2020 External Quality Review Technical Report

April 2021

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

Abbreviations and Acronyms Used in This Report

ADA.....Americans with Disabilities Act
AHRQ.....Agency for Healthcare Research and Quality
AL/ADL.....Aggregate Lifetime and Annual Dollar Limit
APD.....Aging and Persons with Disabilities
APM.....Alternative Payment Model
CAC.....Community Advisory Council
CAHPS®,* .....Consumer Assessment of Healthcare Providers and Systems
CAP.....Corrective Action Plan
CCO.....Coordinated Care Organization
CEDSU.....Claim and Encounter Data Services Unit
CFR.....Code of Federal Regulations
CLAS.....Culturally and Linguistically Appropriate Services
CMHP.....Community Mental Health Program
CMR.....Compliance Monitoring Review
CMS.....Centers for Medicare & Medicaid Services
COPD.....Chronic Obstructive Pulmonary Disease
CORE.....Center for Outcomes Research and Education
COVID-19.....Coronavirus Disease 2019
CR.....Concurrent Review
CRM.....Customer Relationship Management
CY.....Calendar Year
DCO.....Dental Care Organization
DME.....Durable Medical Equipment
DRG.....Diagnosis-Related Group
DSN.....Delivery System Network
ED.....Emergency Department
EDIE.....Emergency Department Information Exchange
EDV.....Encounter Data Validation

* **CAHPS®** refers to the Consumer Assessment of Healthcare Providers and Systems and is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

EHR.....Electronic Health Record
EPDH.....Expanded Practice Dental Hygienist
EQR.....External Quality Review
EQRO.....External Quality Review Organization
FQHC.....Federally Qualified Health Center
FFS.....Fee-for-Service
FR.....Financial Requirement
HEDIS®,† .....Healthcare Effectiveness Data and Information Set
HIPAA .....Health Insurance Portability and Accountability Act of 1996
HSAG.....Health Services Advisory Group, Inc.
HOSP .....Hospital
HPV.....Human Papillomavirus
HRSA.....Health Resources and Services
HSD.....Health Systems Division
ICC.....Intensive Care Coordination
ICD-10 .....International Classification of Diseases, Tenth Revision
ICD-10-CM.....International Classification of Diseases, Tenth Revision, Clinical Modification
IP.....Improvement Plan
IPA.....Independent Physician Association
IRR.....Interrater Reliability
ISCA.....Information Systems Capabilities Assessment
ISCAT.....Information Systems Capabilities Assessment Tool
IT.....Information Technology
LGBTQI.....Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex
LTCSS.....Long-Term Care Services and Supports
LTSS .....Long-Term Services and Supports
MAT.....Medication-Assisted Treatment
MCE.....Managed Care Entity
MCO.....Managed Care Organization
MH .....Mental Health
