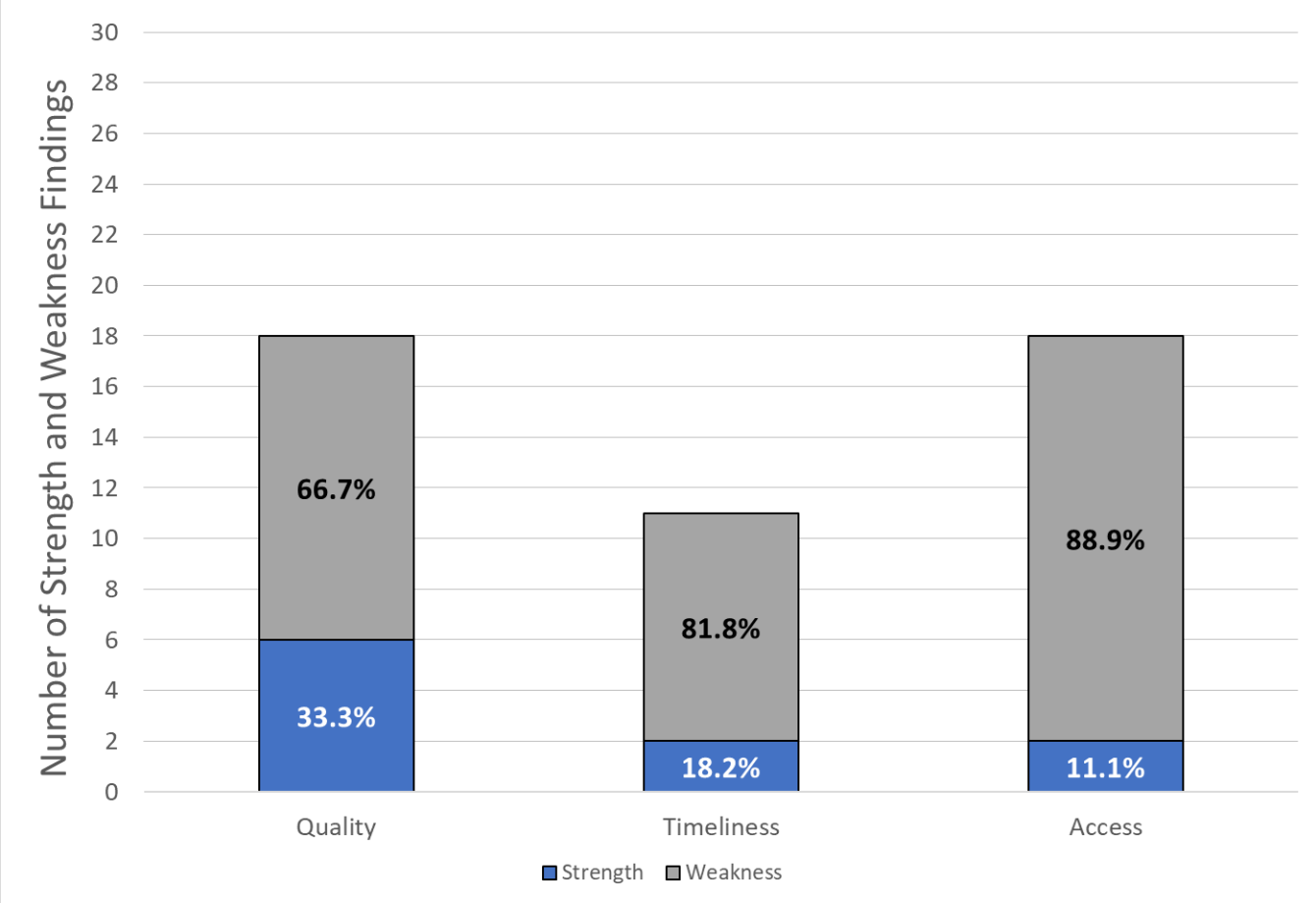
CY 2022 Recommendation	CY 2023 Assessment
submissions, medical record documentation, and coding practices.	
Mental Health Parity Evaluation	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.

PacificSource Community Solutions–Columbia Gorge

Results and Conclusions

HSAG assessed the strengths and weaknesses of each CCO with respect to the quality, timeliness, and accessibility of health care services. Figure 5-19 illustrates the number of strengths exhibited by PCS-CG relative to the number of weaknesses identified during the CY 2023 EQR activities across the three domains. The greater the proportion of weaknesses, the greater opportunities for improvement.

Figure 5-19—PCS-CG Overall Number of Findings (Strengths and Weaknesses) by Domain



Detailed results from the EQR's substantive findings are summarized in Table 5-19 for each activity. This table highlights the extent to which PCS-CG furnishes high quality, timely, and appropriate access to health care services, and recommendations for how PCS-CG can best address issues identified for each activity.[5-19]

[5-19] See Section 4—Comparative Statewide Results for detailed, CCO-specific scores associated with EQR activity.

Table 5-19—PCS-CG Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)[5-20]
Compliance Monitoring Review		
−	**Weakness:** PCS-CG received a score of 88.9 percent in Standard III—Coordination and Continuity of Care due to a lack of operational structure and failure to appropriately assess/reassess members of prioritized populations and members for care coordination services. **Why the weakness exists:** PCS-CG's policies and procedures did not align with State requirements. Additionally, PCS-CG failed to demonstrate a streamlined method of assessing and reassessing members and updating the care plan within the appropriate time frame for members enrolled in ICC. **Recommendations:** PCS-CG must revise its policies and procedures to align with State requirements. PCS-CG must also demonstrate implementation of appropriate assessments, reassessments, and revision of treatment plans according to federal and State requirements.	
−	**Weakness:** PCS-CG received a score of 77.8 percent in Standard IV—Coverage and Authorization of Services due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting PCS-CG's ability to ensure the appropriate services and coverage are offered to members. **Why the weakness exists:** PCS-CG's policies and procedures did not align with federal and State requirements. Additionally, PCS-CG failed to demonstrate mechanisms for ensuring the services offered by the CCO are appropriate. PCS-CG also failed to adhere to requirements for the appropriate decision-makers and proper outreach to obtain information needed to process authorization requests. **Recommendations:** PCS-CG must revise its policies and procedures to align with federal and State requirements. PCS-CG must also demonstrate the implementation of appropriate service offerings. PCS-CG must also demonstrate proper outreach to retrieve the information needed to process service authorization requests.	
−	**Weakness:** PCS-CG received a score of 70.0 percent in Standard VII—Member Rights and Protections due to a lack of operational structure and failure to demonstrate implementation of an established process, impacting PCS-CG's ability to ensure that member rights are respected and allowed to be exercised freely without affecting the treatment of members and that members are notified of their rights as required by federal and State requirements.	

[5-20] = Quality, = Timeliness, = Access

Strength/ Weakness	Description	Domain(s)[5-20]
	Why the weakness exists: PCS-CG's policies and procedures and member- and provider-facing materials did not align with federal and State requirements. **Recommendations:** PCS-CG must revise its policies and procedures and member- and provider-facing materials to align with federal and State requirements.	
−	**Weakness:** PCS-CG received a score of 88.9 percent in Standard X—Grievance and Appeal Systems due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting PCS-CG's ability to ensure member grievances and appeals are addressed and responded to appropriately. **Why the weakness exists:** PCS-CG's policies and procedures did not align with federal and State requirements. PCS-CG also failed to adhere to requirements for the appropriate decision-makers on grievances and appeals, maintenance of an expedited process, and time frames for acknowledging and resolving grievances and/or appeals. PCS-CG also failed to communicate grievance and/or appeal requirements to providers and subcontractors. **Recommendations:** PCS-CG must revise its policies and procedures to align with federal and State requirements. PCS-CG must also adhere to federal and State requirements for the appropriate decision-makers on grievances and appeals, maintenance of an expedited process for appeals, and time frames for acknowledging and resolving grievances and appeals. PCS-CG must also demonstrate implementation of federal and State requirements within communications to providers and subcontractors.	
−	**Weakness:** PCS-CG received a score of 90.9 percent in Standard XIV—Member Information due to deficiencies in its operational structure and failure to demonstrate implementation of an established process, impacting PCS-CG's ability to ensure timely and proper member communication. **Why the weakness exists:** PCS-CG's policies and procedures and member-facing materials, including the member handbook and provider directory, did not align with federal and State requirements. Additionally, PCS-CG did not provide proper notification to members of the availability of member information. **Recommendations:** PCS-CG must revise its policies, procedures, and member-facing materials to align with federal and State requirements. PCS-CG must also notify members of the availability of member information.	
−	**Weakness:** PCS-CG received a score of 87.5 percent in Standard XVI—Emergency and Poststabilization Services due to failure to demonstrate implementation of appropriate processes and workflows,	

Strength/ Weakness	Description	Domain(s)[5-20]
	impacting PCS-CG's ability to ensure emergency and poststabilization services are covered appropriately. **Why the weakness exists:** PCS-CG failed to demonstrate evidence of processes to ensure payment of emergency and poststabilization services. **Recommendations:** PCS-CG must demonstrate evidence of processes to ensure payment of emergency and poststabilization services.	
Performance Improvement Projects		
Statewide Mental Health Service Access Monitoring PIP		
−	**Weakness:** PCS-CG's reported indicator results did not demonstrate any improvement over baseline performance. **Why the weakness exists:** The indicator results demonstrated a decline in performance from baseline to RY 1. **Recommendations:** PCS-CG should revisit root cause analyses identifying barriers to improving access to MH services to determine which barriers to improvement were not effectively addressed. PCS-CG should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to improve indicator results.	
Statewide Substance Use Disorder PIP		
+	**Strength:** PCS-CG successfully initiated the Implementation stage for the PIP, receiving a *Met* score for 100 percent of applicable evaluation elements in the PIP validation tool. In the Implementation stage, PCS-CG accurately reported baseline performance indicator data; identified and analyzed barriers for initiation, engagement, and treatment of alcohol and other drug use disorders; and began to carry out interventions to address those barriers.	
Performance Measure Validation		
+	**Strength:** PCS-CG's MY 2022 performance on the *Child and Adolescent Well-Care Visits—Ages 3 to 6 Years* measure indicator demonstrated ongoing improvement since MY 2020. In addition, the CCO's MY 2022 rate exceeded the statewide aggregate and the 2020 CCO 75th percentile benchmark set by OHA for MY 2022 by 5 percentage points or more.	
−	**Weakness:** PCS-CG's MY 2022 performance on the *Members Receiving Preventive Dental or Oral Health Services—Ages 1 to 5 Years* measure indicators fell below the statewide aggregate and the 2020 CCO 75th percentile benchmark set by OHA for MY 2022 by 5 percentage points or more. In addition, while the CCO's rate for the *Ages 6 to 14 Years* measure indicator continued to exceed the OHA benchmark, the CCO's MY 2022 rate for this age group declined	

Strength/ Weakness	Description	Domain(s)[5-20]
	slightly compared to MY 2021, specifically for members ages 6 to 14 years (-1.5 percentage points). **Why the weakness exists:** PCS-CG demonstrated substantial improvement in performance on this measure between MY 2020 and MY 2021 (8.4 percentage points for members ages 6 to 14 years); however, PCS-CG did not continue to perform well on this measure in MY 2022. Despite statewide improvement in this measure for members ages 1 to 5 years, PCS-CG demonstrated no improvement and continued to perform below the OHA benchmark. **Recommendations:** PCS-CG should conduct root cause analyses to identify specific factors affecting performance on this measure and develop, implement, and evaluate targeted interventions to ensure improvement strategies are adopted. Additionally, PCS-CG should monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches for ensuring the timeliness and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	
Validation of Network Adequacy		
Delivery System Network Evaluation		
+	**Strength:** PCS-CG demonstrated full compliance with all elements of the DSN Provider Narrative, showing a high degree of competency in its network adequacy processes, narrative responses, documentation, and overall organization of the deliverable submission.	
+	**Strength:** PCS-CG described and demonstrated sophisticated collection and use of member and provider information to support network adequacy monitoring and decision-making by both strategic bodies and smaller "front line" teams.	
−	**Weakness:** PCS-CG's global reporting of almost all provider data did not allow for a full assessment of the network available to members within specific CCOs. **Why the weakness exists:** With the exception of PCPs, all providers and their statuses were reported globally and were identical for all PCS CCOs, including but not limited to active status and accepting new patients status. Nearly all providers were shown as operating outside of PCS-CG's service area. **Recommendations:** PCS-CG should seek technical assistance with OHA to determine the nature of the provider capacity data issues and take corrective action, as necessary.	
Secret Shopper Survey		
−	**Weakness:** The total secret shopper survey response rate was 84.8 percent across all PCP and PCD cases. Of the total responsive	

Strength/ Weakness	Description	Domain(s)[5-20]
	cases, 69.2 percent of the offices confirmed the location, 35.9 percent offered the requested services, 25.6 percent accepted OHP, 23.1 percent accepted PCS-CG, and 20.5 percent accepted new patients. Although 100 percent of the PCD cases confirmed the location and offered the requested services, PCP offices confirmed the location for 62.5 percent of the cases and offered the requested services for 35.9 percent of the cases. **Why the weakness exists:** In addition to limitations related to the secret shopper approach, the accuracy of PCS-CG's provider data may have contributed to the low accuracy results. **Recommendations:** HSAG recommends that PCS-CG use the case-level analytic data files to address the data deficiencies identified during the secret shopper survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
−	**Weakness:** Of the total secret shopper survey responsive cases, only 5.1 percent resulted in an appointment. Of the cases that offered an appointment, 50.0 percent were within the wait time compliance standard. **Why the weakness exists:** In addition to limitations related to the secret shopper approach, the accuracy of PCS-CG's provider data may have contributed to the low appointment availability rate. Additionally, internal office procedures may have contributed to the long wait times. **Recommendations:** HSAG recommends that PCS-CG confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. PCS-CG should use the case-level analytic data files containing data deficiencies identified during the secret shopper survey calls.	
Revealed Telephone Survey		
−	**Weakness:** Overall, 32.8 percent of the revealed telephone survey total sampled cases were reached, of which seven, or 35.0 percent, refused to participate in the survey. Of the total responsive cases, 60.0 percent of the offices confirmed the location, 45.0 percent offered the requested specialty, 35.0 percent accepted OHP, 25.0 percent accepted PCS-CG, and 25.0 percent accepted new patients. **Why the weakness exists:** In addition to limitations related to the revealed telephone approach, the accuracy of PCS-CG's provider data may have contributed to the low response rate and accuracy results. **Recommendations:** HSAG recommends that PCS-CG use the case-level analytic data files to address the data deficiencies identified during the revealed telephone survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty	

Strength/ Weakness	Description	Domain(s)[5-20]
	information that does not correspond to the sampled location, plan name, and program information).	
−	**Weakness:** Of the sampled cases, only 8.2 percent of the revealed telephone survey respondents offered an appointment to new or existing patients, each. Of the total cases that offered an appointment, 80.0 percent of routine appointments and 50.0 percent of urgent appointments were within the wait time compliance standard. **Why the weakness exists:** In addition to limitations related to the revealed telephone approach, the accuracy of PCS-CG's provider data may have contributed to the low appointment availability rate. Additionally, internal office staffing structures and procedures may have contributed to the long wait times. **Recommendations:** HSAG recommends that PCS-CG confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. PCS-CG should use the case-level analytic data files containing data deficiencies identified during the revealed telephone survey calls and work with BH outpatient offices to identify the root cause for delays in appointment availability.	
Encounter Data Validation		
+	**Strength:** PCS-CG-submitted data exhibited high record-level data completeness, with low record omission and surplus rates.	
+	**Strength:** Among records that could be matched between the two data sources, a high level of element accuracy (i.e., data elements from both sources had the same values when populated) was exhibited across all evaluated key data elements.	
+	**Strength:** PCS-CG-submitted data had high all-element accuracy for all evaluated key data elements, indicating that the values (missing or non-missing) in both data sources (PCS-CG and OHA) were the same for almost all records.	
−	**Weakness:** The *Rendering Provider NPI* showed that information was present in the OHA-submitted data but not in the PCS-CG-submitted data. **Why the weakness exists:** More than 99.9 percent of the *Rendering Provider NPI* values in the OHA-submitted data, not found in the PCS-CG-submitted data, had the same values as the *Billing Provider NPI*. This discrepancy is likely a result of the data processing approach in OHA's MMIS. In OHA's MMIS, if the *Rendering Provider NPI* value is not submitted, the system populates the value with the *Billing Provider NPI* value. Consequently, when comparing this data element across the two sources, the *Rendering Provider NPI* is present in the OHA-submitted data but not in the PCS-CG-submitted data.	

Strength/ Weakness	Description	Domain(s)[5-20]
	Recommendations: While encounter submission to OHA did not require the inclusion of the *Rendering Provider NPI* value if it matched the *Billing Provider NPI* value, the data request for the EDV comparative analysis had different requirements. To address this, HSAG recommends that PCS-CG and its subcontractor(s) ensure that values for both *Billing Provider NPI* and *Rendering Provider NPI* are included in the data submission, irrespective of their equivalence. This adjustment will enhance the accuracy and completeness of the comparative analysis data. Additionally, it will provide HSAG with the means to verify and ensure the accuracy of the MMIS' process of populating the *Rendering Provider NPI* with the *Billing Provider NPI*.	
Mental Health Parity Evaluation		
−	**Weakness:** PCS-CG was partially compliant with the Pharmacy Management—Formulary Design NQTL requirement. **Why the weakness exists:** PCS-CG did not provide its rationale for the assignment of the NQTL (i.e., prescription drug formulary), procedures used for the development of the formulary (e.g., individuals involved in formulary development, professional guidelines used, and how often the formulary is reviewed and updated or by whom), or how frequently or strictly the NQTL is applied (e.g., ability of the provider to request an exception). **Recommendations:** PCS-CG should identify processes, strategies, evidentiary standards, and other factors that are used in formulary design and the application for prescription drugs.	
−	**Weakness:** PCS-CG was partially compliant with the Pharmacy Management—Prescription Drug Benefit Tiers NQTL requirement. **Why the weakness exists:** PCS-CG did not provide its rationale for the assignment of the NQTL (i.e., formulary drug tiering), procedures related to formulary tiering (e.g., individuals involved, factors used to determine tier placement, or professional guidelines used), or how frequently or strictly the NQTL is applied (e.g., decision-making process). **Recommendations:** PCS-CG should identify processes, strategies, evidentiary standards, and other factors that are used in formulary tiering.	
−	**Weakness:** PCS-CG showed a substantial difference in the percentage of paid, out-of-network MH/SUD OP claims compared to M/S OP claims. Although the difference in the percentage of paid claims may be legitimate, it may also highlight procedural or network differences, indicating potential barriers for members accessing MH/SUD services. **Why the weakness exists:** Out-of-network OP MH/SUD claims were paid less frequently than M/S claims.	

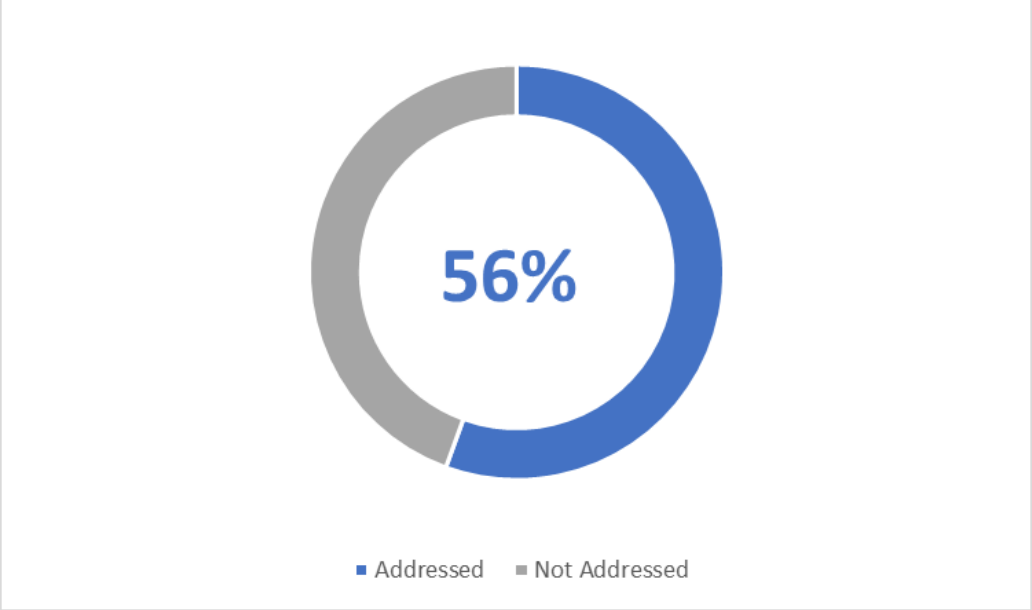
Strength/ Weakness	Description	Domain(s)[5-20]
	Recommendations: PCS-CG should review out-of-network claim denials to understand the factors affecting the lower percentage of paid MH/SUD OP claims compared to M/S OP claims. PCS-CG should assess whether any barriers exist for members accessing MH/SUD services, including the need to seek services outside of the CCO's network (e.g., appointment availability).	

Follow-Up on Prior Year Recommendations

HSAG evaluated PCS-CG's approach to addressing the recommendations and/or findings issued during CY 2022 and unresolved findings from CY 2020 and CY 2021 while conducting the CY 2023 EQR activities. The CCOs not addressing findings and recommendations are at risk of being out of compliance with their contracts.

Figure 5-20 illustrates the degree in which the CCO sufficiently addressed the recommendations for QI made by HSAG during the CY 2022 EQR.

Figure 5-20—Percentage of CY 2022 EQR Recommendations Addressed by PCS-CG



PCS-CG-specific CY 2022 recommendations and follow-up CY 2023 assessments are summarized in Table 5-20.

Table 5-20—Assessment of PCS-CG's Approach to Addressing Previous Annual Recommendations

CY 2022 Recommendation	CY 2023Assessment
Compliance Monitoring Review	
Standard I—Availability of Services	
This recommendation was initially given during the CY 2021 EQR. PCS-CG should ensure policies as well as provider and member facing materials include accurate information related to information related to direct access for female members to a women's health specialist and access to out-of-network services when the CCO is unable to provide the services. The CCO should also ensure its member handbook and provider manual include correct specialty BH care time frames. Finally, the CCO should ensure monitoring mechanisms include monitoring of BH and oral health access and fully comply with all State requirements for appointment availability, including oversight of subcontractors.	**PCS-CG did not sufficiently address the recommendation.** PCS-CG implemented processes to monitor its provider network and take corrective actions when providers failed to meet network access standards. The CCO also revised policies as well as provider- and member-facing materials to include correct appointment time frames and access to out-of-network services. However, PCS-CG's provider manual continued to include language that limited access to a women's health specialist to an annual gynecological exam. PCS-CG should ensure its provider manual includes accurate information related to female access to a women's health specialist.
Standard II—Assurances of Adequate Capacity and Services	
This recommendation was initially given during the CY 2021 EQR. PCS-CG should revise its policies to include the CCO's methodology for monitoring based on the expected utilization of services.	**PCS-CG sufficiently addressed the recommendation.** Documentation reviewed during the CY 2023 CMR activity demonstrated compliance with the standard.
Standard III—Coordination and Continuity of Care	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard IV—Coverage and Authorization of Services	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard V—Provider Selection	
This recommendation was initially given during the CY 2021 EQR. PCS-CG should implement an effective credentialing program that includes recredentialing of providers no less than every three years and oversight of its subcontractors.	**PCS-CG sufficiently addressed the recommendation.** Documentation reviewed during the CY 2023 CMR activity demonstrated compliance with the standard.
Standard VI—Subcontractual Relationships and Delegation	
This standard was not assessed during the 2022 CMR.	Not applicable.

CY 2022 Recommendation	CY 2023Assessment
Standard VII—Member Rights and Protections	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard VIII—Confidentiality	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard IX—Enrollment and Disenrollment	
PCS-CG should revise its policies and procedures, member-facing documents, and training provided to staff to align with federal and State requirements. PCS-CG should also demonstrate oversight and monitoring of disenrollment reasons to ensure compliance with the regulatory requirements.	**PCS-CG sufficiently addressed the recommendation.** Documentation reviewed during the CY 2023 CMR activity demonstrated compliance with the standard.
Standard X—Grievance and Appeal Systems	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard XI—Practice Guidelines	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard XII—Quality Assessment and Performance Improvement	
PCS-CG should revise its QAPI program structure to align with federal and State requirements for a QAPI program, including an annual written evaluation of the QAPI program and member care.	**PCS-CG sufficiently addressed the recommendation.** Documentation reviewed during the CY 2023 CMR activity demonstrated compliance with the standard.
Standard XIII—Health Information Systems, including ISCA	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard XIV—Member Information	
This standard was not assessed during the 2022 CMR.	Not applicable.
Performance Improvement Projects	
Statewide Mental Health Service Access Monitoring PIP	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.

CY 2022 Recommendation	CY 2023Assessment
Statewide Substance Use Disorder PIP	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Performance Measure Validation	
This recommendation was initially given during the CY 2021 EQR. PCS-CG should continue to monitor key performance measure rates in alignment with its QAPI goals and objectives. For all key measures that fall below established performance or improvement thresholds, PCS-CG should conduct root cause analyses to identify specific factors affecting performance. Once identified, targeted interventions should be developed, implemented, and evaluated to ensure effective improvement strategies are adopted to increase performance over time. Additionally, PCS-CG should continue to monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches to ensuring the quality, timeliness, and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	**PCS-CG did not provide a response or supporting documentation to address the recommendation.**
Validation of Network Adequacy	
This recommendation was initially given during the CY 2021 EQR. PCS-CG should implement mechanisms to monitor provider directory accuracy and appointment availability.	**PCS-CG did not provide a response or supporting documentation to address the recommendation.**
This recommendation was initially given during the CY 2021 EQR. PCS-CG should identify the nature of the HPSY data error, correct it, and assess the rest of its provider data for similar incorrect categorizations.	**PCS-CG sufficiently addressed the recommendation.** PCS-CG conducted an audit across its Business Intelligence, Provider Network Analytics, and Provider Operations teams to reclassify providers that were incorrectly coded, and data submitted for Q1 2023 provided evidence of implementation.
Encounter Data Validation	
PCS-CG should investigate the root cause for the omissions and consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews would then be provided to providers through periodic education	**PCS-CG did not provide a response or supporting documentation to address the recommendation.**

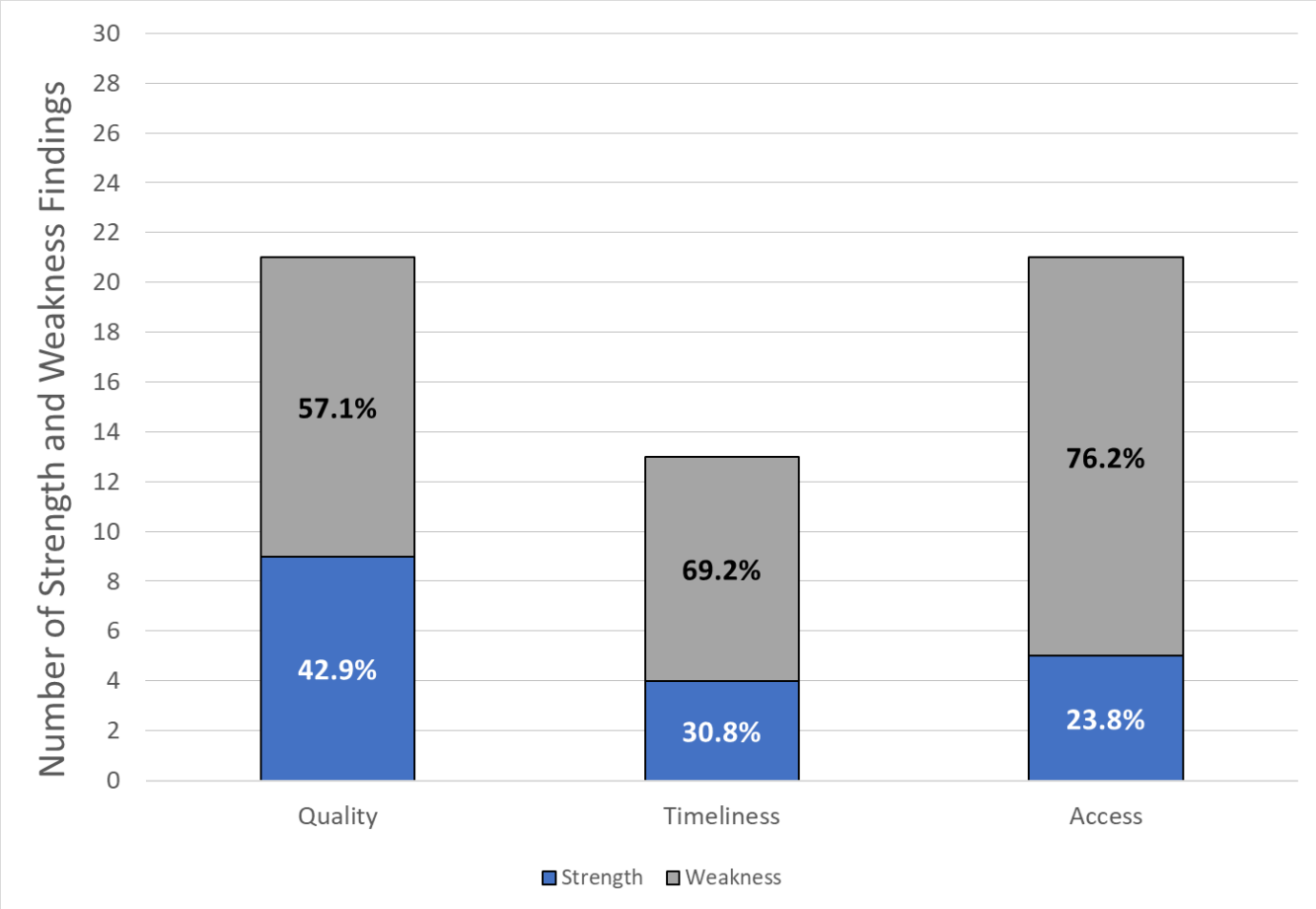
CY 2022 Recommendation	CY 2023Assessment
and training regarding encounter data submissions, medical record documentation, and coding practices.	
Mental Health Parity Evaluation	
PCS-CG met performance expectations; no recommendations were provided in 2022.	Not applicable.

PacificSource Community Solutions–Lane

Results and Conclusions

HSAG assessed the strengths and weaknesses of each CCO with respect to the quality, timeliness, and accessibility of health care services. Figure 5-21 illustrates the number of strengths exhibited by PCS-Lane relative to the number of weaknesses identified during the CY 2023 EQR activities across the three domains. The greater the proportion of weaknesses, the greater opportunities for improvement.

Figure 5-21—PCS-Lane Overall Number of Findings (Strengths and Weaknesses) by Domain



Detailed results from the EQR's substantive findings are summarized in Table 5-21 for each activity. This table highlights the extent to which PCS-Lane furnishes high quality, timely, and appropriate access to health care services, and recommendations for how PCS-Lane can best address issues identified for each activity.[5-21]

[5-21] See Section 4—Comparative Statewide Results for detailed, CCO-specific scores associated with EQR activity.

Table 5-21—PCS-Lane Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)[5-22]
Compliance Monitoring Review		
−	**Weakness:** PCS-Lane received a score of 88.9 percent in Standard III—Coordination and Continuity of Care due to a lack of operational structure and failure to appropriately assess/reassess members of prioritized populations and members for care coordination services. **Why the weakness exists:** PCS-Lane's policies and procedures did not align with State requirements. Additionally, PCS-Lane failed to demonstrate a streamlined method of assessing and reassessing members and updating the care plan within the appropriate time frame for members enrolled in ICC. **Recommendations:** PCS-Lane must revise its policies and procedures to align with State requirements. PCS-Lane must also demonstrate implementation of appropriate assessments, reassessments, and revision of treatment plans according to federal and State requirements.	
−	**Weakness:** PCS-Lane received a score of 72.2 percent in Standard IV—Coverage and Authorization of Services due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting PCS-Lane's ability to ensure the appropriate services and coverage are offered to members. **Why the weakness exists:** PCS-Lane's policies and procedures did not align with federal and State requirements. Additionally, PCS-Lane failed to demonstrate mechanisms for ensuring the services offered by the CCO are appropriate. PCS-Lane also failed to adhere to requirements for the appropriate decision-makers, proper outreach to obtain information needed to process authorization requests, and time frames for notification of adverse benefit determinations. **Recommendations:** PCS-Lane must revise its policies and procedures to align with federal and State requirements. PCS-Lane must also demonstrate the implementation of appropriate service offerings. PCS-Lane must also demonstrate proper outreach to retrieve the information needed to process service authorization requests and adhere to federal and State required time frames for notification of adverse benefit determinations.	
−	**Weakness:** PCS-Lane received a score of 70.0 percent in Standard VII—Member Rights and Protections due to a lack of operational structure and failure to demonstrate implementation of an established process, impacting PCS-Lane's ability to ensure that member rights are respected and allowed to be exercised freely without affecting the	

[5-22] = Quality, = Timeliness, = Access

Strength/ Weakness	Description	Domain(s)[5-22]
	treatment of members and that members are notified of their rights as required by federal and State requirements. **Why the weakness exists:** PCS-Lane's policies and procedures and member- and provider-facing materials did not align with federal and State requirements. **Recommendations:** PCS-Lane must revise its policies and procedures and member- and provider-facing materials to align with federal and State requirements.	
–	**Weakness:** PCS-Lane received a score of 87.0 percent in Standard X—Grievance and Appeal Systems due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting PCS-Lane's ability to ensure member grievances and appeals are addressed and responded to appropriately. **Why the weakness exists:** PCS-Lane's policies and procedures did not align with federal and State requirements. PCS-Lane also failed to adhere to requirements for the appropriate decision-makers on grievances and appeals, maintenance of an expedited process, time frames for acknowledging and resolving grievances and/or appeals, and readability of notices. PCS-Lane also failed to communicate grievance and/or appeal requirements to providers and subcontractors. **Recommendations:** PCS-Lane must revise its policies and procedures to align with federal and State requirements. PCS-Lane must also adhere to federal and State requirements for the appropriate decision-makers on grievances and appeals, maintenance of an expedited process for appeals, time frames for acknowledging and resolving grievances and appeals, and readability of notices. PCS-Lane must also demonstrate implementation of federal and State requirements within communications to providers and subcontractors.	
–	**Weakness:** PCS-Lane received a score of 90.9 percent in Standard XIV—Member Information due to deficiencies in its operational structure and failure to demonstrate implementation of an established process, impacting PCS-Lane's ability to ensure timely and proper member communication. **Why the weakness exists:** PCS-Lane's policies and procedures and member-facing materials, including the member handbook and provider directory, did not align with federal and State requirements. Additionally, PCS-Lane did not provide proper notification to members of the availability of member information. **Recommendations:** PCS-Lane must revise its policies, procedures, and member-facing materials to align with federal and State requirements. PCS-Lane must also notify members of the availability of member information.	

Strength/ Weakness	Description	Domain(s)[5-22]
−	**Weakness:** PCS-Lane received a score of 87.5 percent in Standard XVI—Emergency and Poststabilization Services due to failure to demonstrate implementation of appropriate processes and workflows, impacting PCS-Lane's ability to ensure emergency and poststabilization services are covered appropriately. **Why the weakness exists:** PCS-Lane failed to demonstrate evidence of processes to ensure payment of emergency and poststabilization services. **Recommendations:** PCS-Lane must demonstrate evidence of processes to ensure payment of emergency and poststabilization services.	
Performance Improvement Projects		
Statewide Mental Health Service Access Monitoring PIP		
−	**Weakness:** PCS-Lane's reported indicator results did not demonstrate any improvement over baseline performance. **Why the weakness exists:** The indicator results demonstrated a decline in performance from baseline to RY 1. **Recommendations:** PCS-Lane should revisit root cause analyses identifying barriers to improving access to MH services to determine which barriers to improvement were not effectively addressed. PCS-Lane should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to improve indicator results.	
Statewide Substance Use Disorder PIP		
+	**Strength:** PCS-Lane successfully initiated the Implementation stage for the PIP, receiving a *Met* score for 100 percent of applicable evaluation elements in the PIP validation tool. In the Implementation stage, PCS-Lane accurately reported baseline performance indicator data; identified and analyzed barriers for initiation, engagement, and treatment of alcohol and other drug use disorders; and began to carry out interventions to address those barriers.	
Performance Measure Validation		
+	**Strength:** PCS-Lane's MY 2022 performance for members ages 6 to 14 years receiving preventive dental or oral health services improved by more than 5 percentage points compared to MY 2021 (5.5 percentage points). The CCO's performance on the *Members Receiving Preventive Dental or Oral Health Services—Ages 6 to 14 Years* measure indicators demonstrated ongoing improvement since MY 2020. In addition, the CCO's MY 2022 rate for the *Ages 6 to 14 Years* measure indicator exceeded the statewide aggregate and the 2020 CCO 75th percentile benchmark set by OHA for MY 2022 by 5 percentage points or more.	

Strength/ Weakness	Description	Domain(s)[5-22]
+	**Strength:** PCS-Lane's MY 2022 rate on the *Initiation and Engagement of SUD Treatment* measure for members ages 18 years and older exceeded the statewide aggregate and the 2020 HEDIS national Medicaid median benchmark set by OHA for MY 2022 by 5 percentage points or more.	
+	**Strength:** PCS-Lane's performance on the *Oral Evaluation for Adults With Diabetes* measure demonstrated ongoing improvement since MY 2020.	
−	**Weakness:** PCS-Lane's MY 2022 rate for the *Child and Adolescent Well-Care Visits—Ages 3 to 6 Years* measure indicator fell below the statewide aggregate and the 2020 CCO 75th percentile benchmark set by OHA for MY 2022 by 5 percentage points or more. **Why the weakness exists:** PCS-Lane's performance on this measure declined slightly compared to MY 2021 (-1.7 percentage points). Although PCS-Lane's eligible population for this measure increased from MY 2021 to MY 2022, nearly the same number of children ages 3 to 6 years had a comprehensive well-care visit with their PCP in both MY 2021 and MY 2022. OHA's 2022 CCO Performance Metrics Annual Report showed statewide performance for the *Child and Adolescent Well-Care Visits—Ages 3 to 6 Years* measure indicator declined slightly (0.6 percent) from MY 2021. **Recommendations:** PCS-Lane should conduct root cause analyses to identify specific factors affecting performance on this measure and develop, implement, and evaluate targeted interventions to ensure improvement strategies are adopted. Additionally, PCS-Lane should monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches for ensuring the timeliness and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	
Validation of Network Adequacy		
Delivery System Network Evaluation		
+	**Strength:** PCS-Lane demonstrated full compliance with all elements of the DSN Provider Narrative, showing a high degree of competency in its network adequacy processes, narrative responses, documentation, and overall organization of the deliverable submission.	
+	**Strength:** PCS-Lane described and demonstrated sophisticated collection and use of member and provider information to support network adequacy monitoring and decision-making by both strategic bodies and smaller "front line" teams.	

Strength/ Weakness	Description	Domain(s)[5-22]
	**Weakness:** PCS-Lane's global reporting of almost all provider data did not allow for a full assessment of the network available to members within specific CCOs. **Why the weakness exists:** With the exception of PCPs, all providers and their statuses were reported globally and were identical for all PCS CCOs, including but not limited to active status and accepting new patients status. Most providers were shown as operating outside of PCS-Lane's service area. **Recommendations:** PCS-Lane should seek technical assistance with OHA to determine the nature of the provider capacity data issues and take corrective action, as necessary.	
Secret Shopper Survey		
	**Strength:** Of the total secret shopper survey responsive cases, 96.0 percent of the PCD offices and 93.8 percent of the PCP offices confirmed the location.	
	**Weakness:** The total secret shopper survey response rate was 88.1 percent across all PCP and PCD cases. Of the total responsive cases, 43.9 percent of the offices offered the requested services, 31.6 percent accepted OHP, 24.5 percent accepted PCS-Lane, and 18.1 percent accepted new patients. While 96.0 percent of the PCD cases offered the requested services, the percentage of PCP offices offering the requested services was only 33.8 percent. **Why the weakness exists:** In addition to limitations related to the secret shopper approach, the accuracy of PCS-Lane's provider data may have contributed to the low accuracy results. **Recommendations:** HSAG recommends that PCS-Lane use the case-level analytic data files to address the data deficiencies identified during the secret shopper survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
	**Weakness:** Of the secret shopper survey responsive cases, only 13.1 percent of the PCP cases and 0.0 percent of the PCD cases resulted in an appointment. **Why the weakness exists:** In addition to limitations related to the secret shopper approach, the accuracy of PCS-Lane's provider data may have contributed to the low appointment availability rate. **Recommendations:** HSAG recommends that PCS-Lane confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. PCS-Lane should use the case-level analytic data files containing data deficiencies identified during the secret shopper survey calls.	

Strength/ Weakness	Description	Domain(s)[5-22]
Revealed Telephone Survey		
−	**Weakness:** Overall, 25.0 percent of the revealed telephone survey total sampled cases were reached, of which 15, or 24.6 percent, refused to participate in the survey. Of the total responsive cases, 70.5 percent of the offices confirmed the location; 42.6 percent offered the requested specialty, accepted OHP, and accepted PCS-Lane; 34.4 percent accepted new patients; and 76.9 percent offered translation or interpreter services. **Why the weakness exists:** In addition to limitations related to the revealed telephone approach, the accuracy of PCS-Lane's provider data may have contributed to the low response rate and accuracy results. **Recommendations:** HSAG recommends that PCS-Lane use the case-level analytic data files to address the data deficiencies identified during the revealed telephone survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, program information, and translation/interpreter services offered).	
−	**Weakness:** Of the sampled cases, only 6.6 percent of the revealed telephone survey respondents offered a new patient appointment, while only 9.0 percent of survey respondents offered an appointment for an existing patient. Of the total cases that offered an appointment, 78.9 percent of routine appointments and 31.6 percent of urgent appointments were within the wait time compliance standard. **Why the weakness exists:** In addition to limitations related to the revealed telephone approach, the accuracy of PCS-Lane's provider data may have contributed to the low appointment availability rate. Additionally, internal office staffing structures and procedures may have contributed to the long wait times. **Recommendations:** HSAG recommends that PCS-Lane confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. PCS-Lane should use the case-level analytic data files containing data deficiencies identified during the revealed telephone survey calls and work with BH outpatient offices to identify the root cause for delays in appointment availability.	
Encounter Data Validation		
+	**Strength:** The PCS-Lane-submitted data exhibited high record-level data completeness, with low record omission and surplus rates.	
+	**Strength:** Among records that could be matched between the two data sources, a high level of element accuracy (i.e., data elements from both sources had the same values when populated) was exhibited across all evaluated key data elements.	

Strength/ Weakness	Description	Domain(s)[5-22]
+	**Strength:** The PCS-Lane-submitted data had high all-element accuracy for all evaluated key data elements, indicating that the values (missing or non-missing) in both data sources (PCS-Lane and OHA) were the same for almost all records.	
−	**Weakness:** The *Rendering Provider NPI* showed that information was present in the OHA-submitted data but not in the PCS-Lane-submitted data. **Why the weakness exists:** More than 99.9 percent of the *Rendering Provider NPI* values in the OHA-submitted data, not found in the PCS-Lane-submitted data, had the same values as the *Billing Provider NPI*. This discrepancy is likely a result of the data processing approach in OHA's MMIS. In OHA's MMIS, if the *Rendering Provider NPI* value is not submitted, the system populates the value with the *Billing Provider NPI* value. Consequently, when comparing this data element across the two sources, the *Rendering Provider NPI* is present in the OHA-submitted data but not in the PCS-Lane-submitted data. **Recommendations:** While encounter submission to OHA did not require the inclusion of the *Rendering Provider NPI* value if it matched the *Billing Provider NPI* value, the data request for the EDV comparative analysis had different requirements. To address this, HSAG recommends that PCS-Lane and its subcontractor(s) ensure that values for both *Billing Provider NPI* and *Rendering Provider NPI* are included in the data submission, irrespective of their equivalence. This adjustment will enhance the accuracy and completeness of the comparative analysis data. Additionally, it will provide HSAG with the means to verify and ensure the accuracy of the MMIS' process of populating the *Rendering Provider NPI* with the *Billing Provider NPI*.	
Mental Health Parity Evaluation		
−	**Weakness:** PCS-Lane was partially compliant with the Pharmacy Management—Formulary Design NQTL requirement. **Why the weakness exists:** PCS-Lane did not provide its rationale for the assignment of the NQTL (i.e., prescription drug formulary), procedures used for the development of the formulary (e.g., individuals involved in formulary development, professional guidelines used, and how often the formulary is reviewed and updated or by whom), or how frequently or strictly the NQTL is applied (e.g., ability of the provider to request an exception). **Recommendations:** PCS-Lane should identify processes, strategies, evidentiary standards, and other factors that are used in formulary design and the application for prescription drugs.	
−	**Weakness:** PCS-Lane was partially compliant with the Pharmacy Management—Prescription Drug Benefit Tiers NQTL requirement.	

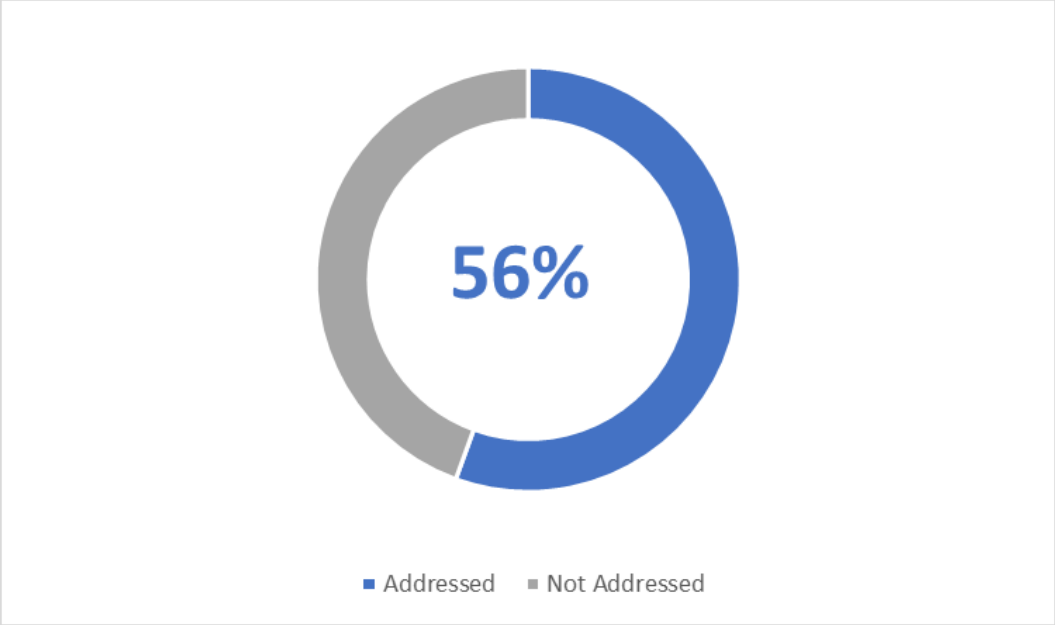
Strength/ Weakness	Description	Domain(s)[5-22]
	Why the weakness exists: PCS-Lane did not provide its rationale for the assignment of the NQTL (i.e., formulary drug tiering), procedures related to formulary tiering (e.g., individuals involved, factors used to determine tier placement, or professional guidelines used), or how frequently or strictly the NQTL is applied (e.g., decision making process). **Recommendations:** PCS-Lane should identify processes, strategies, evidentiary standards, and other factors that are used in formulary tiering.	
−	**Weakness:** PCS-Lane showed substantial differences in the percentage of paid, out-of-network MH/SUD IP and OP claims compared to M/S IP and OP claims. Although the difference in the percentage of paid claims may be legitimate, it may also highlight procedural or network differences, indicating potential barriers for members accessing MH/SUD services. **Why the weakness exists:** Out-of-network IP and OP MH/SUD claims were paid less frequently than M/S claims. **Recommendations:** PCS-Lane should review out-of-network claim denials to understand the factors affecting the lower percentage of paid MH/SUD OP claims compared to M/S OP claims. PCS-Lane should assess whether any barriers exist for members accessing MH/SUD services, including the need to seek services outside of the CCO's network (e.g., appointment availability).	

Follow-Up on Prior Year Recommendations

HSAG evaluated PCS-Lane's approach to addressing the recommendations and/or findings issued during CY 2022 and unresolved findings from CY 2020 and CY 2021 while conducting the CY 2023 EQR activities. The CCOs not addressing findings and recommendations are at risk of being out of compliance with their contracts.

Figure 5-22 illustrates the degree in which the CCO sufficiently addressed the recommendations for QI made by HSAG during the CY 2022 EQR.

Figure 5-22—Percentage of CY 2022 EQR Recommendations Addressed by PCS-Lane



PCS-Lane-specific CY 2022 recommendations and follow-up CY 2023 assessments are summarized in Table 5-22.

Table 5-22—Assessment of PCS-Lane's Approach to Addressing Previous Annual Recommendations

CY 2022 Recommendation	CY 2023 Assessment
Compliance Monitoring Review	
Standard I—Availability of Services	
This recommendation was initially given during the CY 2021 EQR. PCS-Lane should ensure policies as well as provider and member facing materials include accurate information related to information related to direct access for female members to a women's health specialist and access to out-of-network services when the CCO is unable to provide the services. The CCO should also ensure its member handbook and provider manual include correct specialty BH care time frames. Finally, the CCO should ensure monitoring mechanisms include monitoring of BH and oral health access and fully comply with all State requirements for appointment availability, including oversight of subcontractors.	**PCS-Lane did not sufficiently address the recommendation.** PCS-Lane implemented processes to monitor its provider network and take corrective actions when providers failed to meet network access standards. The CCO also revised policies as well as provider- and member-facing materials to include correct appointment time frames and access to out-of-network services. However, PCS-Lane's provider manual continued to include language that limited access to a women's health specialist to an annual gynecological exam. PCS-Lane should ensure its provider manual includes accurate information related to female access to a women's health specialist.

CY 2022 Recommendation	CY 2023 Assessment
Standard II—Assurances of Adequate Capacity and Services	
This recommendation was initially given during the CY 2021 EQR. PCS-Lane should revise its policies to include the CCO's methodology for monitoring based on the expected utilization of services.	**PCS-Lane sufficiently addressed the recommendation.** Documentation reviewed during the CY 2023 CMR activity demonstrated compliance with the standard.
Standard III—Coordination and Continuity of Care	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard IV—Coverage and Authorization of Services	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard V—Provider Selection	
This recommendation was initially given during the CY 2021 EQR. PCS-Lane should implement an effective credentialing program that includes recredentialing of providers no less than every three years and oversight of its subcontractors.	**PCS-Lane sufficiently addressed the recommendation.** Documentation reviewed during the CY 2023 CMR activity demonstrated compliance with the standard.
Standard VI—Subcontractual Relationships and Delegation	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard VII—Member Rights and Protections	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard VIII—Confidentiality	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard IX—Enrollment and Disenrollment	
PCS-Lane should revise its policies and procedures, member-facing documents, and training provided to staff to align with federal and State requirements.	**PCS-Lane sufficiently addressed the recommendation.** Documentation reviewed during the CY 2023 CMR activity demonstrated compliance with the standard.
Standard X—Grievance and Appeal Systems	
This standard was not assessed during the 2022 CMR.	Not applicable.

CY 2022 Recommendation	CY 2023 Assessment
Standard XI—Practice Guidelines	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard XII—Quality Assessment and Performance Improvement	
PCS-Lane should revise its QAPI program structure to align with federal and State requirements for a QAPI program, including an annual written evaluation of the QAPI program and member care**.**	**PCS-Lane sufficiently addressed the recommendation.** Documentation reviewed during the CY 2023 CMR activity demonstrated compliance with the standard.
Standard XIII—Health Information Systems, including ISCA	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard XIV—Member Information	
This standard was not assessed during the 2022 CMR.	Not applicable.
Performance Improvement Projects	
Statewide Mental Health Service Access Monitoring PIP	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Statewide Substance Use Disorder PIP	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Performance Measure Validation	
This recommendation was initially given during the CY 2021 EQR. PCS-Lane should continue to monitor key performance measure rates in alignment with its QAPI goals and objectives. For all key measures that fall below established performance or improvement thresholds, PCS-Lane should conduct root cause analyses to identify specific factors affecting performance. Once identified, targeted interventions should be developed, implemented, and evaluated to ensure effective improvement strategies are adopted to increase performance over time. Additionally, PCS-Lane should continue to monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches to	**PCS-Lane did not provide a response or supporting documentation to address the recommendation.**

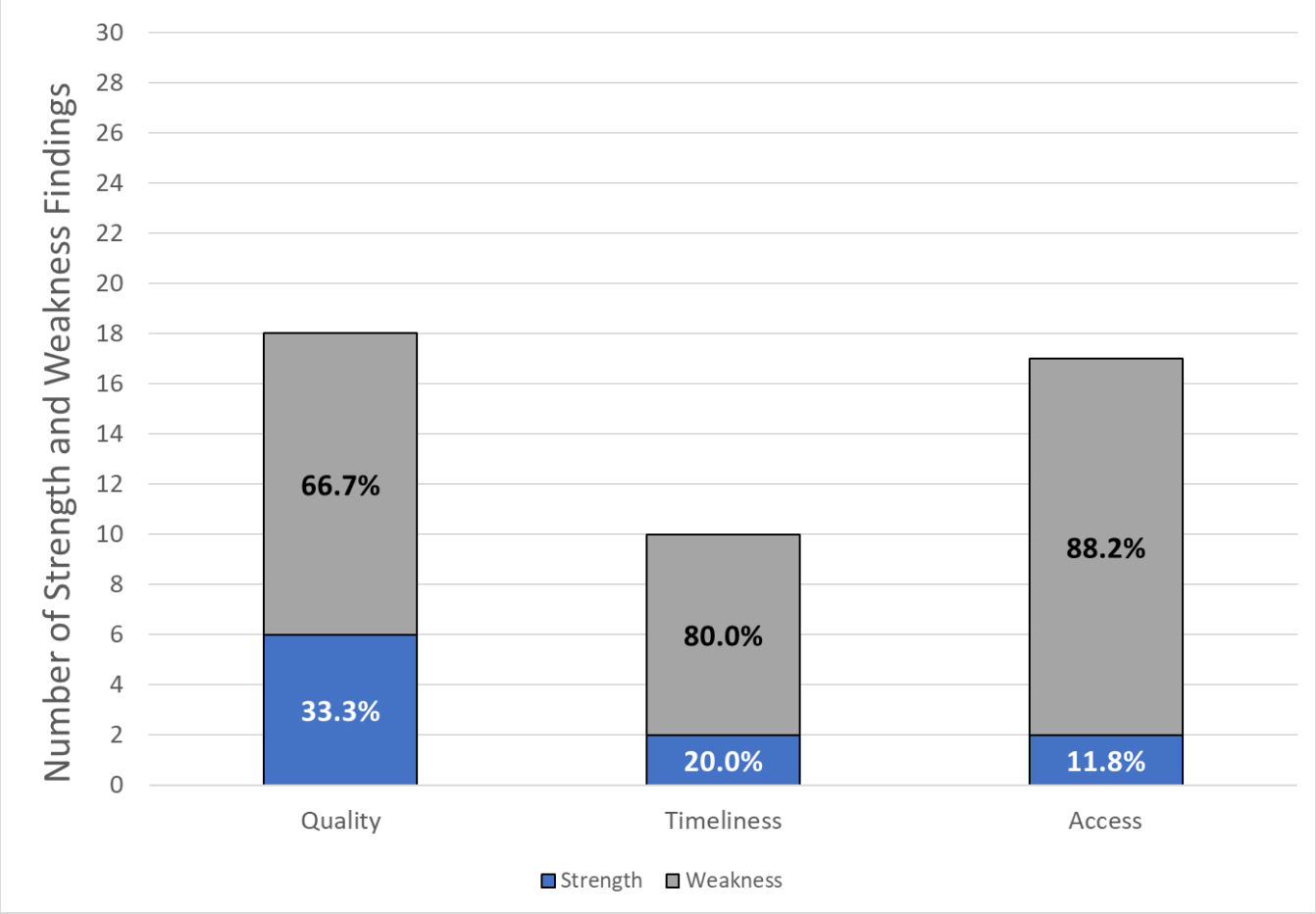
CY 2022 Recommendation	CY 2023 Assessment
ensuring the quality, timeliness, and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	
Validation of Network Adequacy	
This recommendation was initially given during the CY 2021 EQR. PCS-Lane should implement mechanisms to monitor provider directory accuracy and appointment availability.	**PCS-Lane did not provide a response or supporting documentation to address the recommendation.**
This recommendation was initially given during the CY 2021 EQR. PCS-Lane should identify the nature of the HPSY data error, correct it, and assess the rest of its provider data for similar incorrect categorizations.	**PCS-Lane sufficiently addressed the recommendation.** PCS-Lane conducted an audit across its Business Intelligence, Provider Network Analytics, and Provider Operations teams to reclassify providers that were incorrectly coded, and data submitted for Q1 2023 provided evidence of implementation.
Encounter Data Validation	
PCS-Lane should investigate the root cause for the omissions and consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews would then be provided to providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.	**PCS-Lane did not provide a response or supporting documentation to address the recommendation.**
Mental Health Parity Evaluation	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.

PacificSource Community Solutions–Marion Polk

Results and Conclusions

HSAG assessed the strengths and weaknesses of each CCO with respect to the quality, timeliness, and accessibility of health care services. Figure 5-23 illustrates the number of strengths exhibited by PCS-MP relative to the number of weaknesses identified during the CY 2023 EQR activities across the three domains. The greater the proportion of weaknesses, the greater opportunities for improvement.

Figure 5-23—PCS-MP Overall Number of Findings (Strengths and Weaknesses) by Domain



Detailed results from the EQR's substantive findings are summarized in Table 5-23 for each activity. This table highlights the extent to which PCS-MP furnishes high quality, timely, and appropriate access to health care services, and recommendations for how PCS-MP can best address issues identified for each activity.[5-23]

[5-23] See Section 4—Comparative Statewide Results for detailed, CCO-specific scores associated with EQR activity.

Table 5-23—PCS-MP Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)[5-24]
Compliance Monitoring Review		
−	**Weakness:** PCS-MP received a score of 88.9 percent in Standard III—Coordination and Continuity of Care due to a lack of operational structure and failure to appropriately assess/reassess members of prioritized populations and members for care coordination services. **Why the weakness exists:** PCS-MP's policies and procedures did not align with State requirements. Additionally, PCS-MP failed to demonstrate a streamlined method of assessing and reassessing members and updating the care plan within the appropriate time frame for members enrolled in ICC. **Recommendations:** PCS-MP must revise its policies and procedures to align with State requirements. PCS-MP must also demonstrate implementation of appropriate assessments, reassessments, and revision of treatment plans according to federal and State requirements.	
−	**Weakness:** PCS-MP received a score of 75.0 percent in Standard IV—Coverage and Authorization of Services due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting PCS-MP's ability to ensure the appropriate services and coverage are offered to members. **Why the weakness exists:** PCS-MP's policies and procedures did not align with federal and State requirements. Additionally, PCS-MP failed to demonstrate mechanisms for ensuring the services offered by the CCO are appropriate. PCS-MP also failed to adhere to requirements for the appropriate decision-makers, proper outreach to obtain information needed to process authorization requests, and time frames for notification of adverse benefit determinations. **Recommendations:** PCS-MP must revise its policies and procedures to align with federal and State requirements. PCS-MP must also demonstrate the implementation of appropriate service offerings. PCS-MP must also demonstrate proper outreach to retrieve the information needed to process service authorization requests and adhere to federal and State required time frames for notification of adverse benefit determinations.	
−	**Weakness:** PCS-MP received a score of 70.0 percent in Standard VII—Member Rights and Protections due to a lack of operational structure and failure to demonstrate implementation of an established process, impacting PCS-MP's ability to ensure that member rights are respected and allowed to be exercised freely without affecting the treatment of	

[5-24] = Quality, = Timeliness, = Access

Strength/ Weakness	Description	Domain(s)[5-24]
	members and that members are notified of their rights as required by federal and State requirements. **Why the weakness exists:** PCS-MP's policies and procedures and member- and provider-facing materials did not align with federal and State requirements. **Recommendations:** PCS-MP must revise its policies and procedures and member- and provider-facing materials to align with federal and State requirements.	
−	**Weakness:** PCS-MP received a score of 88.9 percent in Standard X—Grievance and Appeal Systems due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting PCS-MP's ability to ensure member grievances and appeals are addressed and responded to appropriately. **Why the weakness exists:** PCS-MP's policies and procedures did not align with federal and State requirements. PCS-MP also failed to adhere to requirements for the appropriate decision-makers on grievances and appeals, maintenance of an expedited process, and time frames for acknowledging and resolving grievances and/or appeals. PCS-MP also failed to communicate grievance and/or appeal requirements to providers and subcontractors. **Recommendations:** PCS-MP must revise its policies and procedures to align with federal and State requirements. PCS-MP must also adhere to federal and State requirements for the appropriate decision-makers on grievances and appeals, maintenance of an expedited process for appeals, and time frames for acknowledging and resolving grievances and appeals. PCS-MP must also demonstrate implementation of federal and State requirements within communications to providers and subcontractors.	
−	**Weakness:** PCS-MP received a score of 90.9 percent in Standard XIV—Member Information due to deficiencies in its operational structure and failure to demonstrate implementation of an established process, impacting PCS-MP's ability to ensure timely and proper member communication. **Why the weakness exists:** PCS-MP's policies and procedures and member-facing materials, including the member handbook and provider directory, did not align with federal and State requirements. Additionally, PCS-MP did not provide proper notification to members of the availability of member information. **Recommendations:** PCS-MP must revise its policies, procedures, and member-facing materials to align with federal and State requirements. PCS-MP must also notify members of the availability of member information.	

Strength/ Weakness	Description	Domain(s)[5-24]
−	**Weakness:** PCS-MP received a score of 87.5 percent in Standard XVI—Emergency and Poststabilization Services due to failure to demonstrate implementation of appropriate processes and workflows, impacting PCS-MP's ability to ensure emergency and poststabilization services are covered appropriately. **Why the weakness exists:** PCS-MP failed to demonstrate evidence of processes to ensure payment of emergency and poststabilization services. **Recommendations:** PCS-MP must demonstrate evidence of processes to ensure payment of emergency and poststabilization services.	
Performance Improvement Projects		
Statewide Mental Health Service Access Monitoring PIP		
−	**Weakness:** PCS-MP's reported indicator results did not demonstrate improvement or statistically significant improvement over the baseline across all performance indicators. **Why the weakness exists:** The indicator results demonstrated a decline in performance from baseline to RY 1. **Recommendations:** PCS-MP should revisit root cause analyses identifying barriers to improving access to MH services to determine which barriers to improvement were not effectively addressed. PCS-MP should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to improve indicator results.	
Statewide Substance Use Disorder PIP		
+	**Strength:** PCS-MP successfully initiated the Implementation stage for the PIP, receiving a *Met* score for 100 percent of applicable evaluation elements in the PIP validation tool. In the Implementation stage, PCS-MP accurately reported baseline performance indicator data; identified and analyzed barriers for initiation, engagement, and treatment of alcohol and other drug use disorders; and began to carry out interventions to address those barriers.	
Performance Measure Validation		
+	**Strength:** PCS-MP's MY 2022 performance for members ages 6 to 14 years receiving preventive dental or oral health services improved by more than 5 percentage points compared to MY 2021 (5.9 percentage points). The CCO's performance on the *Members Receiving Preventive Dental or Oral Health Services—Ages 1 to 5 Years* and *Ages 6 to 14 Years* measure demonstrated ongoing improvement for both age groups since MY 2020. In addition, the CCO's MY 2022 rates in both age groups exceeded the 2020 CCO 75th percentile benchmark set by OHA	

Strength/ Weakness	Description	Domain(s)[5-24]
	for MY 2022 by 5 percentage points or more, and the rate for the *Ages 6 to 14 Years* measure indicator also exceeded the statewide aggregate.	
Validation of Network Adequacy		
Delivery System Network Evaluation		
+	**Strength:** PCS-MP demonstrated full compliance with all elements of the DSN Provider Narrative, showing a high degree of competency in its network adequacy processes, narrative responses, documentation, and overall organization of the deliverable submission.	
+	**Strength:** PCS-MP described and demonstrated sophisticated collection and use of member and provider information to support network adequacy monitoring and decision-making by both strategic bodies and smaller "front line" teams.	
−	**Weakness:** PCS-MP's global reporting of almost all provider data did not allow for a full assessment of the network available to members within specific CCOs. **Why the weakness exists:** With the exception of PCPs, all providers and their statuses were reported globally and were identical for all PCS CCOs, including but not limited to active status and accepting new patients status. Most providers were shown as operating outside of PCS-MP's service area. **Recommendations:** PCS-MP should seek technical assistance with OHA to determine the nature of the provider capacity data issues and take corrective action, as necessary.	
Secret Shopper Survey		
−	**Weakness:** The total secret shopper survey response rate was 75.5 percent across all PCP and PCD cases. Of the total responsive cases, 86.7 percent of the offices confirmed the location, 44.2 percent of the offices offered the requested services, 33.3 percent accepted OHP, 23.3 percent accepted PCS-MP, and 16.7 percent accepted new patients. **Why the weakness exists:** In addition to limitations related to the secret shopper approach, the accuracy of PCS-MP's provider data may have contributed to the low accuracy results. **Recommendations:** HSAG recommends that PCS-MP use the case-level analytic data files to address the data deficiencies identified during the secret shopper survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
−	**Weakness:** Of the total secret shopper survey responsive cases, only 11.7 percent resulted in an appointment. Of the cases that offered an	

Strength/ Weakness	Description	Domain(s)[5-24]
	appointment, 28.6 percent were within the wait time compliance standard. **Why the weakness exists:** In addition to limitations related to the secret shopper approach, the accuracy of PCS-MP's provider data may have contributed to the low appointment availability rate. Additionally, internal office procedures may have contributed to the long wait times. **Recommendations:** HSAG recommends that PCS-MP confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. PCS-MP should use the case-level analytic data files containing data deficiencies identified during the secret shopper survey calls.	
Revealed Telephone Survey		
−	**Weakness:** Overall, 41.4 percent of the revealed telephone survey total sampled cases were reached, of which one, or 1.4 percent, refused to participate in the survey. Of the total responsive cases, 51.4 percent of the offices offered the requested specialty, 51.4 percent accepted OHP, 50.0 percent accepted PCS-MP, 27.8 percent accepted new patients, and 69.4 percent offered translation or interpreter services. **Why the weakness exists:** In addition to limitations related to the revealed telephone approach, the accuracy of PCS-MP's provider data may have contributed to the low response rate and accuracy results. **Recommendations:** HSAG recommends that PCS-MP use the case-level analytic data files to address the data deficiencies identified during the revealed telephone survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, program information, and translation/interpreter services offered).	
−	**Weakness:** Of the sampled cases, only 5.7 percent of the revealed telephone survey respondents offered a new patient appointment, while only 14.9 percent of survey respondents offered an appointment for an existing patient. Of the total cases that offered an appointment, 69.4 percent of routine appointments and 46.9 percent of urgent appointments were within the wait time compliance standard. **Why the weakness exists:** In addition to limitations related to the revealed telephone approach, the accuracy of PCS-MP's provider data may have contributed to the low appointment availability rate. Additionally, internal office staffing structures and procedures may have contributed to the long wait times. **Recommendations:** HSAG recommends that PCS-MP confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. PCS-MP should use the case-level analytic data files containing data deficiencies identified	

Strength/ Weakness	Description	Domain(s)[5-24]
	during the revealed telephone survey calls and work with BH outpatient offices to identify the root cause for delays in appointment availability.	
Encounter Data Validation		
	**Strength:** PCS-MP-submitted data exhibited high record-level data completeness, with low record omission and surplus rates.	
	**Strength:** Among records that could be matched between the two data sources, a high level of element accuracy (i.e., data elements from both sources had the same values when populated) was exhibited across all evaluated key data elements.	
	**Strength:** PCS-MP-submitted data had high all-element accuracy for all evaluated key data elements, indicating that the values (missing or non-missing) in both data sources (PCS-MP and OHA) were the same for almost all records.	
	**Weakness:** The *Rendering Provider NPI* showed that information was present in the OHA-submitted data but not in the PCS-MP-submitted data. **Why the weakness exists:** More than 99.9 percent of the *Rendering Provider NPI* values in the OHA-submitted data, not found in the PCS-MP-submitted data, had the same values as the *Billing Provider NPI*. This discrepancy is likely a result of the data processing approach in OHA's MMIS. In OHA's MMIS, if the *Rendering Provider NPI* value is not submitted, the system populates the value with the *Billing Provider NPI* value. Consequently, when comparing this data element across the two sources, the *Rendering Provider NPI* is present in the OHA-submitted data but not in the PCS-MP-submitted data. **Recommendations:** While encounter submission to OHA did not require the inclusion of the *Rendering Provider NPI* value if it matched the *Billing Provider NPI* value, the data request for the EDV comparative analysis had different requirements. To address this, HSAG recommends that PCS-MP and its subcontractor(s) ensure that values for both *Billing Provider NPI* and *Rendering Provider NPI* are included in the data submission, irrespective of their equivalence. This adjustment will enhance the accuracy and completeness of the comparative analysis data. Additionally, it will provide HSAG with the means to verify and ensure the accuracy of the MMIS' process of populating the *Rendering Provider NPI* with the *Billing Provider NPI*.	
Mental Health Parity Evaluation		
	**Weakness:** PCS-MP was partially compliant with the Pharmacy Management—Formulary Design NQTL requirement. **Why the weakness exists:** PCS-MP did not provide its rationale for the assignment of the NQTL (i.e., prescription drug formulary), procedures	

Strength/ Weakness	Description	Domain(s)[5-24]
	used for the development of the formulary (e.g., individuals involved in formulary development, professional guidelines used, and how often the formulary is reviewed and updated or by whom), or how frequently or strictly the NQTL is applied (e.g., ability of the provider to request an exception). **Recommendations:** PCS-MP should identify processes, strategies, evidentiary standards, and other factors that are used in formulary design and the application for prescription drugs.	
−	**Weakness:** PCS-MP was partially compliant with the Pharmacy Management—Prescription Drug Benefit Tiers NQTL requirement. **Why the weakness exists:** PCS-MP did not provide its rationale for the assignment of the NQTL (i.e., formulary drug tiering), procedures related to formulary tiering (e.g., individuals involved, factors used to determine tier placement, or professional guidelines used), or how frequently or strictly the NQTL is applied (e.g., decision making process). **Recommendations:** PCS-MP should identify processes, strategies, evidentiary standards, and other factors that are used in formulary tiering.	
−	**Weakness:** PCS-MP showed moderate differences in the percentage of paid, out-of-network MH/SUD OP claims compared to M/S OP claims. Although differences in the percentage of paid claims may be legitimate, they may also highlight procedural or network differences indicating potential barriers to members' access to MH/SUD services. **Why the weakness exists:** Out-of-network OP MH/SUD claims were paid less frequently than M/S claims. **Recommendations:** PCS-MP should review out-of-network claim denials to understand factors affecting the lower percentage of paid MH/SUD OP claims compared to M/S OP claims. PCS-MP should assess whether any barriers exist for members accessing MH/SUD services, including the need to seek services outside of the CCO's network (e.g., appointment availability).	

Follow-Up on Prior Year Recommendations

HSAG evaluated PCS-MP's approach to addressing the recommendations and/or findings issued during CY 2022 and unresolved findings from CY 2020 and CY 2021 while conducting the CY 2023 EQR activities. The CCOs not addressing findings and recommendations are at risk of being out of compliance with their contracts.

Figure 5-24 illustrates the degree in which the CCO sufficiently addressed the recommendations for QI made by HSAG during the CY 2022 EQR.

Figure 5-24—Percentage of CY 2022 EQR Recommendations Addressed by PCS-MP

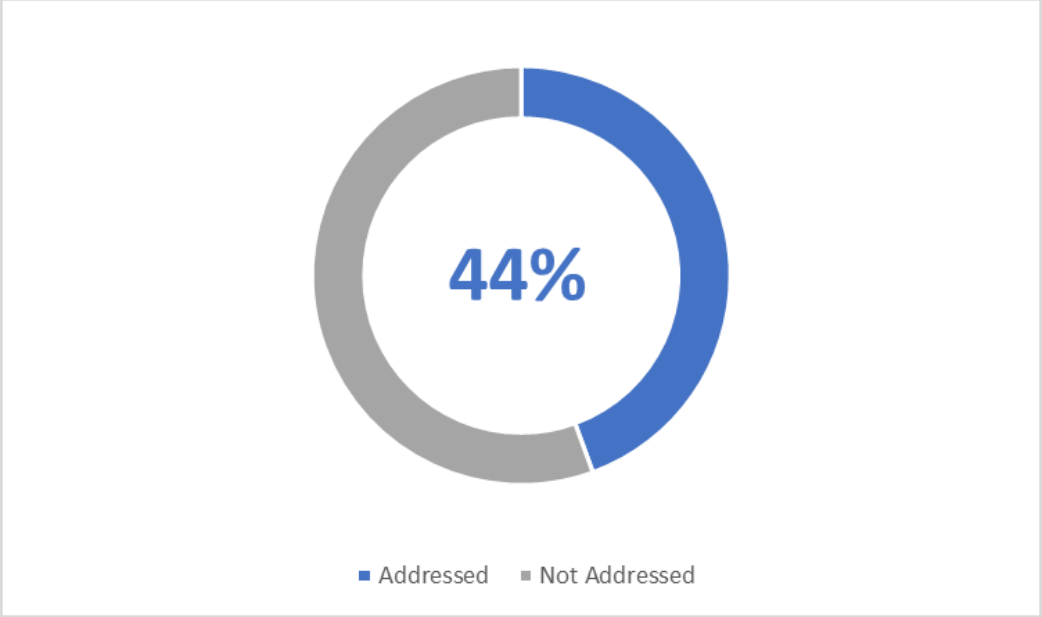


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Table 5-24—Assessment of PCS-MP's Approach to Addressing Previous Annual Recommendations

CY 2022 Recommendation	CY 2023 Assessment
Compliance Monitoring Review	
Standard I—Availability of Services	
This recommendation was initially given during the CY 2021 EQR. PCS-MP should ensure policies as well as provider and member facing materials include accurate information related to information related to direct access for female members to a women's health specialist and access to out-of-network services when the CCO is unable to provide the services. The CCO should also ensure its member handbook and provider manual include correct specialty BH care time frames. Finally, the CCO should ensure monitoring mechanisms include monitoring of BH and oral health access and fully comply with all State requirements for appointment availability, including oversight of subcontractors.	**PCS-MP did not sufficiently address the recommendation.** PCS-MP implemented processes to monitor its provider network and take corrective actions when providers failed to meet network access standards. The CCO also revised policies as well as provider- and member-facing materials to include correct appointment time frames and access to out-of-network services. However, PCS-MP's provider manual continued to include language that limited access to a women's health specialist to an annual gynecological exam. PCS-MP should ensure its provider manual includes accurate information related to female access to a women's health specialist.

CY 2022 Recommendation	CY 2023 Assessment
Standard II—Assurances of Adequate Capacity and Services	
This recommendation was initially given during the CY 2021 EQR. PCS-MP should revise its policies to include the CCO's methodology for monitoring based on the expected utilization of services.	**PCS-MP sufficiently addressed the recommendation.** Documentation reviewed during the CY 2023 CMR activity demonstrated compliance with the standard.
Standard III—Coordination and Continuity of Care	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard IV—Coverage and Authorization of Services	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard V—Provider Selection	
This recommendation was initially given during the CY 2021 EQR. PCS-MP should implement an effective credentialing program that includes recredentialing of providers no less than every three years and oversight of its subcontractors.	**PCS-MP sufficiently addressed the recommendation.** Documentation reviewed during the CY 2023 CMR activity demonstrated compliance with the standard.
Standard VI—Subcontractual Relationships and Delegation	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard VII—Member Rights and Protections	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard VIII—Confidentiality	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard IX—Enrollment and Disenrollment	
PCS-MP should revise its policies and procedures, member-facing documents, and training provided to staff to align with federal and State requirements.	Not applicable.
Standard X—Grievance and Appeal Systems	
This standard was not assessed during the 2022 CMR.	Not applicable.

CY 2022 Recommendation	CY 2023 Assessment
Standard XI—Practice Guidelines	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard XII—Quality Assessment and Performance Improvement	
PCS-MP should revise its QAPI program structure to align with federal and State requirements for a QAPI program, including an annual written evaluation of the QAPI program and member care.	**PCS-MP sufficiently addressed the recommendation.** Documentation reviewed during the CY 2023 CMR activity demonstrated compliance with the standard.
Standard XIII—Health Information Systems, including ISCA	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard XIV—Member Information	
This standard was not assessed during the 2022 CMR.	Not applicable.
Performance Improvement Projects	
Statewide Mental Health Service Access Monitoring PIP	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Statewide Substance Use Disorder PIP	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Performance Measure Validation	
This recommendation was initially given during the CY 2021 EQR. PCS-MP should continue to monitor key performance measure rates in alignment with its QAPI goals and objectives. For all key measures that fall below established performance or improvement thresholds, PCS-MP should conduct root cause analyses to identify specific factors affecting performance. Once identified, targeted interventions should be developed, implemented, and evaluated to ensure effective improvement strategies are adopted to increase performance over time. Additionally, PCS-MP should continue to monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches to ensuring the quality,	**PCS-MP did not provide a response or supporting documentation to address the recommendation.**

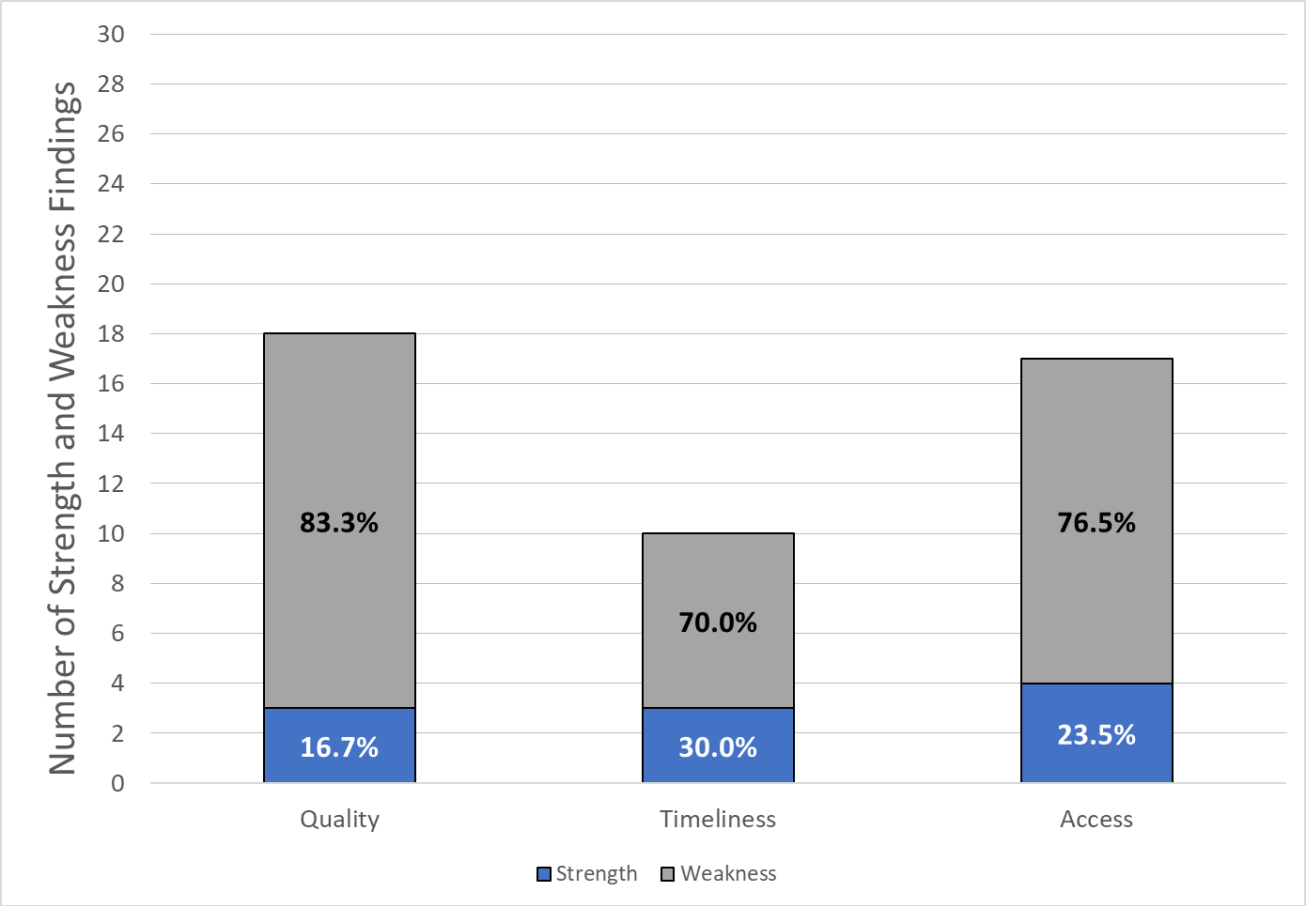
CY 2022 Recommendation	CY 2023 Assessment
timeliness, and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	
Validation of Network Adequacy	
This recommendation was initially given during the CY 2021 EQR. PCS-MP should implement mechanisms to monitor provider directory accuracy and appointment availability.	**PCS-MP did not provide a response or supporting documentation to address the recommendation.**
This recommendation was initially given during the CY 2021 EQR. PCS-MP should identify the nature of the HPSY data error, correct it, and assess the rest of its provider data for similar incorrect categorizations.	**PCS-MP sufficiently addressed the recommendation.** PCS-MP conducted an audit across its Business Intelligence, Provider Network Analytics, and Provider Operations teams to reclassify providers that were incorrectly coded, and data submitted for Q1 2023 provided evidence of implementation.
Encounter Data Validation	
PCS-MP should ensure its contracted providers' accountability in responding to medical record requests for the purposes of auditing, inspection, and oversight. HSAG recommends PCS-MP consider strengthening and/or enforcing its contract requirements with its providers in providing the requested documentation.	**PCS-MP did not provide a response or supporting documentation to address the recommendation.**
PCS-MP should investigate the root cause for the omissions and consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews would then be provided to providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.	**PCS-MP did not provide a response or supporting documentation to address the recommendation.**
Mental Health Parity Evaluation	
PCS-MP met performance expectations; no recommendations were provided in 2022.	Not applicable.

Trillium Community Health Plan, Inc.–North

Results and Conclusions

HSAG assessed the strengths and weaknesses of each CCO with respect to the quality, timeliness, and accessibility of health care services. Figure 5-25 illustrates the number of strengths exhibited by TCHP-North relative to the number of weaknesses identified during the CY 2023 EQR activities across the three domains. The greater the proportion of weaknesses, the greater opportunities for improvement.

Figure 5-25—TCHP-North Overall Number of Findings (Strengths and Weaknesses) by Domain



Detailed results from the EQR's substantive findings are summarized in Table 5-25 for each activity. This table highlights the extent to which TCHP-North furnishes high quality, timely, and appropriate access to health care services, and recommendations for how TCHP-North can best address issues identified for each activity.[5-25]

[5-25] See Section 4—Comparative Statewide Results for detailed, CCO-specific scores associated with EQR activity.

Table 5-25—TCHP-North Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)[5-26]
Compliance Monitoring Review		
+	**Strength:** TCHP-North achieved full compliance for Standard XVI—Emergency and Poststabilization Services, demonstrating TCHP-North has policies and procedures and has implemented the appropriate processes and workflows to ensure the emergency and poststabilization services are covered appropriately.	
−	**Weakness:** TCHP-North received a score of 94.4 percent in Standard III—Coordination and Continuity of Care due to failure to appropriately assess/reassess members for care coordination services. **Why the weakness exists:** TCHP-North failed to demonstrate that health risk screenings are conducted appropriately. TCHP-North also failed to demonstrate the appropriate outreach attempts and compliance with state-established time frames for assessing and reassessing members enrolled in ICC. **Recommendations:** TCHP-North must demonstrate implementation of appropriate assessments and reassessments, according to federal and State requirements. TCHP-North must also demonstrate compliance with its policies, specifically for outreach attempts to members for care coordination services.	
−	**Weakness:** TCHP-North received a score of 61.1 percent in Standard IV—Coverage and Authorization of Services due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting TCHP-North's ability to adhere to federal and State requirements for authorizing services, and to ensure proper and timely notification of adverse benefit determinations. **Why the weakness exists:** TCHP-North's policies and procedures did not align with federal and State requirements. Additionally, TCH-North failed to adhere to requirements for the appropriate decision-makers and demonstrated reversing service authorization decisions outside the appeal process. TCHP-North also failed to adhere to requirements for required content and time frames for notification of adverse benefit determinations. **Recommendations:** TCHP-North must revise its policies and procedures to align with federal and State requirements. TCHP-North must also demonstrate the implementation of appropriate service offerings. TCHP-North must also demonstrate proper outreach to retrieve the information needed to process service authorization requests.	

[5-26] = Quality, = Timeliness, = Access

Strength/ Weakness	Description	Domain(s)[5-26]
−	**Weakness:** TCHP-North received a score of 70.0 percent in Standard VII—Member Rights and Protections due to a lack of operational structure and failure to demonstrate implementation of an established process, impacting TCHP-North's ability to ensure that member rights are respected and allowed to be exercised freely without affecting the treatment of members and that members are notified of their rights as required by federal and State requirements. **Why the weakness exists:** TCHP-North's policies and procedures and member- and provider-facing materials did not align with federal and State requirements. **Recommendations:** TCHP-North must revise its policies and procedures and member- and provider-facing materials to align with federal and State requirements.	
−	**Weakness:** TCHP-North received a score of 85.2 percent in Standard X—Grievance and Appeal Systems due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting TCHP-North's ability to ensure member grievances and appeals are addressed and responded to appropriately. **Why the weakness exists:** TCHP-North's policies and procedures did not align with federal and State requirements. TCHP-North failed to adhere to required content within resolution notices and time frames for acknowledging and resolving grievances and/or appeals. TCHP-North also failed to communicate grievance and/or appeal requirements to staff, members, providers, and subcontractors. **Recommendations:** TCHP-North must revise its policies and procedures to align with federal and State requirements. TCHP-North must adhere to federal and State requirements for content in resolution notices and time frames for acknowledging and resolving grievances and appeals. TCHP-North must also demonstrate implementation of federal and State requirements within communications to staff, members, providers, and subcontractors.	
−	**Weakness:** TCHP-North received a score of 77.3 percent in Standard XIV—Member Information due to a lack of operational structure and failure to demonstrate implementation of an established process, impacting TCHP-North's ability to ensure timely and proper member communication. **Why the weakness exists:** TCHP-North's policies and procedures and member-facing materials (i.e., the member handbook, member notices, and provider directory) did not align with federal and State requirements. Additionally, TCHP-North failed to track and monitor the timely provision of required member information. **Recommendations:** TCHP-North must revise its policies, procedures, and member-facing materials to align with federal and State	

Strength/ Weakness	Description	Domain(s)[5-26]
	requirements. Additionally, TCHP-North must track and monitor the timely provision of required member information.	
Performance Improvement Projects		
Statewide Mental Health Service Access Monitoring PIP		
−	**Weakness:** TCHP-North's reported indicator results did not demonstrate any improvement over baseline performance. **Why the weakness exists:** The indicator results demonstrated a decline in performance from baseline to RY 1. **Recommendations:** TCHP-North should revisit root cause analyses identifying barriers to improving access to MH services to determine which barriers to improvement were not effectively addressed. TCHP-North should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to improve indicator results.	
Statewide Substance Use Disorder PIP		
+	**Strength:** TCHP-North successfully initiated the Implementation stage for the PIP, receiving a *Met* score for 100 percent of applicable evaluation elements in the PIP validation tool. In the Implementation stage, TCHP-North accurately reported baseline performance indicator data; identified and analyzed barriers for initiation, engagement, and treatment of alcohol and other drug use disorders; and began to carry out interventions to address those barriers.	
Performance Measure Validation		
+	**Strength:** TCHP-North's MY 2022 performance for members ages 1 to 5 years receiving preventive dental or oral health services improved by more than 5 percentage points compared to MY 2021 (7.5 percentage points).	
−	**Weakness:** TCHP-North's MY 2022 rate on the *Initiation of SUD Treatment* measure indicator for members ages 18 years and older fell below the 2020 HEDIS national Medicaid median benchmark set by OHA for MY 2022. **Why the weakness exists:** TCHP-North's performance on this measure indicator suggests there are barriers impacting efforts to initiate treatment for members diagnosed with SUD. **Recommendations:** TCHP-North should conduct root cause analyses to identify specific factors affecting performance on this measure and develop, implement, and evaluate targeted interventions to ensure improvement strategies are adopted. Additionally, TCHP-North should monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches for ensuring the	

Strength/ Weakness	Description	Domain(s)[5-26]
	timeliness and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	
Validation of Network Adequacy		
Delivery System Network Evaluation		
	**Strength:** TCHP-North showed substantial improvement in the overall quality and completeness of its DSN Provider Narrative Template responses and documentation, continuing a trend from the CY 2021 DSN Evaluation. This allowed for a fuller understanding and more accurate evaluation of its network adequacy processes and status. TCHP-North's continued improvement was due in part to TCHP-North's responsivity to feedback as well as proactive outreach for technical assistance.	
	**Weakness:** TCHP-North showed potential issues within its provider data, including but not limited to provider counts and status of accepting new patients. **Why the weakness exists:** TCHP-North's provider data showed multiple substantial increases and decreases in provider counts between Q2 2022 and Q1 2023, indicating potential data issues, potential barriers to care, or both. With the exception of PCDs, all providers were listed as having 100 percent acceptance of new patients, indicating potential data issues. **Recommendations:** TCHP-North should seek technical assistance with OHA to determine the nature of the provider capacity data issues and correct them.	
	**Weakness:** TCHP-North showed potential data issues and/or barriers to access to primary dental and BH services that were not substantively addressed within its DSN Provider Narrative Template. **Why the weakness exists:** A moderate to low percentage of both MHP and SUD providers were determined to be active in TCHP-North's network within the prior two years. A low percentage of TCHP-North's PCDs were listed as accepting new patients. These results indicated potential data issues, potential barriers to access to care, or both. **Recommendations:** TCHP-North should seek technical assistance with OHA to determine the nature of the provider capacity data issues and correct them.	
Secret Shopper Survey		
	**Weakness:** The total secret shopper survey response rate was 66.7 percent across all PCP and PCD cases. Of the total responsive cases, 59.4 percent of the offices offered the requested services, 48.8 percent accepted OHP, 32.5 percent accepted TCHP-North, and 29.4 percent accepted new patients. However, while 96.2 percent of the	

Strength/ Weakness	Description	Domain(s)[5-26]
	PCD offices confirmed the location, only 80.5 percent of the PCP offices confirmed the location. **Why the weakness exists:** In addition to limitations related to the secret shopper approach, the accuracy of TCHP-North's provider data may have contributed to the low response rate and accuracy results. **Recommendations:** HSAG recommends that TCHP-North use the case-level analytic data files to address the data deficiencies identified during the secret shopper survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
−	**Weakness:** Of the total secret shopper survey responsive cases, only 15.6 percent resulted in an appointment. **Why the weakness exists:** In addition to limitations related to the secret shopper approach, the accuracy of TCHP-North's provider data may have contributed to the low appointment availability rate. **Recommendations:** HSAG recommends that TCHP-North confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. TCHP-North should use the case-level analytic data files containing data deficiencies identified during the secret shopper survey calls.	
Revealed Telephone Survey		
−	**Weakness:** Overall, 38.6 percent of the revealed telephone survey total sampled cases were reached, of which 11, or 16.2 percent, refused to participate in the survey. Of the total responsive cases, 66.2 percent of the offices confirmed the location, 60.3 percent offered the requested specialty, 57.4 percent accepted OHP, 47.1 percent accepted TCHP-North, 38.2 percent accepted new patients, and 75.0 percent offered translation or interpreter services. **Why the weakness exists:** In addition to limitations related to the revealed telephone approach, the accuracy of TCHP-North's provider data may have contributed to the low response rate and accuracy results. **Recommendations:** HSAG recommends that TCHP-North use the case-level analytic data files to address the data deficiencies identified during the revealed telephone survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, program information, and translation/interpreter services offered).	
−	**Weakness:** Of the sampled cases, only 4.5 percent of the revealed telephone survey respondents offered a new patient appointment, while only 6.8 percent of survey respondents offered an appointment for an	

Strength/ Weakness	Description	Domain(s)[5-26]
	existing patient. Of the total cases that offered an appointment, 73.7 percent of routine appointments and 56.3 percent of urgent appointments were within the wait time compliance standard. **Why the weakness exists:** In addition to limitations related to the revealed telephone approach, the accuracy of TCHP-North's provider data may have contributed to the low appointment availability rate. Additionally, internal office staffing structures and procedures may have contributed to the long wait times. **Recommendations:** HSAG recommends that TCHP-North confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. TCHP-North should use the case-level analytic data files containing data deficiencies identified during the revealed telephone survey calls and work with BH outpatient offices to identify the root cause for delays in appointment availability.	
Encounter Data Validation		
+	**Strength:** TCHP-North-submitted data exhibited high record-level data completeness, with low record omission and surplus rates.	
−	**Weakness:** The *Rendering Provider NPI* showed that information was present in the OHA-submitted data but not in the TCHP-North-submitted data. **Why the weakness exists:** More than 99.9 percent of the *Rendering Provider NPI* values in the OHA-submitted data, not found in the TCHP-North-submitted data, had the same values as the *Billing Provider NPI*. This discrepancy is likely a result of the data processing approach in OHA's MMIS. In OHA's MMIS, if the *Rendering Provider NPI* value is not submitted, the system populates the value with the *Billing Provider NPI* value. Consequently, when comparing this data element across the two sources, the *Rendering Provider NPI* is present in the OHA-submitted data but not in the TCHP-North-submitted data. **Recommendations:** While encounter submission to OHA did not require the inclusion of the *Rendering Provider NPI* value if it matched the *Billing Provider NPI* value, the data request for the EDV comparative analysis had different requirements. To address this, HSAG recommends that TCHP-North and its subcontractor(s) ensure that values for both *Billing Provider NPI* and *Rendering Provider NPI* are included in the data submission, irrespective of their equivalence. This adjustment will enhance the accuracy and completeness of the comparative analysis data. Additionally, it will provide HSAG with the means to verify and ensure the accuracy of the MMIS' process of populating the *Rendering Provider NPI* with the *Billing Provider NPI*.	

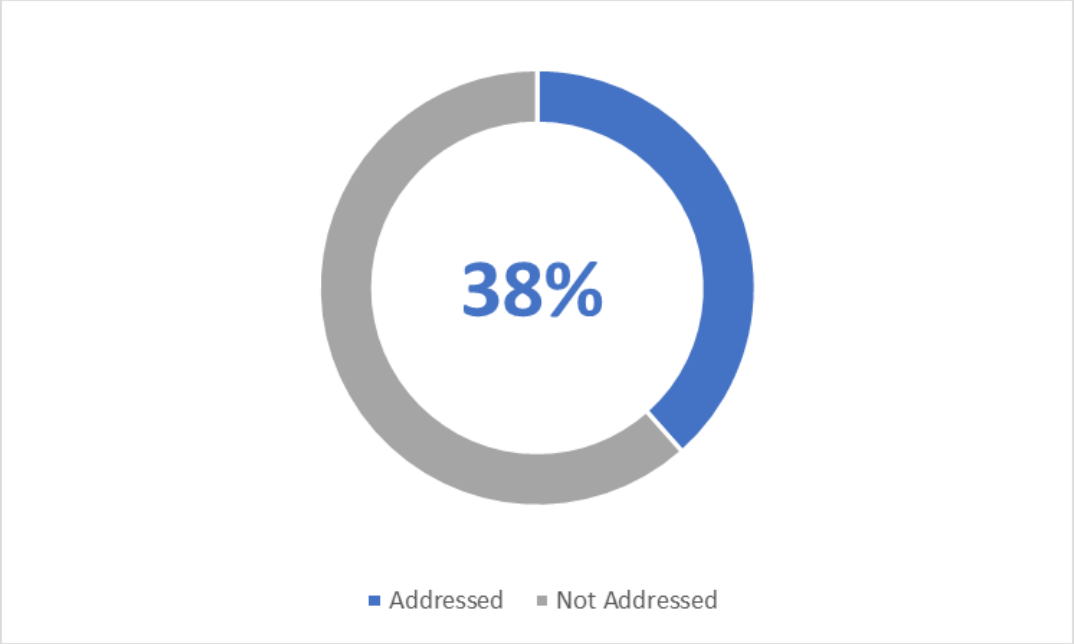
Strength/ Weakness	Description	Domain(s)[5-26]
−	**Weakness:** The all-element accuracy rate was low at 70.6 percent, indicating that nearly 30 percent of records present in both data sources do not have the same values (either missing or non-missing) for all key data elements. This issue is directly related to other identified weaknesses: the high element omission rates for *Tooth Number* and *Tooth Surface 1*, and the low accuracy rates for *CDT Code*, *Tooth Number*, *and Tooth Surface 1* through *Tooth Surface 4.* **Why the weakness exists:** The underlying cause of the issues is related to the CCO-submitted data for Capitol Dental, where misalignment occurred for multiple data elements, leading to inaccurate matching of fields. **Recommendations:** HSAG recommends that TCHP-North implement standardized quality controls to ensure data are accurately aligned in its data extracts from their encounter data system(s). However, it is also important to note that in the data requirements document, HSAG requested data to be extracted from the CCOs' subcontractors' data systems and was anticipating three distinct data extracts from TCHP-North's subcontractors. Instead, TCHP-North stacked all data extracts before submission to HSAG, rather than submitting the raw data extracts directly received from the subcontractors. The stacking of the data caused the misalignment observed in Capitol Dental Care's data. To address this, HSAG suggests submitting the raw data extracts separately, maintaining the integrity of the original data and avoiding misalignments during the stacking process.	
Mental Health Parity Evaluation		
+	**Strength:** TCHP-North achieved full compliance with parity requirements for application of NQTLs applied to MH/SUD and M/S benefits.	

Follow-Up on Prior Year Recommendations

HSAG evaluated TCHP-North's approach to addressing the recommendations and/or findings issued during CY 2022 and unresolved findings from CY 2020 and CY 2021 while conducting the CY 2023 EQR activities. The CCOs not addressing findings and recommendations are at risk of being out of compliance with their contracts.

Figure 5-26 illustrates the degree in which the CCO sufficiently addressed the recommendations for QI made by HSAG during the CY 2022 EQR.

Figure 5-26—Percentage of CY 2022 EQR Recommendations Addressed by TCHP-North



TCHP-North-specific CY 2022 recommendations and follow-up CY 2023 assessments are summarized in Table 5-26.

Table 5-26—Assessment of TCHP-North's Approach to Addressing Previous Annual Recommendations

CY 2022 Recommendation	CY 2023 Assessment
Compliance Monitoring Review	
Standard I—Availability of Services	
This recommendation was initially given during the CY 2021 EQR. TCHP-North should revise its policies and procedures as well as member and provider communications to include complete and accurate network access information. In addition, TCHP-North should ensure processes include ongoing monitoring of provider network compliance and corrective actions when providers fail to meet network access requirements.	**TCHP-North did not sufficiently address the recommendation.** TCHP-North revised policies and procedures as well as member and provider communications to include complete and accurate network access information. However, the CCO's documentation revealed monitoring provider compliance against incorrect network access standards, and the CCO was not monitoring provider compliance against all network access standards. In addition, the CCO was unable to demonstrate taking corrective action when providers failed to meet appointment timeliness. TCHP-North should ensure processes include ongoing monitoring of provider network compliance against all network access standards

CY 2022 Recommendation	CY 2023 Assessment
	and taking corrective actions when providers fail to meet network access requirements.
Standard II—Assurances of Adequate Capacity and Services	
This recommendation was initially given during the CY 2021 EQR. TCHP-North should provide evidence of monitoring the provider network, which encompasses all elements of the State and federal requirements. In addition, TCHP-North should monitor its provider network using a process that enables the CCO to determine whether the geographic location and distribution of preventive and specialty services are adequate for the population enrolled or expected to be enrolled in the service area.	**TCHP-North did not sufficiently address the recommendation.** TCHP-North's GeoAccess reporting continued to demonstrate the CCO monitoring specialty providers as a combined group rather than as individual provider specialties. In addition, the CCO's policies and procedures were not in alignment with the CCO's processes related to monitoring the characteristics of the member population compared to the CCO's provider network. TCHP-North should ensure its GeoAccess monitoring includes individual provider specialties and revise its policies and procedures to align with current monitoring practices.
Standard III—Coordination and Continuity of Care	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard IV—Coverage and Authorization of Services	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard V—Provider Selection	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard VI—Subcontractual Relationships and Delegation	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard VII—Member Rights and Protections	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard VIII—Confidentiality	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.

CY 2022 Recommendation	CY 2023 Assessment
Standard IX—Enrollment and Disenrollment	
TCHP-North should revise its policies and procedures and member-facing documents to align with federal and State requirements.	**TCHP-North did not sufficiently address the recommendation.** TCHP-North demonstrated oversight and monitoring of disenrollment reasons, and the CCO revised its policy and member-facing documents. However, its provider-facing materials as well as staff training materials failed to address all discrimination reasons. TCHP-North should revise all applicable documents to include all discrimination reasons required by State and federal regulations.
Standard X—Grievance and Appeal Systems	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard XI—Practice Guidelines	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard XII—Quality Assessment and Performance Improvement	
TCHP-North should revise its QAPI program structure to align with federal and State requirements for a QAPI program. TCHP-North should also demonstrate appropriate oversight of its QAPI program.	**TCHP-North did not sufficiently address the recommendation.** TCHP-North revised its processes to ensure appropriate oversight of its QAPI program. However, the CCO was unable to demonstrate mechanisms to assess the quality and appropriateness of care provided to LTSS members. The CCO should revise its QAPI program structure to align with federal and State requirements for assessing the quality and appropriateness of care.
Standard XIII—Health Information Systems, including ISCA	
TCHP-North should amend its policies, procedures, and information systems to capture all required data elements and make them available for reporting to align with CCO contract requirements. The CCO should also update its policy and procedure to include oversight processes for monitoring MOTS data submissions from its BH providers. TCHP-North should ensure that its staff are trained in, knowledgeable of, and implement those defined processes, including the documentation of all oversight	**TCHP-North sufficiently addressed the recommendation.** Documentation reviewed during the CY 2023 CMR activity demonstrated compliance with the standard. HSAG provided an additional recommendation to the CCO to add a step to its policy that includes the CCO's monitoring process.

CY 2022 Recommendation	CY 2023 Assessment
activities and follow-up actions taken when issues are identified.	
Standard XIV—Member Information	
This standard was not assessed during the 2022 CMR.	Not applicable.
Performance Improvement Projects	
Statewide Mental Health Service Access Monitoring PIP	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Statewide Substance Use Disorder PIP	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Performance Measure Validation	
TCHP-North should continue to monitor performance of the *Child and Adolescent Well-Care Visits—Ages 3 to 6 Years* and *Members Receiving Preventive Dental or Oral Health Services—Ages 1 to 5 Years* and *Ages 6 to 14 Years* measures. TCHP-North should conduct root cause analyses to identify specific factors affecting performance and develop, implement, and evaluate targeted interventions to ensure improvement strategies are adopted to increase performance over time. Additionally, TCHP-North should continue to monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches to ensuring the quality, timeliness, and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	**TCHP-North sufficiently addressed the recommendation.** TCHP-North reported several interventions that were implemented to improve the quality, timeliness, and accessibility of health care services for children and young members. These interventions included requiring a capacity attestation from providers biannually, administering an access and availability survey to collect data on care gaps, working to secure contracts with providers where gaps were identified in the provider network, revamping incentives for young members to receive well-checks and preventive dental/oral health services, and advocating for providers to incorporate fluoride application into well-child visits.
Validation of Network Adequacy	
This recommendation was initially given during the CY 2021 EQR. TCHP-North should implement mechanisms to monitor provider directory accuracy and appointment availability.	**TCHP-North did not provide a response or supporting documentation to address the recommendation.**
This recommendation was initially given during the CY 2021 EQR. TCHP-North should ensure that it reports DSN Provider Capacity Reporting data values for all required data fields	**TCHP-North did not sufficiently address the recommendation.** The CCO's response and results from OHA's Q1 2023 DSN Provider Capacity Report demonstrated multiple improvements for most data fields, but also

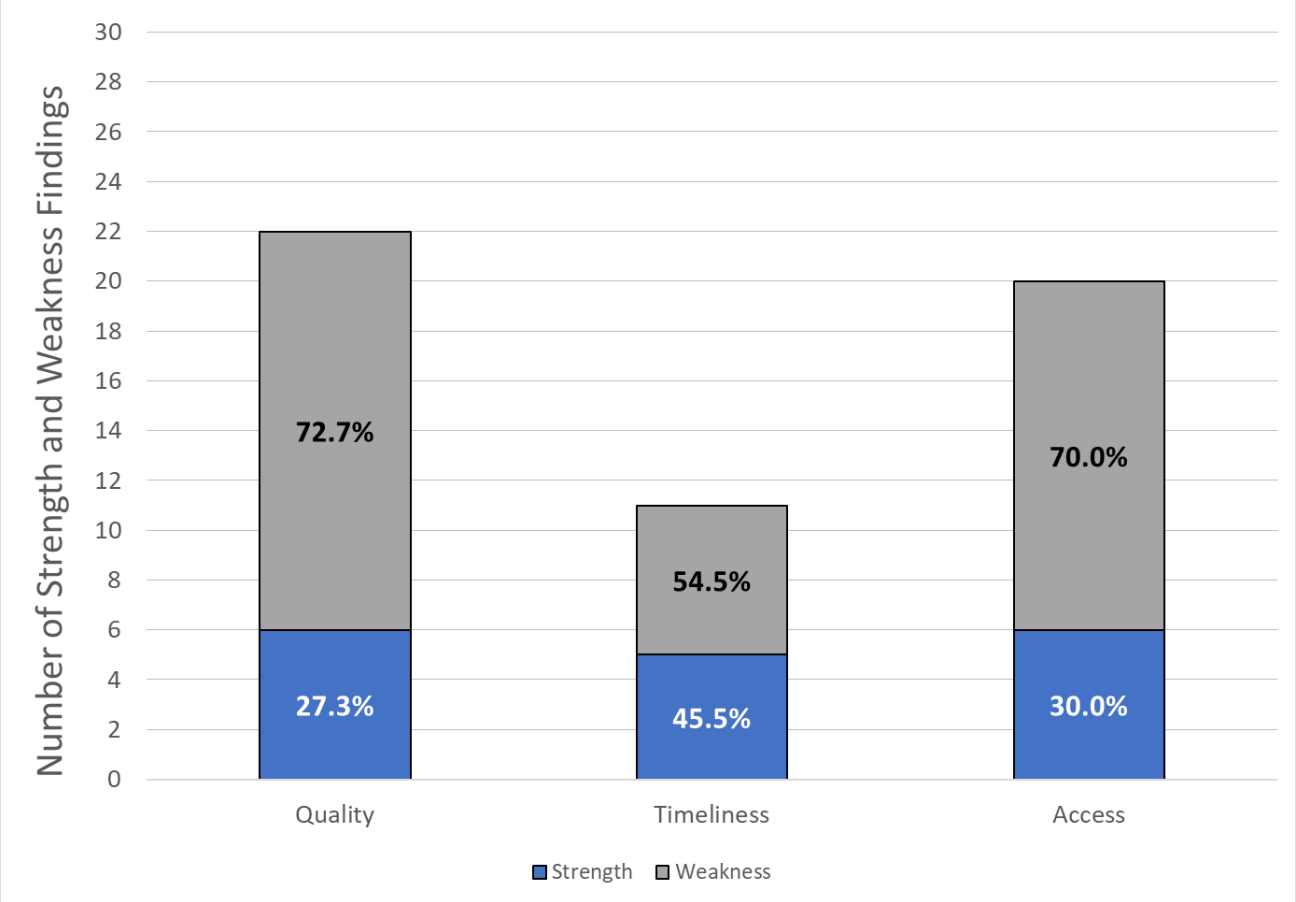
CY 2022 Recommendation	CY 2023 Assessment
and seek technical assistance from OHA as needed.	ongoing quality issues with the *Credentialing Date* data field. Further, the CCO's suggested course of action in resolving the quality concern was not in alignment with OHA guidance.
TCHP-North should conduct monitoring for access to and timeliness of care at least quarterly to effectively monitor access to services.	**TCHP-North sufficiently addressed the recommendation.** TCHP-North described and provided evidence for a semiannual survey, quarterly notices, and monthly review of access-related issues.
TCHP-North should describe processes and provide evidence for utilizing data regarding members with disabilities and SHCN as part of its network adequacy decision-making.	**TCHP-North sufficiently addressed the recommendation.** TCHP-North's CY 2023 DSN Provider Narrative submission included responses and documentation sufficient to demonstrate use of member data to support its network adequacy decision-making.
TCHP-North should ensure it submits a full response to all DSN Provider Narrative elements.	**TCHP-North sufficiently addressed the recommendation.** TCHP-North submitted full responses to all DSN Provider Narrative elements in its CY 2023 submission.
Encounter Data Validation	
TCHP-North should investigate and follow up with its providers to determine why encounters were submitted to OHA; however, no medical records/documentation were available for the member and/or the requested dates of service, or the member was not a patient of the practice.	**TCHP-North did not provide a response or supporting documentation to address the recommendation.**
TCHP-North should investigate the root cause for the omissions and consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews would then be provided to providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.	**TCHP-North did not provide a response or supporting documentation to address the recommendation.**
Mental Health Parity Evaluation	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.

Trillium Community Health Plan, Inc.–South

Results and Conclusions

HSAG assessed the strengths and weaknesses of each CCO with respect to the quality, timeliness, and accessibility of health care services. Figure 5-27 illustrates the number of strengths exhibited by TCHP-South relative to the number of weaknesses identified during the CY 2023 EQR activities across the three domains. The greater the proportion of weaknesses, the greater opportunities for improvement.

Figure 5-27—TCHP-South Overall Number of Findings (Strengths and Weaknesses) by Domain



Detailed results from the EQR's substantive findings are summarized in Table 5-27 for each activity. This table highlights the extent to which TCHP-South furnishes high quality, timely, and appropriate access to health care services, and recommendations for how TCHP-South can best address issues identified for each activity.[5-27]

[5-27] See Section 4—Comparative Statewide Results for detailed, CCO-specific scores associated with EQR activity.

Table 5-27—TCHP-South Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)[5-28]
Compliance Monitoring Review		
+	**Strength:** TCHP-South achieved full compliance for Standard XVI—Emergency and Poststabilization Services, demonstrating TCHP-South has policies and procedures and has implemented the appropriate processes and workflows to ensure the emergency and poststabilization services are covered appropriately.	
−	**Weakness:** TCHP-South received a score of 94.4 percent in Standard III—Coordination and Continuity of Care due to failure to appropriately assess/reassess members for care coordination services. **Why the weakness exists:** TCHP-South failed to demonstrate that health risk screenings are conducted appropriately. TCHP-South also failed to demonstrate the appropriate outreach attempts and compliance with state-established time frames for assessing and reassessing members enrolled in ICC. **Recommendations:** TCHP-South must demonstrate implementation of appropriate assessments and reassessments, according to federal and State requirements. TCHP-South must also demonstrate compliance with its policies, specifically for outreach attempts to members for care coordination services.	
−	**Weakness:** THCP-South received a score of 61.1 percent in Standard IV—Coverage and Authorization of Services due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting TCHP-South's ability to adhere to federal and State requirements for authorizing services, and to ensure proper and timely notification of adverse benefit determinations. **Why the weakness exists:** TCHP-South's policies and procedures did not align with federal and State requirements. Additionally, TCHP-South failed to adhere to requirements for the appropriate decision-makers and demonstrated reversing service authorization decisions outside the appeal process. TCHP-South also failed to adhere to requirements for required content and time frames for notification of adverse benefit determinations. **Recommendations:** TCHP-South must revise its policies and procedures to align with federal and State requirements. TCHP-South must also demonstrate the implementation of appropriate service offerings. TCHP-South must also demonstrate proper outreach to retrieve the information needed to process service authorization requests.	

[5-28]  = Quality,  = Timeliness,  = Access

Strength/ Weakness	Description	Domain(s)[5-28]
−	**Weakness:** TCHP-South received a score of 70.0 percent in Standard VII—Member Rights and Protections due to a lack of operational structure and failure to demonstrate implementation of an established process, impacting TCHP-South's ability to ensure that member rights are respected and allowed to be exercised freely without affecting the treatment of members and that members are notified of their rights as required by federal and State requirements. **Why the weakness exists:** TCHP-South's policies and procedures and member- and provider-facing materials did not align with federal and State requirements. **Recommendations:** TCHP-South must revise its policies and procedures and member- and provider-facing materials to align with federal and State requirements.	
−	**Weakness:** TCHP-South received a score of 83.3 percent in Standard X—Grievance and Appeal Systems due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting TCHP-South's ability to ensure member grievances and appeals are addressed and responded to appropriately. **Why the weakness exists:** TCHP-South's policies and procedures did not align with federal and State requirements. TCHP-South failed to adhere to required content within resolution notices and time frames for acknowledging and resolving grievances and/or appeals. TCHP-South also failed to communicate grievance and/or appeal requirements to staff, members, providers, and subcontractors. **Recommendations:** TCHP-South must revise its policies and procedures to align with federal and State requirements. TCHP-South must adhere to federal and State requirements for content in resolution notices and time frames for acknowledging and resolving grievances and appeals. TCHP-South must also demonstrate implementation of federal and State requirements within communications to staff, members, providers, and subcontractors.	
−	**Weakness:** TCHP-South received a score of 77.3 percent in Standard XIV—Member Information due to a lack of operational structure and failure to demonstrate implementation of an established process, impacting TCHP-South's ability to ensure timely and proper member communication. **Why the weakness exists:** TCHP-South's policies and procedures and member-facing materials (i.e., the member handbook, member notices, and provider directory) did not align with federal and State requirements. Additionally, TCHP-South failed to track and monitor the timely provision of required member information. **Recommendations:** TCHP-South must revise its policies, procedures, and member-facing materials to align with federal and State	

Strength/ Weakness	Description	Domain(s)[5-28]
	requirements. Additionally, TCHP-South must track and monitor the timely provision of required member information.	
Performance Improvement Projects		
Statewide Mental Health Service Access Monitoring PIP		
−	**Weakness:** TCHP-South did not report accurate RY 1 performance indicator results. **Why the weakness exists:** TCHP-South's reported RY 1 indicator data and statistical testing results could not be replicated. **Recommendations:** TCHP-South should ensure all indicator data and statistical testing results are accurately and consistently reported throughout the PIP documentation.	
−	**Weakness:** TCHP-South did not report a complete interpretation of RY 1 indicator results. **Why the weakness exists:** TCHP-South did not state in the narrative whether the RY 1 results represented an improvement or decline in performance compared to baseline results, and whether the change was statistically significant. **Recommendations:** TCHP-South should revise the RY 1 narrative and ensure it aligns with the RY 1 data reported in the Step 7 table of the resubmission. TCHP-South should state in the narrative whether the RY 1 results represented an improvement or decline in performance compared to baseline results, and whether the change was statistically significant.	
−	**Weakness:** TCHP-South's reported indicator results did not demonstrate any improvement over baseline performance. **Why the weakness exists:** The indicator results demonstrated a decline in performance from baseline to RY 1. **Recommendations:** TCHP-South should revisit root cause analyses identifying barriers to improving access to MH services to determine which barriers to improvement were not effectively addressed. TCHP-South should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to improve indicator results.	
Statewide Substance Use Disorder PIP		
+	**Strength:** TCHP-South successfully initiated the Implementation stage for the PIP, receiving a *Met* score for 100 percent of applicable evaluation elements in the PIP validation tool. In the Implementation stage, TCHP-South accurately reported baseline performance indicator data; identified and analyzed barriers for initiation, engagement, and treatment of alcohol and other drug use disorders; and began to carry out interventions to address those barriers.	

Strength/ Weakness	Description	Domain(s)[5-28]
Performance Measure Validation		
⊕	**Strength:** TCHP-South's performance on the *Members Receiving Preventive Dental or Oral Health Services—Ages 1 to 5 Years* and *Ages 6 to 14 Years* measure indicators demonstrated ongoing improvement for members ages 6 to 14 years since MY 2020.	
⊕	**Strength:** TCHP-South's performance on the *Oral Evaluation for Adults With Diabetes* measure demonstrated ongoing improvement since MY 2020.	
⊕	**Strength:** TCHP-South's performance on the *Child and Adolescent Well-Care Visits—Ages 3 to 6 Years* measure indicator demonstrated ongoing improvement since MY 2020.	
Validation of Network Adequacy		
Delivery System Network Evaluation		
⊕	**Strength:** TCHP-South showed substantial improvement in the overall quality and completeness of its DSN Provider Narrative Template responses and documentation, continuing a trend from the CY 2021 DSN Evaluation. This allowed for a fuller understanding and more accurate evaluation of its network adequacy processes and status. TCHP-South's continued improvement was due in part to TCHP-South's responsivity to feedback as well as proactive outreach for technical assistance.	
⊖	**Weakness:** TCHP-South showed potential issues within its provider data, including but not limited to provider counts and status of accepting new patients. **Why the weakness exists:** TCHP-South's provider data showed multiple substantial increases and decreases in provider counts between Q2 2022 and Q1 2023, indicating potential data issues, potential barriers to care, or both. With the exception of PCDs, all providers were listed as having 100 percent acceptance of new patients, indicating potential data issues. **Recommendations:** TCHP-South should seek technical assistance with OHA to determine the nature of the provider capacity data issues and correct them.	
⊖	**Weakness:** TCHP-South showed potential data issues and/or barriers to access to dental, BH, and PUL specialty provider services that were not substantively addressed within its DSN Provider Narrative Template. **Why the weakness exists:** A moderate to low percentage of both MH and SUD providers were determined to be active in TCHP-South's network within the prior two years. A low percentage of TCHP-South's PCDs were listed as accepting new patients. TCHP-South did not meet time and distance access standards for PUL specialty providers in a	

Strength/ Weakness	Description	Domain(s)[5-28]
	rural setting. These results indicated potential data issues, potential barriers to access to care, or both. **Recommendations:** TCHP-South should seek technical assistance with OHA to determine the nature of the provider capacity data issues and correct them.	
Secret Shopper Survey		
−	**Weakness:** The total secret shopper survey response rate was 71.5 percent across all PCP and PCD cases. Of the total responsive cases, 56.1 percent of the offices offered the requested services, 49.6 percent accepted OHP, 30.9 percent accepted TCHP-South, and 28.5 percent accepted new patients. However, while 97.4 percent of PCD offices confirmed the location, the rate for PCP offices was 80.0 percent. **Why the weakness exists:** In addition to limitations related to the secret shopper approach, the accuracy of TCHP-South's provider data may have contributed to the low response rate and accuracy results. **Recommendations:** HSAG recommends that TCHP-South use the case-level analytic data files to address the data deficiencies identified during the secret shopper survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
−	**Weakness:** Of the total secret shopper survey responsive cases, only 13.8 percent resulted in an appointment. **Why the weakness exists:** In addition to limitations related to the secret shopper approach, the accuracy of TCHP-South's provider data may have contributed to the low appointment availability rate. **Recommendations:** HSAG recommends that TCHP-South confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. TCHP-South should use the case-level analytic data files containing data deficiencies identified during the secret shopper survey calls.	
Revealed Telephone Survey		
−	**Weakness:** Overall, 38.0 percent of the revealed telephone survey total sampled cases were reached, of which six, or 8.8 percent, refused to participate in the survey. Of the total responsive cases, 72.1 percent of the offices offered the requested specialty, 70.6 percent accepted OHP, 63.2 percent accepted TCHP-South, 58.8 percent accepted new patients, and 67.4 percent offered translation or interpreter services. **Why the weakness exists:** In addition to limitations related to the revealed telephone approach, the accuracy of TCHP-South's provider data may have contributed to the low response rate and accuracy results.	

Strength/ Weakness	Description	Domain(s)[5-28]
	Recommendations: HSAG recommends that TCHP-South use the case-level analytic data files to address the data deficiencies identified during the revealed telephone survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, program information, and translation/interpreter services offered).	
−	**Weakness:** Of the sampled cases, only 11.2 percent of the survey respondents offered a new patient appointment, while only 16.2 percent of survey respondents offered an appointment for an existing patient. Of the total cases that offered an appointment, 92.7 percent of routine appointments and 47.9 percent of urgent appointments were within the wait time compliance standard. **Why the weakness exists:** In addition to limitations related to the revealed telephone approach, the accuracy of TCHP-South's provider data may have contributed to the low appointment availability rate. Additionally, internal office staffing structures and procedures may have contributed to the long wait times. **Recommendations:** HSAG recommends that TCHP-South confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. TCHP-South should use the case-level analytic data files containing data deficiencies identified during the survey calls and work with BH outpatient offices to identify the root cause for delays in appointment availability.	
Encounter Data Validation		
+	**Strength:** Encounters that could be matched between data extracted from OHA's data warehouse and data extracted from TCHP-South's or the subcontractor's data system exhibited a high level of element completeness (i.e., low element omission and surplus rates) for nearly all evaluated key data elements.	
+	**Strength:** Among records that could be matched between the two data sources, a high level of element accuracy (i.e., data elements from both sources had the same values when populated) was exhibited across all evaluated key data elements.	
+	**Strength:** TCHP-South-submitted data had high all-element accuracy for all evaluated key data elements, indicating that the values (missing or non-missing) in both data sources (TCHP-South and OHA) were the same for almost all records.	
−	**Weakness:** There were a moderately high number and percentage of records present in the files submitted by OHA but not found in the files submitted by TCHP-South's subcontractor(s) (i.e., record surplus).	

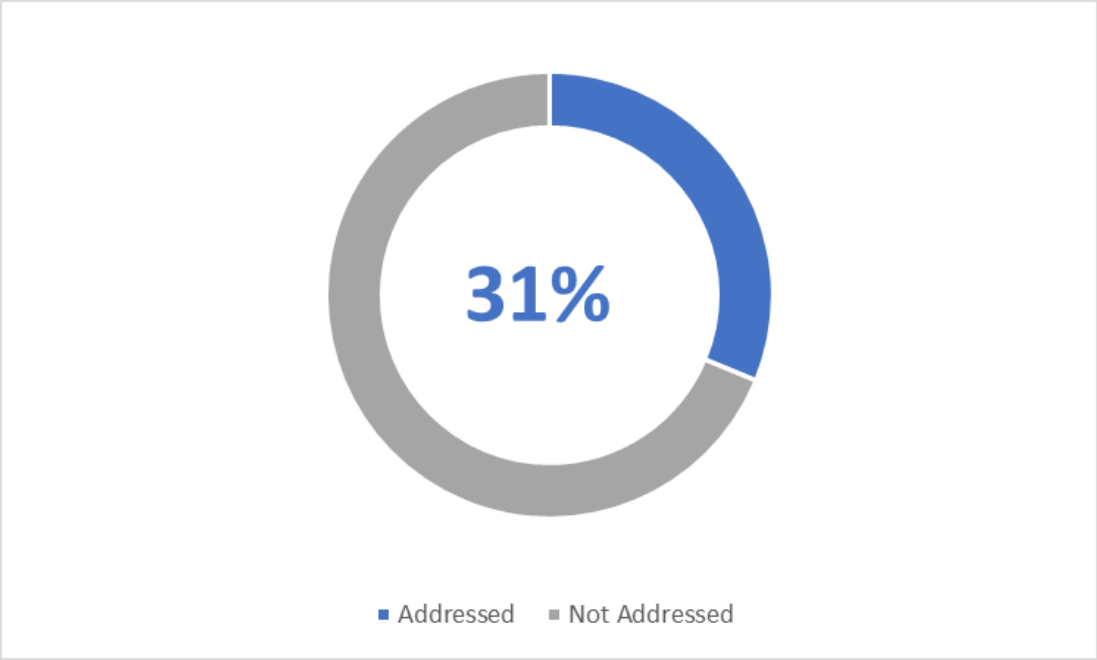
Strength/ Weakness	Description	Domain(s)[5-28]
	Why the weakness exists: Based on the data discrepancy report response, TCHP-South explained the surplus records identified were adjusted to have a claim status of "void" after their data submission to OHA, which resulted in those records not being sent to HSAG since voided claims are not part of the comparative analysis data requirements. **Recommendations:** HSAG recommends TCHP-South follow the submission guidance outlined in the data requirements document, which indicated, "Only include claims and encounters that are in a final, fully adjudicated status as of May 31, 2023." This would ensure HSAG receives encounters with the same claim status from the anchor date of May 31, 2023.	
	**Weakness:** TCHP-South stacked all data extracts before submitting them to HSAG, instead of directly submitting the raw data extracts received from the subcontractors. **Why the weakness exists:** Stacking of the data before submission introduces an additional step in the data handling process. This intermediate step may increase the likelihood of errors or inconsistencies during the compilation, potentially affecting the accuracy and integrity of the data submitted to HSAG; for example, it may cause misalignment in data fields in one or more of the subcontractor-submitted data extracts. **Recommendations:** To address this, HSAG suggests submitting the raw data extracts separately, maintaining the integrity of the original data and preventing potential misalignments during the stacking process. Additionally, HSAG recommends TCHP-South establish robust quality checks during the data compilation phase to promptly identify and address any discrepancies. This proactive approach will contribute to maintaining data accuracy and reliability throughout the submission process.	
Mental Health Parity Evaluation		
	**Strength:** TCHP-South achieved full compliance with parity requirements for application of NQTLs applied to MH/SUD and M/S benefits.	

Follow-Up on Prior Year Recommendations

HSAG evaluated TCHP-South's approach to addressing the recommendations and/or findings issued during CY 2022 and unresolved findings from CY 2020 and CY 2021 while conducting the CY 2023 EQR activities. The CCOs not addressing findings and recommendations are at risk of being out of compliance with their contracts.

Figure 5-28 illustrates the degree in which the CCO sufficiently addressed the recommendations for QI made by HSAG during the CY 2022 EQR.

Figure 5-28—Percentage of CY 2022 EQR Recommendations Addressed by TCHP-South



TCHP-South-specific CY 2022 recommendations and follow-up CY 2023 assessments are summarized in Table 5-28.

Table 5-28—Assessment of TCHP-South's Approach to Addressing Previous Annual Recommendations

CY 2022 Recommendation	CY 2023 Assessment
Compliance Monitoring Review	
Standard I—Availability of Services	
This recommendation was initially given during the CY 2021 EQR. TCHP-South should revise its policies and procedures as well as member and provider communications to include complete and accurate network access information. In addition, TCHP-South should ensure processes include ongoing monitoring of provider network compliance and corrective actions when providers fail to meet network access requirements.	**TCHP-South did not sufficiently address the recommendation.** TCHP-South revised policies and procedures as well as member and provider communications to include complete and accurate network access information. However, the CCO's documentation revealed monitoring provider compliance against incorrect network access standards, and the CCO was not monitoring provider compliance against all network access standards. In addition, the CCO was unable to demonstrate taking corrective action when providers failed to meet appointment timeliness. TCHP-South should ensure processes include

CY 2022 Recommendation	CY 2023 Assessment
	ongoing monitoring of provider network compliance against all network access standards and taking corrective actions when providers fail to meet network access requirements.
Standard II—Assurances of Adequate Capacity and Services	
This recommendation was initially given during the CY 2021 EQR. TCHP-South should provide evidence of monitoring the provider network, which encompasses all elements of the State and federal requirements. In addition, TCHP-South should monitor its provider network using a process that enables the CCO to determine whether the geographic location and distribution of preventive and specialty services are adequate for the population enrolled or expected to be enrolled in the service area.	**TCHP-South did not sufficiently address the recommendation.** TCHP-South's GeoAccess reporting continued to demonstrate the CCO monitoring specialty providers as a combined group rather than as individual provider specialties. In addition, the CCO's policies and procedures were not in alignment with the CCO's processes related to monitoring the characteristics of the member population compared to the CCO's provider network. TCHP-South should ensure its GeoAccess monitoring includes individual provider specialties and revise its policies and procedures to align with current monitoring practices.
Standard III—Coordination and Continuity of Care	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard IV—Coverage and Authorization of Services	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard V—Provider Selection	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard VI—Subcontractual Relationships and Delegation	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard VII—Member Rights and Protections	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard VIII—Confidentiality	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.

CY 2022 Recommendation	CY 2023 Assessment
Standard IX—Enrollment and Disenrollment	
TCHP-South should revise its policies and procedures and member-facing documents to align with federal and State requirements. TCHP-South should also demonstrate oversight and monitoring of disenrollment reasons to ensure compliance with the regulatory requirements.	**TCHP-South did not sufficiently address the recommendation.** TCHP-South demonstrated oversight and monitoring of disenrollment reasons, and the CCO revised its policy and member-facing documents. However, its provider-facing materials as well as staff training materials failed to address all discrimination reasons. TCHP-South should revise all applicable documents to include all discrimination reasons required by State and federal regulations.
Standard X—Grievance and Appeal Systems	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard XI—Practice Guidelines	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard XII—Quality Assessment and Performance Improvement	
TCHP-South should revise its QAPI program structure to align with federal and State requirements for a QAPI program. TCHP-South should also demonstrate appropriate oversight of its QAPI program.	**TCHP-South did not sufficiently address the recommendation.** TCHP-South revised its processes to ensure appropriate oversight of its QAPI program. However, the CCO was unable to demonstrate mechanisms to assess the quality and appropriateness of care provided to LTSS members. The CCO should revise its QAPI program structure to align with federal and State requirements for assessing the quality and appropriateness of care.
Standard XIII—Health Information Systems, including ISCA	
TCHP-South should amend its policies, procedures, and information systems to capture all required data elements and make them available for reporting to align with CCO contract requirements. The CCO should also update its policy and procedure to include oversight processes for monitoring MOTS data submissions from its BH providers. TCHP-South should ensure its staff are trained in, knowledgeable of, and implement those defined processes, including the documentation of all oversight activities and	**TCHP-South sufficiently addressed the recommendation.** Documentation reviewed during the CY 2023 CMR activity demonstrated compliance with the standard. HSAG provided an additional recommendation to the CCO to add a step to its policy that includes the CCO's monitoring process.

CY 2022 Recommendation	CY 2023 Assessment
follow-up actions taken when issues are identified.	
Standard XIV—Member Information	
This standard was not assessed during the 2022 CMR.	Not applicable.
Performance Improvement Projects	
Statewide Mental Health Service Access Monitoring PIP	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Statewide Substance Use Disorder PIP	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Performance Measure Validation	
TCHP-South should continue to monitor performance of the *Child and Adolescent Well-Care Visits—Ages 3 to 6 Years* measure. TCHP-South should conduct root cause analyses to identify specific factors affecting performance and develop, implement, and evaluate targeted interventions to ensure improvement strategies are adopted to increase performance over time. Additionally, TCHP-South should continue to monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches to ensuring the quality, timeliness, and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	**TCHP-South did not provide a response or supporting documentation to address the recommendation.**
Validation of Network Adequacy	
This recommendation was initially given during the CY 2021 EQR. TCHP-South should implement mechanisms to monitor provider directory accuracy and appointment availability.	**TCHP-South did not provide a response or supporting documentation to address the recommendation.**
This recommendation was initially given during the CY 2021 EQR. TCHP-South should ensure that it reports DSN Provider Capacity Reporting data values for all required data fields and seek technical assistance from OHA as needed.	**TCHP-South did not sufficiently address the recommendation.** The CCO's response and results from OHA's Q1 2023 DSN Provider Capacity Report demonstrated multiple improvements for most data fields, but also ongoing quality issues with the *Credentialing Date* data field. Further, the CCO's suggested

CY 2022 Recommendation	CY 2023 Assessment
	course of action in resolving the quality concern was not in alignment with OHA guidance.
TCHP-South should conduct monitoring for access to and timeliness of care at least quarterly to effectively monitor access to services.	**TCHP-South sufficiently addressed the recommendation.** TCHP-South described and provided evidence for a semiannual survey, quarterly notices, and monthly review of access-related issues.
TCHP-South should describe processes and provide evidence for utilizing data regarding members with disabilities and SHCN as part of its network adequacy decision-making.	**TCHP-South sufficiently addressed the recommendation.** TCHP-South's CY 2023 DSN Provider Narrative submission included responses and documentation sufficient to demonstrate use of member data to support its network adequacy decision-making.
TCHP-South should continue to engage and pursue contracting with all available IHS/THCs, rural health centers, urgent care centers (UCCs), and federally qualified health centers (FQHCs) to ensure access for members and provide evidence of efforts to obtain contracts with all centers/facilities located within its service area. For specific service categories that TCHP-South is unable to meet time and distance requirements, the CCO should describe and show how members have access to the services through other providers and/or facilities.	**TCHP-South sufficiently addressed the recommendation.** TCHP-South described and provided evidence for contracting with additional facilities to close specific gaps.
TCHP-South should ensure it submits a full response to all DSN Provider Narrative elements.	**TCHP-South sufficiently addressed the recommendation.** TCHP-South submitted full responses to all DSN Provider Narrative elements in its CY 2023 submission.
Encounter Data Validation	
This recommendation was initially given during the CY 2021 EQR. HSAG recommends that TCHP-South implement standard quality controls to ensure accurate data extracts and decrease record omission and surplus rates. Through the development of standard data extraction procedures and quality control, the number of errors associated with extracted data could be reduced.	**TCHP-South did not provide a response or supporting documentation to address the recommendation.**
This recommendation was initially given during the CY 2021 EQR. HSAG recommends that TCHP-South implement standard quality controls to ensure accurate data extracts. Through	**TCHP-South did not provide a response or supporting documentation to address the recommendation.**

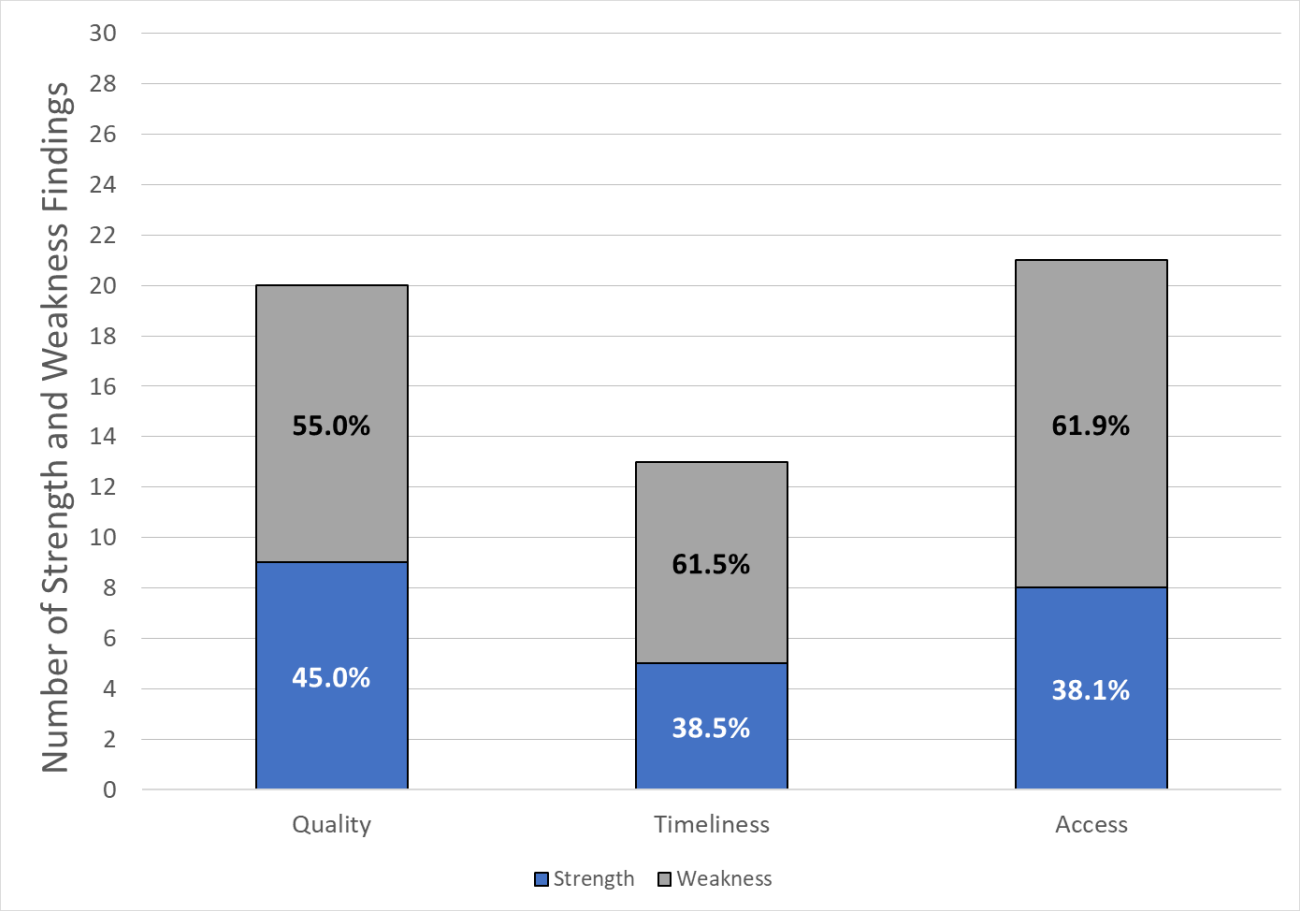
CY 2022 Recommendation	CY 2023 Assessment
the development of standard data extraction procedures and quality control, the number of errors associated with extracted data could be reduced. For the *diagnosis-related group* (*DRG)* data element, HSAG also recommends TCHP-South work with OHA to ensure that the *DRG* values submitted to OHA are in alignment and are an accurate representation of values within TCHP-South's data system. Additionally, HSAG recommends that TCHP-South continually monitor its encounter submissions to OHA to ensure complete, accurate, and timely encounter data submissions.	
TCHP-South should investigate and follow up with its providers regarding its provider information and determine why encounters were submitted to OHA, but the provider indicated the member was not a patient at the practice.	**TCHP-South did not provide a response or supporting documentation to address the recommendation.**
TCHP-South should investigate the root cause for the omissions and consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews would then be provided to providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.	**TCHP-South did not provide a response or supporting documentation to address the recommendation.**
Mental Health Parity Evaluation	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.

Umpqua Health Alliance, LLC

Results and Conclusions

HSAG assessed the strengths and weaknesses of each CCO with respect to the quality, timeliness, and accessibility of health care services. Figure 5-29 illustrates the number of strengths exhibited by UHA relative to the number of weaknesses identified during the CY 2023 EQR activities across the three domains. The greater the proportion of weaknesses, the greater opportunities for improvement.

Figure 5-29—UHA Overall Number of Findings (Strengths and Weaknesses) by Domain



Detailed results from the EQR's substantive findings are summarized in Table 5-29 for each activity. This table highlights the extent to which UHA furnishes high quality, timely, and appropriate access to health care services, and recommendations for how UHA can best address issues identified for each activity.[5-29]

[5-29] See Section 4—Comparative Statewide Results for detailed, CCO-specific scores associated with EQR activity.

Table 5-29—UHA Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)[5-30]
Compliance Monitoring Review		
+	**Strength:** UHA achieved full compliance for Standard XVI—Emergency and Poststabilization Services, demonstrating UHA had policies and procedures and demonstrated implementation of appropriate processes and workflows to ensure the emergency and poststabilization services are covered appropriately.	
−	**Weakness:** UHA received a score of 94.4 percent in Standard III—Coordination and Continuity of Care due to failure to appropriately assess/reassess members for care management and ICC services. **Why the weakness exists:** UHA failed to demonstrate completion of appropriate assessments/reassessments and treatment plan development in accordance with federal and State requirements. **Recommendations:** UHA must demonstrate assessments and reassessments, and development and revision of treatment plans according to federal and State requirements.	
−	**Weakness:** UHA received a score of 86.1 percent in Standard IV—Coverage and Authorization of Services due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting UHA's ability to adhere to federal and State requirements for authorizing services and to ensure proper and timely notification of adverse benefit determinations. **Why the weakness exists:** UHA's policies and procedures did not align with federal and State requirements. Additionally, UHA failed to adhere to requirements for decision-makers, and required content and time frames for notification of adverse benefit determinations. **Recommendations:** UHA must revise its policies and procedures to align with federal and State requirements. UHA must demonstrate adherence to federal and State requirements for authorization of services, and required content and time frames for notification of adverse benefit determinations.	
−	**Weakness:** UHA received a score of 90.0 percent in Standard VII—Member Rights and Protections due deficits in its operational structure, impacting UHA's ability to ensure that member rights are respected. **Why the weakness exists:** UHA's policies and procedures and provider-facing materials did not align with federal and State requirements.	

[5-30] = Quality, = Timeliness, = Access

Strength/ Weakness	Description	Domain(s)[5-30]
	Recommendations: UHA must revise its policies and procedures and provider-facing materials to align with federal and State requirements.	
−	**Weakness:** UHA received a score of 92.6 percent in Standard X—Grievance and Appeal Systems due to a deficit in its operational structure and failure to demonstrate appropriate implementation, impacting UHA's ability to ensure member grievances and appeals are addressed and responded to appropriately. **Why the weakness exists:** UHA failed to adhere to requirements for time frames for acknowledging and responding to grievances and/or appeals and readability of notices. UHA also failed to communicate grievance and/or appeal requirements to providers and subcontractors. **Recommendations:** UHA must demonstrate adherence to federal and State requirements for time frames for acknowledging and responding to grievances and appeals and readability of notices. UHA must also demonstrate implementation of federal and State requirements within communications to providers and subcontractors.	
−	**Weakness:** UHA received a score of 93.2 percent in Standard XIV—Member Information due to deficiencies in its implementation of an established process, impacting UHA's ability to ensure proper member communication. **Why the weakness exists:** UHA's member-facing materials, including the member handbook and provider directory, did not align with federal and State requirements. **Recommendations:** UHA must revise its member-facing materials to align with federal and State requirements.	
Performance Improvement Projects		
Statewide Mental Health Service Access Monitoring PIP		
+	**Strength:** UHA successfully continued the Implementation stage for the PIP, receiving a *Met* score for 100 percent of applicable evaluation elements in the PIP validation tool. In the Implementation stage, UHA accurately reported baseline and RY 1 performance indicator data, identified and analyzed barriers to improving MH service access, carried out interventions to address those barriers, and refined interventions based on intervention evaluation results.	
+	**Strength:** UHA's RY 1 performance indicator results demonstrated statistically significant improvement in MH service access compared to baseline indicator results.	

Strength/ Weakness	Description	Domain(s)[5-30]
Statewide Substance Use Disorder PIP		
⊕	**Strength:** UHA successfully initiated the Implementation stage for the PIP, receiving a *Met* score for 100 percent of applicable evaluation elements in the PIP validation tool. In the Implementation stage, UHA accurately reported baseline performance indicator data; identified and analyzed barriers for initiation, engagement, and treatment of alcohol and other drug use disorders; and began to carry out interventions to address those barriers.	
Performance Measure Validation		
⊕	**Strength:** UHA's MY 2022 performance on the *Child and Adolescent Well-Care Visits—Ages 3 to 6 Years* measure indicator improved by more than 5 percentage points compared to MY 2021 (5.9 percentage points). The CCO's performance on the *Child and Adolescent Well-Care Visits—Ages 3 to 6 Years* measure indicator demonstrated ongoing improvement since MY 2020. In addition, the CCO's MY 2022 rates for this measure exceeded the statewide aggregate and 2020 CCO 75th percentile benchmark set by OHA for MY 2022 by 5 percentage points or more.	
⊕	**Strength:** UHA's MY 2022 performance for members ages 6 to 14 years receiving preventive dental or oral health services improved by more than 5 percentage points compared to MY 2021 (5.3 percentage points). In addition, the CCO's performance on the *Members Receiving Preventive Dental or Oral Health Services—Ages 1 to 5 Years* and *Ages 6 to 14 Years* measure indicators demonstrated ongoing improvement since MY 2020.	
⊕	**Strength:** UHA's MY 2022 performance on the *Oral Evaluation for Adults With Diabetes* measure demonstrated ongoing improvement since MY 2020.	
⊖	**Weakness:** UHA's MY 2022 rate on the *Initiation of SUD Treatment* measure indicator for members ages 18 years and older fell below the 2020 HEDIS national Medicaid median benchmark set by OHA for MY 2022. **Why the weakness exists:** In response to EQR recommendations, UHA developed and implemented interventions to ensure the quality, timeliness, and accessibility of SUD treatment. UHA implemented these interventions starting Q3 2022. **Recommendations:** Beginning Q3 2022, UHA took several steps to improve its performance on this measure. Key department leads at UHA met with providers to address their low performance on this measure. Additionally, UHA developed a Quality Program to guide the implementation of various interventions to address gaps in SUD treatment. UHA should continue implementing these efforts to raise its	

Strength/ Weakness	Description	Domain(s)[5-30]
	rate on this measure indicator to the level of the benchmark set by OHA.	
Validation of Network Adequacy		
Delivery System Network Evaluation		
	**Strength:** UHA described and demonstrated a rigorous approach to using data on members with physical, intellectual, and developmental disabilities to monitor and adjust its network with regard to the needs of the population as well as support individual members via care coordination.	
	**Weakness:** Results showed potentially broad issues with UHA's provider capacity data, impacting a full evaluation of UHA's DSN, and raising concerns about data issues and barriers to access to care. **Why the weakness exists:** UHA's provider data showed substantial increases and decreases in most provider counts between Q2 2022 and Q1 2023. UHA's percentages of providers with active status, operating within the service area, and accepting new patients were widely varied and, in some cases, potentially contradictory (e.g., SUD providers). With the exception of PCDs, all providers were listed as having 100 percent acceptance of new patients, indicating potential data issues. **Recommendations:** UHA should seek technical assistance with OHA to determine the nature of the provider capacity data issues and correct them.	
Secret Shopper Survey		
	**Weakness:** The total secret shopper survey response rate was 75.0 percent across all PCP and PCD cases. Of the total responsive cases, 45.5 percent of offices accepted OHP, 42.4 percent accepted UHA, and 30.3 percent accepted new patients. However, while 100 percent of the PCD offices confirmed the location and offered the requested services, the rates for the PCP offices were 88.0 percent and 40.0 percent, respectively. **Why the weakness exists:** In addition to limitations related to the secret shopper approach, the accuracy of UHA's provider data may have contributed to the low response rate and accuracy results. **Recommendations:** HSAG recommends that UHA use the case-level analytic data files to address the data deficiencies identified during the secret shopper survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
	**Weakness:** Of the total secret shopper survey responsive cases, only 9.1 percent resulted in an appointment. Of the cases that were offered	

Strength/ Weakness	Description	Domain(s)[5-30]
	an appointment, only 33.3 percent were within the wait time compliance standard. **Why the weakness exists:** In addition to limitations related to the secret shopper approach, the accuracy of UHA's provider data may have contributed to the low appointment availability rate. Additionally, internal office procedures may have contributed to the long wait times. **Recommendations:** HSAG recommends that UHA confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. UHA should use the case-level analytic data files containing data deficiencies identified during the secret shopper survey calls.	
Revealed Telephone Survey		
−	**Weakness:** Overall, 69.0 percent of the revealed telephone survey total sampled cases were reached, of which one, or 3.4 percent, refused to participate in the survey. Of the total responsive cases, 69.0 percent of the offices offered the requested specialty, 65.5 percent accepted OHP, 58.6 percent accepted UHA, 58.6 percent accepted new patients, and 70.6 percent offered translation or interpreter services. **Why the weakness exists:** In addition to limitations related to the revealed telephone approach, the accuracy of UHA's provider data may have contributed to the low response rate and accuracy results. **Recommendations:** HSAG recommends that UHA use the case-level analytic data files to address the data deficiencies identified during the revealed telephone survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, program information, and translation/interpreter services offered).	
−	**Weakness:** Of the sampled cases, only 19.0 percent of the revealed telephone survey respondents offered a new patient appointment, while only 33.3 percent of survey respondents offered an appointment for an existing patient. Of the total cases that offered an appointment, 75.0 percent of routine appointments and 38.5 percent of urgent appointments were within the wait time compliance standard. **Why the weakness exists:** In addition to limitations related to the revealed telephone approach, the accuracy of UHA's provider data may have contributed to the low appointment availability rate. Additionally, internal office staffing structures and procedures may have contributed to the long wait times. **Recommendations:** HSAG recommends that UHA confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. UHA should use the case-level analytic data files containing data deficiencies identified	

Strength/ Weakness	Description	Domain(s)[5-30]
	during the revealed telephone survey calls and work with BH outpatient offices to identify the root cause for delays in appointment availability.	
Encounter Data Validation		
⊕	**Strength:** The UHA-submitted data exhibited high record-level data completeness, with low record omission and surplus rates.	
⊕	**Strength:** Encounters that could be matched between data extracted from OHA's data warehouse and data extracted from UHA's or the subcontractor's data system exhibited a high level of element completeness (i.e., low element omission and surplus rates) across all evaluated key data elements.	
⊕	**Strength:** Among records that could be matched between the two data sources, a high level of element accuracy (i.e., data elements from both sources had the same values when populated) was exhibited across all evaluated key data elements.	
⊕	**Strength:** The UHA-submitted data had high all-element accuracy for all evaluated key data elements, indicating that the values (missing or non-missing) in both data sources (UHA and OHA) were the same for almost all records.	
Mental Health Parity Evaluation		
⊕	**Strength:** UHA provided comprehensive responses in the MHP Treatment Limitation Review Tool, including narrative responses to the questionnaire and explanations in the subsections to clarify information as needed.	
⊖	**Weakness:** UHA was partially compliant with the Pharmacy Management—Formulary Design NQTL requirement. **Why the weakness exists:** UHA did not provide its rationale for the assignment of the NQTL (i.e., prescription drug formulary), procedures used for the development formulary (e.g., individuals involved in formulary development, professional guidelines used, or how often the formulary is reviewed and updated or by whom), or how frequently or strictly the NQTL is applied (e.g., ability of the provider to request an exception). **Recommendations:** UHA should identify processes, strategies, evidentiary standards, and other factors used in formulary design and the application for prescription drugs.	
⊖	**Weakness:** UHA showed substantial differences in the percentages of paid, out-of-network MH/SUD OP claims compared to M/S OP claims. Although differences in the percentages of paid claims may be legitimate, they may also highlight procedural or network differences indicating potential barriers for members accessing MH/SUD services.	

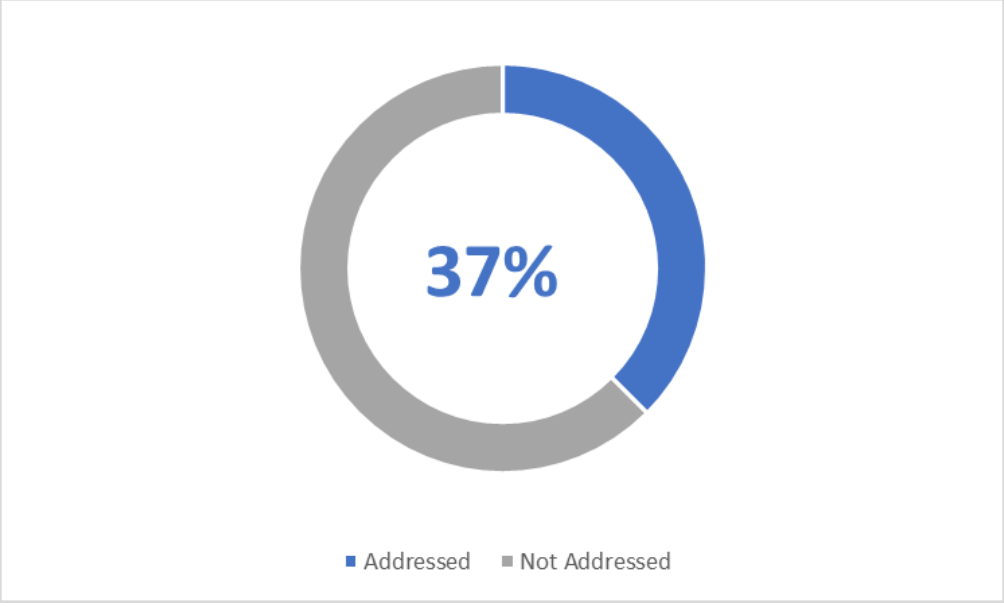
Strength/ Weakness	Description	Domain(s)[5-30]
	Why the weakness exists: Out-of-network OP MH/SUD claims were paid less frequently than M/S claims. **Recommendations:** UHA should review out-of-network claim denials to understand the factors affecting the lower percentage of paid MH/SUD OP claims compared to M/S OP claims. UHA should assess whether any barriers exist for members accessing MH/SUD services, including the need to seek services outside the CCO's network (e.g., appointment availability).	

Follow-Up on Prior Year Recommendations

HSAG evaluated UHA's approach to addressing the recommendations and/or findings issued during CY 2022 and unresolved findings from CY 2020 and CY 2021 while conducting the CY 2023 EQR activities. The CCOs not addressing findings and recommendations are at risk of being out of compliance with their contracts.

Figure 5-30 illustrates the degree in which the CCO sufficiently addressed the recommendations for QI made by HSAG during the CY 2022 EQR.

Figure 5-30—Percentage of CY 2022 EQR Recommendations Addressed by UHA



UHA-specific CY 2022 recommendations and follow-up CY 2023 assessments are summarized in Table 5-30.

Table 5-30—Assessment of UHA's Approach to Addressing Previous Annual Recommendations

CY 2022 Recommendation	CY 2023 Assessment
Compliance Monitoring Review	
Standard I—Availability of Services	
This recommendation was initially given during the CY 2021 EQR. UHA should revise its provider and member communications to include complete and accurate network access information. In addition, the CCO should ensure processes include ongoing monitoring of provider network compliance and corrective actions when providers fail to meet network access requirements.	**UHA did not sufficiently address the recommendation.** UHA revised its provider and member communications. However, the CCO was unable to demonstrate ongoing monitoring network provider compliance against state-established standards or taking corrective action when providers failed to meet appointment timeliness. UHA should continue to develop processes to ensure the CCO is monitoring compliance of its provider network and corrective actions when providers fail to meet network access requirements.
Standard II—Assurances of Adequate Capacity and Services	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard III—Coordination and Continuity of Care	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard IV—Coverage and Authorization of Services	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard V—Provider Selection	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard VI—Subcontractual Relationships and Delegation	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard VII—Member Rights and Protections	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard VIII—Confidentiality	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.

CY 2022 Recommendation	CY 2023 Assessment
Standard IX—Enrollment and Disenrollment	
UHA should revise its member-facing documents and training provided to staff to align with federal and State requirements. UHA should also demonstrate oversight and monitoring of disenrollment reasons to ensure compliance with the regulatory requirements.	**UHA sufficiently addressed the recommendation.** Documentation reviewed during the CY 2023 CMR activity demonstrated compliance with the standard.
Standard X—Grievance and Appeal Systems	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard XI—Practice Guidelines	
This standard was not assessed during the 2022 CMR.	Not applicable.
Standard XII—Quality Assessment and Performance Improvement	
UHA should revise its QAPI program structure to align with federal and State requirements for a QAPI program. UHA should also demonstrate implementation and appropriate oversight of its QAPI program.	**UHA did not sufficiently address the recommendation.** UHA's impact analysis included a high-level analysis of its QAPI program structure and identified barriers as well as some key priorities for the CCO. However, the analysis was not inclusive of all QAPI program activities. UHA should conduct an annual assessment of activities outlined in the QAPI program description or policies, including background and rationale. This should include a discussion of goals and objectives. At a minimum, it should address key priority areas and the elements outlined in the QAPI standard.
Standard XIII—Health Information Systems, including ISCA	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard XIV—Member Information	
This standard was not assessed during the 2022 CMR.	Not applicable.
Performance Improvement Projects	
Statewide Mental Health Service Access Monitoring PIP	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.

CY 2022 Recommendation	CY 2023 Assessment
Statewide Substance Use Disorder PIP	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Performance Measure Validation	
This recommendation was initially given during the CY 2021 EQR. UHA should continue to monitor key performance measure rates in alignment with its QAPI goals and objectives. For all key measures that fall below established performance or improvement thresholds, UHA should conduct root cause analyses to identify specific factors affecting performance. Once identified, targeted interventions should be developed, implemented, and evaluated to ensure effective improvement strategies are adopted to increase performance over time. Additionally, UHA should continue to monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches to ensuring the quality, timeliness, and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	**UHA sufficiently addressed the recommendation.** UHA reported several interventions that were implemented beginning Q3 2022 to ensure the quality, timeliness, and accessibility of SUD treatment. UHA developed a Tiger Team consisting of department leads to individually meet with low-performing providers. UHA developed a Quality Program, implemented a Value-Based Payment measure for hospitals with a high number of SUD index episodes, launched an a IET cohort in PointClickCare, and leveraged peer support specialists to connect members with SUD treatment services. UHA should continue implementing these efforts to raise its rate on this measure indicator to the level of the benchmark set by OHA.
Validation of Network Adequacy	
This recommendation was initially given during the CY 2021 EQR. UHA should implement mechanisms to monitor provider directory accuracy and appointment availability.	**UHA did not sufficiently address the recommendation.** The CCO partially addressed the recommendation by implementing secret shopper calls and a new internal database to monitor inactive providers and those with missing data. However, the CCO has not addressed providers with incorrect information or mechanisms to address appointment availability issues. The CCO's response indicated it has interpreted OAR 410-141-3515 (11) to mean the CCO is responsible for meeting appointment availability standards, not individual providers, and the CCO reported its overall provider network has the capacity to meet appointment availability standards. However, the results of the CY 2023 secret shopper and revealed telephone survey activities conducted by HSAG demonstrated substantial data deficiencies, low appointment rates, and long wait times for members. UHA should reevaluate its current mechanisms to

CY 2022 Recommendation	CY 2023 Assessment
	monitor provider directory accuracy and appointment availability, and implement processes to improve access to care for members.
UHA should ensure that it reports DSN Provider Capacity Reporting data values for all required data fields and seek technical assistance from OHA as needed.	**UHA sufficiently addressed the recommendation.** UHA described processes implemented to ensure complete reporting. Results from OHA's Q1 2023 DSN Provider Capacity Report demonstrated sufficient improvements in the quality of identified data fields.
Encounter Data Validation	
This recommendation was initially given during the CY 2021 EQR. UHA should implement standard quality controls to ensure accurate data extracts. Through the development of standard data extraction procedures and quality control, the number of errors associated with extracted data could be reduced. Additionally, HSAG recommends that UHA continually monitor its encounter submissions to OHA to ensure complete, accurate, and timely encounter data submissions.	**UHA did not sufficiently address the recommendation.** UHA noted in its response that it has implemented initiatives to address the recommendation. UHA has added an additional data feed from a third-party administrator and implemented reporting to compare encounter event data. UHA's response notes increased visibility as a performance improvement. UHA also identifies the absence of *ICN* numbers on National Council for Prescription Drug Program response files as a barrier. However, to fully address the recommendation, UHA should provide more specific information on how the additional data feed and reporting have directly contributed to reducing errors associated with extracted data. Additionally, detailing any quantifiable improvements in accuracy, completeness, or timeliness of encounter data submissions would provide a clearer picture of the outcomes of the implemented initiatives. Lastly, UHA should develop a more explicit strategy for continued improvement, such as plans for addressing the identified barrier, which would further strengthen the response.
UHA should investigate the root cause for the omissions and consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews would then be provided to providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.	**UHA did not sufficiently address the recommendation.** UHA noted in its response that it has implemented initiatives to address the recommendation. UHA has hired a program integrity investigator and program integrity manager, both certified professional coders, to conduct periodic MRRs. UHA noted that the reviews will verify the appropriateness of claims and codes billed, with education and training

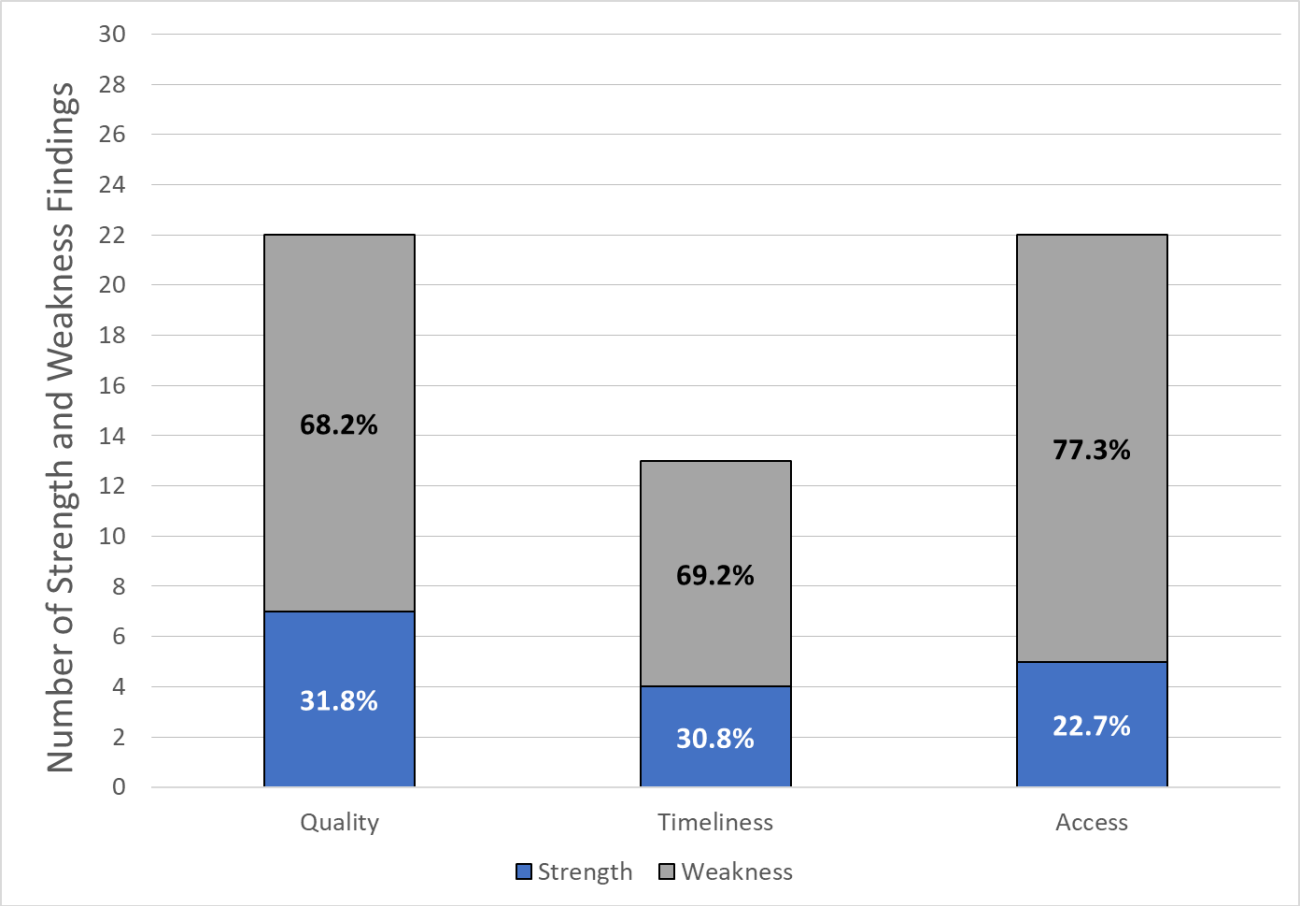
CY 2022 Recommendation	CY 2023 Assessment
	provided based on the findings. UHA's response mentions that no barriers have been identified, and no explicit strategy for continued improvement is specified. To fully address the recommendation, UHA should provide more detail on the frequency and scope of the periodic MRRs. UHA should include information on the expected outcomes or goals of these reviews to help demonstrate the effectiveness of the implemented initiatives. Additionally, UHA should provide a clearer statement on the proactive measures or ongoing plans for continued improvement, even in the absence of identified barriers, to strengthen the response.
Mental Health Parity Evaluation	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.

Yamhill Community Care Organization

Results and Conclusions

HSAG assessed the strengths and weaknesses of each CCO with respect to the quality, timeliness, and accessibility of health care services. Figure 5-31 illustrates the number of strengths exhibited by YCCO relative to the number of weaknesses identified during the CY 2023 EQR activities across the three domains. The greater the proportion of weaknesses, the greater opportunities for improvement.

Figure 5-31—YCCO Overall Number of Findings (Strengths and Weaknesses) by Domain



Detailed results from the EQR's substantive findings are summarized in Table 5-31 for each activity. This table highlights the extent to which YCCO furnishes high quality, timely, and appropriate access to health care services, and recommendations for how YCCO can best address issues identified for each activity.[5-31]

[5-31] See Section 4—Comparative Statewide Results for detailed, CCO-specific scores associated with EQR activity.

Table 5-31—YCCO Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s)[5-32]
Compliance Monitoring Review		
−	**Weakness:** YCCO received a score of 88.9 percent in Standard III—Coordination and Continuity of Care due to failure to appropriately assess/reassess members for care coordination services, develop treatment plans, and ensure health records are maintained in accordance with professional standards. **Why the weakness exists:** YCCO failed to demonstrate a streamlined method of assessing and reassessing members and updating the member's care plan within the appropriate time frames. YCCO also failed to implement mechanisms to ensure the appropriate maintenance of medical records in accordance with professional standards. **Recommendations:** YCCO must demonstrate implementation of appropriate assessments, reassessments, and revision of treatment plans according to federal and State requirements. YCCO must also implement mechanisms to ensure the appropriate maintenance of medical records in accordance with professional standards.	
−	**Weakness:** YCCO received a score of 66.7 percent in Standard IV—Coverage and Authorization of Services due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting YCCO's ability to ensure the appropriate services offered to members, appropriate and consistent coverage determinations, and proper and timely notification of adverse benefit determinations. **Why the weakness exists:** YCCO's policies and procedures did not align with federal and State requirements. Additionally, YCCO demonstrated reversing service authorization decisions outside the appeal process. YCCO also failed to adhere to requirements for appropriate decision-makers, monitoring for consistent application of criteria, and required content and time frames for notification of adverse benefit determinations. **Recommendations:** YCCO must revise its policies and procedures to align with federal and State requirements. YCCO must demonstrate adherence to federal and State requirements for authorization of services, and required content and time frames for notification of adverse benefit determinations.	
−	**Weakness:** YCCO received a score of 80.0 percent in Standard VII—Member Rights and Protections due to a lack of operational structure, impacting YCCO's ability to ensure that member rights are respected and advance directive requirements are met.	

[5-32] = Quality, = Timeliness, = Access

Strength/ Weakness	Description	Domain(s)[5-32]
	Why the weakness exists: YCCO's policies and procedures did not align with federal and State requirements. **Recommendations:** YCCO must revise its policies and procedures to align with federal and State requirements.	
−	**Weakness:** YCCO received a score of 79.6 percent in Standard X—Grievance and Appeal Systems due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting YCCO's ability to ensure member grievances and appeals are addressed and responded to appropriately. **Why the weakness exists:** YCCO's policies and procedures did not align with federal and State requirements. Additionally, YCCO failed to adhere to requirements for time frames for acknowledging and responding to grievances and appeals and readability of notices. YCCO also failed to communicate grievance and/or appeal requirements to providers and subcontractors. **Recommendations:** YCCO must revise its policies and procedures to align with federal and State requirements. YCCO must demonstrate adherence to federal and State requirements for time frames for acknowledging and responding to grievances and appeals and readability of notices. YCCO must also demonstrate implementation of federal and State requirements within communications to providers and subcontractors.	
−	**Weakness:** YCCO received a score of 77.3 percent in Standard XIV—Member Information due to a lack of operational structure and failure to demonstrate implementation of an established process, impacting YCCO's ability to ensure proper member communication. **Why the weakness exists:** YCCO's policies and procedures and member-facing materials (i.e., the member handbook, member notices, medication formulary, and provider directory) did not align with federal and State requirements. YCCO also failed to ensure electronically available information is readily accessible. **Recommendations:** YCCO must revise its policies, procedures, and member-facing materials to align with federal and State requirements.	
−	**Weakness:** YCCO received a score of 95.8 percent in Standard XVI—Emergency and Poststabilization Services due to a lack of operational structure to ensure poststabilization services are covered appropriately. **Why the weakness exists:** YCCO's policies and procedures did not align with federal and State requirements. **Recommendations:** YCCO must revise its policies and procedures to align with federal and State requirements.	

Strength/ Weakness	Description	Domain(s)[5-32]
Performance Improvement Projects		
Statewide Mental Health Service Access Monitoring PIP		
–	**Weakness:** YCCO did not report accurate performance indicator results or statistical testing results. **Why the weakness exists:** YCCO's reported indicator data and statistical testing results could not be replicated. **Recommendations:** YCCO should ensure all indicator data and statistical testing results are accurately and consistently reported throughout the PIP documentation.	
–	**Weakness:** YCCO did not report accurate results of statistical testing comparing remeasurement results to baseline results. **Why the weakness exists:** YCCO's reported *p* value comparing overall baseline and RY 1 results was based on the incorrect baseline indicator data in the narrative interpretation of results. YCCO also did not revise the RY 1 narrative. **Recommendations:** YCCO should ensure statistical testing used to compare baseline and remeasurement results is appropriate and accurate.	
–	**Weakness:** YCCO's interpretation of indicator results was incomplete. **Why the weakness exists:** YCCO did not discuss whether factors were identified that may threaten the validity of the RY 1 results or the ability to compare baseline and RY 1 results. **Recommendations:** In the narrative interpretation of results, YCCO should address whether factors were identified that may threaten the validity of the results or the ability to compare the baseline and remeasurement results.	
–	**Weakness:** YCCO's reported indicator results did not demonstrate any improvement over baseline performance. **Why the weakness exists:** There was no improvement in indicator results from baseline to RY 1. **Recommendations:** YCCO should revisit root cause analyses identifying barriers to improving access to MH services to determine which barriers to improvement were not effectively addressed. YCCO should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to improve indicator results.	

Strength/ Weakness	Description	Domain(s)[5-32]
Statewide Substance Use Disorder PIP		
+	**Strength:** YCCO successfully initiated the Implementation stage for the PIP, receiving a *Met* score for 100 percent of applicable evaluation elements in the PIP validation tool. In the Implementation stage, YCCO accurately reported baseline performance indicator data; identified and analyzed barriers for initiation, engagement, and treatment of alcohol and other drug use disorders; and began to carry out interventions to address those barriers.	
Performance Measure Validation		
+	**Strength:** YCCO's MY 2022 performance on the *Child and Adolescent Well-Care Visits—Ages 3 to 6 Years* measure indicator demonstrated ongoing improvement since MY 2020. In addition, the CCO's MY 2022 rate for this measure exceeded the statewide aggregate and 2020 CCO 75th percentile benchmark set by OHA for MY 2022 by 5 percentage points or more.	
+	**Strength:** YCCO's MY 2022 performance on the *Members Receiving Preventive Dental or Oral Health Services—Ages 1 to 5 Years* and *Ages 6 to 14 Years* measure indicators demonstrated ongoing improvement for members ages 6 to 14 years since MY 2020.	
+	**Strength:** YCCO's performance on the *Oral Evaluation for Adults With Diabetes* measure demonstrated ongoing improvement since MY 2020.	
−	**Weakness:** YCCO's MY 2022 rate on the *Initiation of SUD Treatment* measure indicator for members ages 18 years and older fell below the 2020 HEDIS national Medicaid median benchmark set by OHA for MY 2022. **Why the weakness exists:** YCCO's performance on this measure indicator suggests there are barriers impacting efforts to initiate treatment for members diagnosed with SUD. **Recommendations:** YCCO should conduct root cause analyses to identify specific factors affecting performance on this measure and develop, implement, and evaluate targeted interventions to ensure improvement strategies are adopted. Additionally, YCCO should monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches for ensuring the timeliness and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	

Strength/ Weakness	Description	Domain(s)[5-32]
Validation of Network Adequacy		
Delivery System Network Evaluation		
	**Strength:** Although YCCO did not achieve a high compliance score for its CY 2023 DSN Provider Narrative submission, both the overall quality of submitted documentation and the implementation of substantial process reforms demonstrated YCCO's commitment to improvement and responsiveness to feedback. YCCO showed that, while it still had room for growth in regard to network adequacy monitoring and decision-making, such improvements were specific to individual activities and requirements rather than overall approach.	
	**Weakness:** YCCO showed potential issues within its provider data, including but not limited to provider counts, service area operations, and status of accepting new patients. **Why the weakness exists:** YCCO's provider data showed multiple substantial increases and decreases in provider counts between Q2 2022 and Q1 2023, indicating potential data issues, potential barriers to care, or both. With the exception of PCDs, all providers were listed as having 100 percent acceptance of new patients, indicating potential data issues. **Recommendations:** YCCO should seek technical assistance with OHA to determine the nature of the provider capacity data issues and correct them.	
Secret Shopper Survey		
	**Weakness:** The total secret shopper survey response rate was 79.0 percent across all PCP and PCD cases. Of the total responsive cases, 81.3 percent of the offices confirmed the location, 25.2 percent offered the requested services, 10.7 percent accepted OHP, 9.3 percent accepted YCCO, and 7.5 percent accepted new patients. **Why the weakness exists:** In addition to limitations related to the secret shopper approach, the accuracy of YCCO's provider data may have contributed to the low response rate and accuracy results. **Recommendations:** HSAG recommends that YCCO use the case-level analytic data files to address the data deficiencies identified during the secret shopper survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
	**Weakness:** Of the total secret shopper survey responsive cases, only 3.3 percent resulted in an appointment. **Why the weakness exists:** In addition to limitations related to the secret shopper approach, the accuracy of YCCO's provider data may have contributed to the low appointment availability rate.	

Strength/ Weakness	Description	Domain(s)[5-32]
	Recommendations: HSAG recommends that YCCO confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. YCCO should use the case-level analytic data files containing data deficiencies identified during the secret shopper survey calls.	
Revealed Telephone Survey		
−	**Weakness:** Overall, 52.1 percent of the revealed telephone survey total sampled cases were reached, of which six, or 5.4 percent, refused to participate in the survey. Of the total responsive cases, 79.5 percent of the offices confirmed the location, 56.3 percent offered the requested specialty, 52.7 percent accepted OHP, 33.9 percent accepted YCCO, and 32.1 percent accepted new patients. **Why the weakness exists:** In addition to limitations related to the revealed telephone approach, the accuracy of YCCO's provider data may have contributed to the low response rate and accuracy results. **Recommendations:** HSAG recommends that YCCO use the case-level analytic data files to address the data deficiencies identified during the revealed telephone survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
−	**Weakness:** Of the sampled cases, only 7.9 percent of the revealed telephone survey respondents offered a new patient appointment, while only 13.0 percent of survey respondents offered an appointment for an existing patient. Of the total cases that offered an appointment, 78.6 percent of routine appointments and 60.7 percent of urgent appointments were within the wait time compliance standard. **Why the weakness exists:** In addition to limitations related to the revealed telephone approach, the accuracy of YCCO's provider data may have contributed to the low appointment availability rate. Additionally, internal office staffing structures and procedures may have contributed to the long wait times. **Recommendations:** HSAG recommends that YCCO confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. YCCO should use the case-level analytic data files containing data deficiencies identified during the revealed telephone survey calls and work with BH outpatient offices to identify the root cause for delays in appointment availability.	
Encounter Data Validation		
+	**Strength:** YCCO-submitted data exhibited high record-level data completeness, with low record omission and surplus rates.	

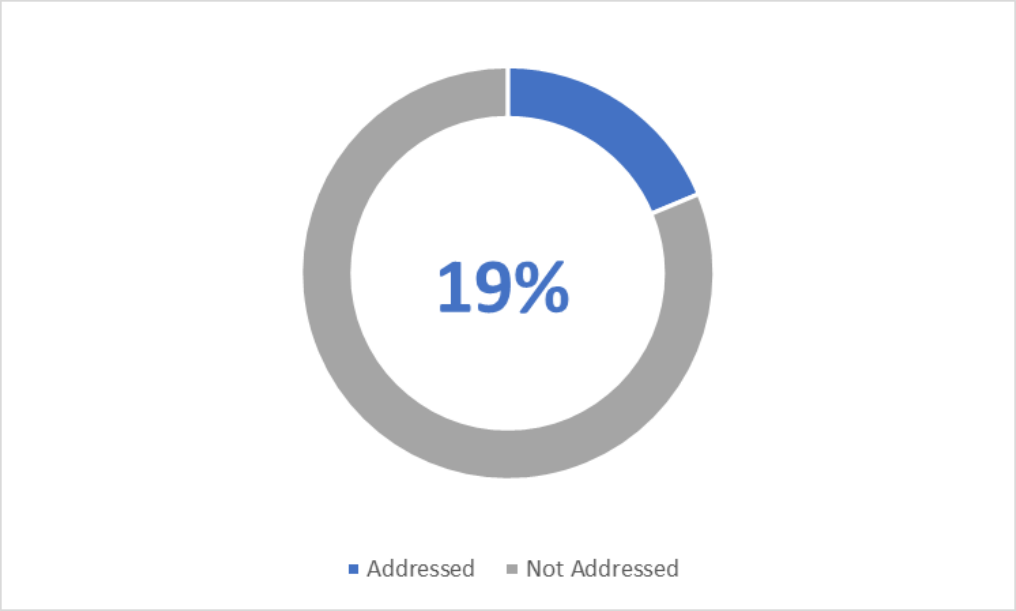
Strength/ Weakness	Description	Domain(s)[5-32]
+	**Strength:** Encounters that could be matched between data extracted from OHA's data warehouse and data extracted from YCCO's or the subcontractor's data system exhibited a high level of element completeness (i.e., low element omission and surplus rates) across all evaluated key data elements.	
+	**Strength:** Among records that could be matched between the two data sources, a high level of element accuracy (i.e., data elements from both sources had the same values when populated) was exhibited across all evaluated key data elements.	
+	**Strength:** YCCO-submitted data had high all-element accuracy for all evaluated key data elements, indicating that the values (missing or non-missing) in both data sources (YCCO and OHA) were the same for almost all records.	
Mental Health Parity Evaluation		
+	**Strength:** YCCO achieved full compliance with parity requirements for application of NQTLs applied to MH/SUD and M/S benefits.	
−	**Weakness:** YCCO reported conflicting information in the MHP Treatment Limitation Review Tool. **Why the weakness exists:** YCCO reported it has not applied the practice guideline criteria for treatment limitation to any service classification of MH/SUD benefits; however, YCCO listed that clinical practice guidelines are utilized to make medical necessity determinations for MH/SUD benefits in the Availability of Information, Section 6, of the MHP Treatment Limitation Review Tool. **Recommendations:** YCCO should identify all treatment limitations applied to MH/SUD benefits.	
−	**Weakness:** YCCO showed substantial differences in the percentages of paid, out-of-network MH/SUD IP and OP claims compared to M/S IP and OP claims. Although differences in the percentage of paid claims may be legitimate, they may also highlight procedural or network differences indicating potential barriers to members' access to MH/SUD services. **Why the weakness exists:** Out-of-network IP and OP MH/SUD claims were paid less frequently than M/S claims. **Recommendations:** YCCO should review out-of-network claim denials to understand the factors affecting the lower percentages of paid MH/SUD IP and OP claims compared to M/S IP and OP claims. YCCO should assess whether any barriers exist for members accessing MH/SUD services, including the need to seek services outside the CCO's network (e.g., appointment availability).	

Follow-Up on Prior Year Recommendations

HSAG evaluated YCCO's approach to addressing the recommendations and/or findings issued during CY 2022 and unresolved findings from CY 2020 and CY 2021 while conducting the CY 2023 EQR activities. The CCOs not addressing findings and recommendations are at risk of being out of compliance with their contracts.

Figure 5-32 illustrates the degree in which the CCO sufficiently addressed the recommendations for QI made by HSAG during the CY 2022 EQR.

Figure 5-32—Percentage of CY 2022 EQR Recommendations Addressed by YCCO



YCCO-specific CY 2022 recommendations and follow-up CY 2023 assessments are summarized in Table 5-32.

Table 5-32—Assessment of YCCO's Approach to Addressing Previous Annual Recommendations

CY 2022 Recommendation	CY 2023 Assessment
Compliance Monitoring Review	
Standard I—Availability of Services	
This recommendation was initially given during the CY 2021 EQR. YCCO should ensure processes include ongoing monitoring of provider network compliance and corrective actions when providers fail to meet network access requirements.	**YCCO did not sufficiently address the recommendation.** YCCO was unable to demonstrate ongoing monitoring of network provider compliance against all state-established standards or taking corrective action when providers failed to meet appointment timeliness. YCCO should continue to develop processes to

CY 2022 Recommendation	CY 2023 Assessment
	ensure the CCO is monitoring compliance of its provider network and corrective actions when providers fail to meet network access requirements.
Standard II—Assurances of Adequate Capacity and Services	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard III—Coordination and Continuity of Care	
This recommendation was initially given during the CY 2020 EQR. YCCO should ensure ongoing monitoring of the timeliness of care coordination activities, including ICC services, to ensure compliance with State and federal requirements.	**YCCO sufficiently addressed the recommendation.** Documentation reviewed during the CY 2023 CMR activity demonstrated compliance with the standard.
Standard IV—Coverage and Authorization of Services	
This recommendation was initially given during the CY 2020 EQR. YCCO should revise its policies to specify the appropriate time frames for processing PA requests.	**YCCO did not sufficiently address the recommendation.** YCCO's policies and procedures failed to address the specific number of days for the CCO to determine whether a PA request is valid or non-valid. Further, the policy did not address providing services after office hours and on weekends that require PA. YCCO should revise its policies to specify the appropriate time frames for processing PA requests.
Standard V—Provider Selection	
This recommendation was initially given during the CY 2021 EQR. YCCO should implement an effective credentialing program that complies with requirements for credentialing THWs; adequate oversight of its credentialing subcontractors; and appropriate training of CCO staff and participating providers and their staff regarding the delivery of covered services, applicable administrative rules, and the CCO's administrative policies.	**YCCO did not sufficiently address the recommendation.** YCCO should ensure its credentialing program complies with requirements for credentialing THWs; adequate oversight of its credentialing subcontractors; and appropriate training of CCO staff and participating providers and their staff regarding the delivery of covered services, applicable administrative rules, and the CCO's administrative policies.
Standard VI—Subcontractual Relationships and Delegation	
This recommendation was initially given during the CY 2021 EQR. YCCO should ensure its subcontractor oversight program implements corrective action for identified deficiencies.	**YCCO did not sufficiently address the recommendation.** YCCO should evaluate current processes to ensure its subcontractor oversight

CY 2022 Recommendation	CY 2023 Assessment
	program implements corrective action for identified deficiencies.
Standard VII—Member Rights and Protections	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard VIII—Confidentiality	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard IX—Enrollment and Disenrollment	
YCCO should revise its policies and procedures, member-facing documents, and training provided to staff to align with federal and State requirements. YCCO must also demonstrate oversight and monitoring of disenrollment reasons to ensure compliance with the regulatory requirements.	**YCCO did not sufficiently address the recommendation.** YCCO updated information on its website and within the member handbook; however, policies and procedures remained out of compliance with federal and State requirements. The CCO also did not demonstrate monitoring reasons for disenrollment other than for loss of eligibility. YCCO should revise its policies and procedures, member-facing documents, and training provided to staff to align with federal and State requirements. YCCO must also demonstrate oversight and monitoring of disenrollment reasons to ensure compliance with the regulatory requirements.
Standard X—Grievance and Appeal Systems	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard XI—Practice Guidelines	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Standard XII—Quality Assessment and Performance Improvement	
YCCO should revise its QAPI program structure to align with federal and State requirements for a QAPI program, including appropriate oversight of its QAPI program.	**YCCO did not sufficiently address the recommendation.** YCCO was unable to demonstrate that corrective actions identified at previous QAPI meetings received follow-up and were addressed within subsequent committee meeting minutes. YCCO should ensure its QAPI program oversight includes ensuring corrective actions needed are addressed and documented within meeting minutes.

CY 2022 Recommendation	CY 2023 Assessment
Standard XIII—Health Information Systems, including ISCA	
YCCO should amend or develop policies and procedures that describe the collection and reporting of required data, as well as oversight processes for monitoring data submissions from BH providers. YCCO should implement and ensure staff are trained and knowledgeable about these defined processes, including the documentation of all oversight activities and follow-up actions taken when issues are identified.	**YCCO did not sufficiently address the recommendation.** YCCO was unable to demonstrate processes in place to monitor its BH providers' compliance with MOTS submission requirements. YCCO should amend or develop policies and procedures that describe the collection and reporting of required data, as well as oversight processes for monitoring data submissions from BH providers. YCCO should implement and ensure staff are trained and knowledgeable about these defined processes, including the documentation of all oversight activities and follow-up actions taken when issues are identified.
Standard XIV—Member Information	
This recommendation was initially given during the CY 2020 EQR. YCCO should revise its provider directory to meet the information requirements pursuant to 42 CFR §438.10, including website URLs and whether the provider is accepting new OHP members.	**YCCO did not sufficiently address the recommendation.** YCCO's provider directory continued to omit required elements. YCCO should ensure both its paper and electronic versions of its provider directory include all federal and State requirements.
Performance Improvement Projects	
Statewide Mental Health Service Access Monitoring PIP	
YCCO should review the final baseline indicator data file distributed by OHA and seek technical assistance, if needed. The CCO should correct the baseline indicator data prior to next year's annual PIP validation.	**YCCO did not sufficiently address the recommendation.** Although YCCO sought and received technical assistance from HSAG and OHA, the CCO did not correctly report the baseline indicator results and did not report statistical testing results comparing baseline results to RY 1 results in this year's PIP submission. YCCO should correct the baseline indicator data and report statistical testing results, seeking additional technical assistance, if needed, prior to next year's annual PIP validation.
Statewide Substance Use Disorder PIP	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.
Performance Measure Validation	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.

CY 2022 Recommendation	CY 2023 Assessment
Validation of Network Adequacy	
YCCO should develop a formal process to address monitoring of appointment availability for members.	**YCCO did not sufficiently address the recommendation.** YCCO's CY 2023 DSN Provider Narrative submission provided descriptions and supporting documentation describing quarterly monitoring methodologies for wait time to appointment availability. However, as previously stated within the assessment of Standard I—Availability of Services, YCCO's provider network monitoring did not include an assessment of compliance with all network access standards. In addition, the results of the CY 2023 secret shopper and revealed telephone survey activities conducted by HSAG demonstrated substantial data deficiencies, low appointment rates, and long wait times for members. YCCO should reevaluate its current mechanisms to monitor provider directory accuracy and appointment availability, and implement processes to improve access to care for members.
This recommendation was initially given during the CY 2021 EQR. YCCO should investigate and resolve all reporting deficiencies and data errors to ensure alignment between data sources, DSN Provider Narrative submissions, supporting documentation (i.e., DSN Provider Capacity Reporting data), and State requirements, specifically due to incomplete and inconsistent information for IHS/THS and UCC facility types.	**YCCO sufficiently addressed the recommendation.** YCCO described and demonstrated investigation and correction of data deficiencies identified with IHS/THS and UCC facility types.
This recommendation was initially given during the CY 2021 EQR. YCCO should provide all required information and ensure that all DSN Provider Narrative responses and supporting documentation are relevant and sufficient.	**YCCO sufficiently addressed the recommendation.** The overall quality of submitted documentation and implementation of targeted efforts clearly demonstrated the CCO's intentionality in addressing prior issues. Although there remained areas for improvement, the nature of these deficiencies was specific to individual network adequacy monitoring processes rather than overall sufficiency of documentation.
Encounter Data Validation	
This recommendation was initially given during the CY 2021 EQR. YCCO should develop standardized data extraction procedures or a process for monitoring encounter submissions	**YCCO did not sufficiently address the recommendation.** The response from YCCO indicates that the CCO has implemented initiatives to address the recommendation. YCCO has finalized encounters through CIM, and its

CY 2022 Recommendation	CY 2023 Assessment
to OHA to ensure complete, accurate, and timely encounter data submissions.	subcontractor, Ayin (PH Tech), monitors completeness by providing copies of all 837 files submitted to OHA. Weekly validation responses and reconciling with CCV and certified validation form numbers is performed, and Ayin uses an audit manager tool for quality checks. Based on the response, YCCO appears to have partially addressed the recommendation. YCCO did not mention performance improvement or identified barriers but states that YCCO will monitor the process for continuous improvement. YCCO should provide more details on the specific procedures implemented for monitoring and validation. YCCO should have included information on the accuracy and completeness rates achieved through these initiatives to help demonstrate their effectiveness. Additionally, YCCO should have provided a more explicit statement on the ongoing commitment to improvement, perhaps outlining specific areas of focus or key performance indicators for monitoring to strengthen the response.
YCCO should ensure contracted providers' accountability in responding to medical record requests for the purposes of auditing, inspection, and oversight. HSAG recommends YCCO consider strengthening and/or enforcing its contract requirements with its providers in providing the requested documentation.	**YCCO did not sufficiently address the recommendation.** The response from YCCO indicates that it has taken steps to address the recommendation. YCCO is incorporating specific language from the OHA-CCO Contract into updated contracts with providers to enforce requirements related to monitoring, audit, and review processes. The contractual language grants access to various entities for examinations, audits, and record evaluations. YCCO's response demonstrated that the recommendation was partially addressed. YCCO did not mention any performance improvement as of the response date (effective from January 1, 2024). The inclusion of this language in contracts is a proactive step toward ensuring provider accountability. To enhance the response, YCCO should consider providing additional details on how it plans to monitor and evaluate the effectiveness of these contractual provisions once they become effective in 2024. YCCO should include specific metrics or indicators related to compliance and improvements in responding to medical record requests.

CY 2022 Recommendation	CY 2023 Assessment
YCCO should investigate the root cause for the omissions and consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews would then be provided to providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.	**YCCO did not sufficiently address the recommendation.** The response from YCCO indicated that the CCO has taken steps to address the recommendation. Specifically, it has included two periodic MRR audits from submitted claims on the 2024 Audit Plan. The senior compliance auditor, who holds various certifications related to coding and auditing, would perform these reviews. YCCO noted that education and training will be provided in cases where noncompliance related to documentation and/or coding practices is identified. YCCO has partially addressed the recommendation. The response lacked information on performance improvement as of the response date. YCCO should consider providing additional details on the specific criteria or focus areas of the MRR audits, as well as any plans for continuous monitoring and improvement based on the findings from these reviews. This could include specifying how the education and training efforts will be tailored to address identified issues.
Mental Health Parity Evaluation	
The CCO met performance expectations; no recommendations were provided in 2022.	Not applicable.

Appendix A. Compliance Monitoring Review Results Summary

Table A-1 provides a summary of the Oregon CCOs' CMR scores and the statewide CCO compliance score for 42 CFR Part 438, part 56, 100, 114, Subparts D, and *QAPI* standards reviewed during the past three reporting cycles (2020–2021, 2021–2022, and 2022–2023).

Table A-1—CMR Summary of Results for the Past Three Reporting Cycles (2020–2021, 2021–2022, and 2022–2023)

Standard	Standard I—Availability of Services 438.206	Standard II—Assurances of Adequate Capacity and Services 438.207	Standard V—Provider Selection 438.12; 438.214	Standard VI—Subcontractual Relationships and Delegation 438.230	Standard XI—Practice Guidelines 438.236	Standard VIII—Confidentiality 438.224	Standard IX—Enrollment and Disenrollment 438.3; 438.56	Standard XII—Quality Assessment and Performance Improvement 438.330	Standard XIII—Health Information Systems 438.242	ISCA Review	Standard III—Coordination and Continuity of Care 438.208	Standard IV—Coverage and Authorization of Services 438.210	Standard VII—Member Rights and Protections 438.100-438.102	Standard X—Grievance and Appeal Systems 438.228; 438.400–438.424	Standard XIV—Member Information 438.10	Standard XVI—Emergency and Poststabilization Services 438.114
Year of Review	**2021**					**2022**					**2023**					
CCOs																
AH	50%	75%	90%	86%	100%	100%	67%	75%	94%	100%	72.2%	63.9%	90.0%	79.6%	84.1%	70.8%
AllCare	62%	63%	85%	100%	100%	100%	67%	75%	89%	94.4%	88.9%	75.0%	60.0%	85.2%	70.5%	87.5%
CHA	50%	63%	75%	100%	83%	100%	67%	81%	89%	100%	72.2%	86.1%	70.0%	81.5%	65.9%	83.3%
CPCCO	31%	63%	75%	93%	33%	100%	33%	38%	89%	100%	88.9%	69.4%	50.0%	87.0%	68.2%	83.3%
EOCCO	81%	88%	80%	100%	67%	100%	67%	88%	100%	94.4%	83.3%	77.8%	70.0%	85.2%	79.5%	83.3%
Health Share	46%	50%	85%	93%	33%	100%	58%	75%	89%	94.4%	44.4%	44.4%	60.0%	77.8%	68.2%	62.5%
IHN	38%	75%	90%	100%	100%	100%	58%	94%	89%	100%	88.9%	61.1%	70.0%	85.2%	86.4%	66.7%
JCC	31%	63%	75%	93%	33%	100%	33%	38%	89%	100%	88.9%	69.4%	50.0%	87.0%	68.2%	83.3%
PCS-CO	65%	63%	75%	100%	100%	100%	75%	94%	100%	94.4%	94.4%	75.0%	70.0%	88.9%	90.9%	87.5%
PCS-CG	65%	63%	75%	100%	100%	100%	75%	94%	100%	94.4%	88.9%	77.8%	70.0%	88.9%	90.9%	87.5%
PCS-Lane	65%	63%	75%	100%	100%	100%	75%	94%	100%	94.4%	88.9%	72.2%	70.0%	87.0%	90.9%	87.5%
PCS-MP	65%	63%	75%	100%	100%	100%	75%	94%	100%	94.4%	88.9%	75.0%	70.0%	88.9%	90.9%	87.5%
TCHP-North	75%	90%	100%	67%	67%	100%	67%	81%	89%	100%	94.4%	61.1%	70.0%	85.2%	77.3%	100%
TCHP-South	46%	75%	90%	100%	67%	100%	67%	81%	89%	100%	94.4%	61.1%	70.0%	83.3%	77.3%	100%
UHA	85%	88%	80%	93%	100%	100%	75%	69%	100%	100%	94.4%	86.1%	90.0%	92.6%	93.2%	100%
YCCO	65%	75%	70%	64%	50%	100%	67%	94%	89%	100%	88.9%	66.7%	80.0%	79.6%	77.3%	95.8%
Statewide CCO Compliance Score	**56%**	**69%**	**80%**	**95%**	**77%**	**100%**	**64%**	**79%**	**93%**	**98.8%**	**85.1%**	**70.1%**	**69.4%**	**85.2%**	**80.0%**	**85.4%**

Appendix B. Comparative CMR Scores for CY 2020 and CY 2023

Table B-1 provides a comparison of the Oregon CCOs' CMR scores for standards reviewed during the CY 2020 and CY 2023 review cycles. The table also indicates, for each CCO and the statewide CCO compliance score, whether the change from CY 2020 to CY 2023 resulted in substantial improvement (i.e., ↑ or 10 percentage points) or decline (i.e., ↓ or 10 percentage points) in performance.

Table B-1—Comparison of CY 2020 and CY 2023 CCO CMR Results

CCO	Standard III—Coordination and Continuity of Care			Standard IV—Coverage and Authorization of Services			Standard VII—Member Rights and Protections			Standard X—Grievance and Appeal Systems			Standard XIV–Member Information		
	2020	2023	↑↓	2020	2023	↑↓	2020	2023	↑↓	2020	2023	↑↓	2020	2023	↑↓
AH	97%	72.2%	↓	97%	63.9%	↓	89%	90.0%		84%	79.6%		95%	84.1%	↓
AllCare	90%	88.9%		100%	75.0%	↓	78%	60.0%	↓	95%	85.2%		100%	70.5%	↓
CHA	80%	72.2%		94%	86.1%		89%	70.0%	↓	89%	81.5%		85%	65.9%	↓
CPCCO	87%	88.9%		82%	64.9%	↓	61%	50.0%	↓	91%	87.0%		80%	68.2%	↓
EOCCO	83%	83.3%		91%	77.8%	↓	83%	70.0%	↓	82%	85.2%		80%	79.5%	
Health Share	90%	44.4%	↓	85%	44.4%	↓	78%	60.0%	↓	86%	77.8%		85%	68.2%	↓
IHN	73%	88.9%	↑	94%	61.1%	↓	89%	70.0%	↓	84%	85.2%		85%	86.4%	
JCC	87%	88.9%		82%	69.4%	↓	61%	50.0%	↓	91%	87.0%		80%	68.2%	↓
PCS-CO	100%	94.4%		97%	75.0%	↓	89%	70.0%	↓	84%	88.9%		95%	90.9%	
PCS-CG	100%	88.9%	↓	97%	77.8%	↓	89%	70.0%	↓	84%	88.9%		95%	90.9%	
PCS-Lane	100%	88.9%	↓	97%	72.2%	↓	89%	70.0%	↓	84%	87.0%		95%	90.9%	
PCS-MP	100%	88.9%	↓	97%	75.0%	↓	89%	70.0%	↓	84%	88.9%		95%	90.9%	
TCHP-North	NA														
TCHP-South	77%	94.4%	↑	94%	61.1%	↓	83%	70.0%	↓	84%	83.3%		90%	77.3%	↓
UHA	93%	94.4%		100%	86.1%	↓	94%	90.0%		89%	92.6%		100%	93.2%	
YCCO	70%	88.9%	↑	91%	66.7%	↓	94%	80.0%	↓	89%	79.6%		90%	77.3%	↓
Statewide CCO Compliance Score	**89%**	**85.1%**		**94%**	**70.1%**	↓	**83%**	**69.4%**	↓	**87%**	**85.2%**		**90%**	**80.0%**	↓

NA=Not Applicable. The CCO was not contracted with OHP during the CY 2020 review period; therefore scores were not available for comparison to CY 2023 CMR performance.

Appendix C. Summary of Unresolved Compliance Review Findings

Table C-1 shows the number of unresolved compliance review findings for each CCO and overall statewide totals from the past three reporting cycles based on HSAG's assessment of the CCOs' improvement plans during the CY 2023 CMR activity.[C-1]

Table C-1—CMR Summary of Unresolved Compliance Review Findings from the Past Three Reporting Cycles (2019–2020, 2020–2021, and 2021–2022)

Standard	Standard III—Coordination and Continuity of Care 438.208	Standard IV—Coverage and Authorization of Services 438.114; 438.210	Standard VII—Member Rights and Protections 438.100–438.102	Standard X—Grievance and Appeal Systems 438.228; 438.400–438.224	Standard XIV—Member Information 438.10	Standard I—Availability of Services 438.206	Standard II—Assurances of Adequate Capacity and Services 438.207	Standard V—Provider Selection 438.12; 438.214	Standard VI—Subcontractual Relationships and Delegation 438.230	Standard XI—Practice Guidelines 438.236	Standard VIII—Confidentiality 438.224	Standard IX—Enrollment and Disenrollment 438.3; 438.56	Standard XII—Quality Assessment and Performance Improvement 438.330	Standard XIII—Health Information Systems 438.242	Total Number of CMR Findings Remaining Unresolved
Year of Review	2020					2021					2022				2023
CCOs															
AH	NA	NA	NA	NA	NA	1	2	NA	NA	NA	NA	1	1	NA	**5**
AllCare	NA	NA	NA	NA	NA	3	NA	NA	NA	NA	NA	NA	2	NA	**5**
CHA	NA	NA	NA	NA	NA	2	1	2	NA	NA	NA	2	2	NA	**9**
CPCCO	NA	NA	NA	NA	NA	3	1	1	NA	NA	NA	1	4	1	**11**
EOCCO	NA	NA	NA	NA	1	NA	NA	NA	NA	NA	NA	1	2	NA	**4**
Health Share	NA	2	1	NA	NA	9	3	2	NA	NA	NA	2	3	1	**23**
IHN	NA	NA	NA	NA	1	NA	NA	1	NA	NA	NA	1	1	1	**5**
JCC	NA	NA	NA	NA	NA	3	1	1	NA	NA	NA	1	4	1	**11**
PCS-CO	NA	NA	NA	NA	NA	1	NA	NA	NA	NA	NA	NA	NA	NA	**1**
PCS-CG	NA	NA	NA	NA	NA	1	NA	NA	NA	NA	NA	NA	NA	NA	**1**
PCS-Lane	NA	NA	NA	NA	NA	1	NA	NA	NA	NA	NA	NA	NA	NA	**1**
PCS-MP	NA	NA	NA	NA	NA	1	NA	NA	NA	NA	NA	NA	NA	NA	**1**
TCHP-North	NA	NA	NA	NA	NA	1	1	NA	NA	NA	NA	1	1	NA	**4**
TCHP-South	NA	NA	NA	NA	NA	1	1	NA	NA	NA	NA	1	1	NA	**4**
UHA	NA	NA	NA	NA	NA	1	NA	NA	NA	NA	NA	NA	1	NA	**2**

[C-1] See Section 5 CCO Individual Plan Results and Conclusions for detailed, plan-specific findings associated with each standard.

Standard	Standard III—Coordination and Continuity of Care 438.208	Standard IV—Coverage and Authorization of Services 438.114; 438.210	Standard VII—Member Rights and Protections 438.100–438.102	Standard X—Grievance and Appeal Systems 438.228; 438.400–438.224	Standard XIV—Member Information 438.10	Standard I—Availability of Services 438.206	Standard II—Assurances of Adequate Capacity and Services 438.207	Standard V—Provider Selection 438.12; 438.214	Standard VI—Subcontractual Relationships and Delegation 438.230	Standard XI—Practice Guidelines 438.236	Standard VIII—Confidentiality 438.224	Standard IX—Enrollment and Disenrollment 438.3; 438.56	Standard XII—Quality Assessment and Performance Improvement 438.330	Standard XIII—Health Information Systems 438.242	Total Number of CMR Findings Remaining Unresolved
Year of Review	2020					2021					2022				2023
YCCO	NA	1	NA	NA	1	1	NA	2	1	NA	NA	2	1	1	**10**
Statewide Number of Unresolved CCO CMR Findings	**NA**	**3**	**1**	**NA**	**3**	**29**	**10**	**9**	**1**	**NA**	**NA**	**13**	**23**	**5**	**97**

NA =Not Applicable. The CCO had no unresolved findings for the standard during the CY 2022 CMR review of CCO improvement plans.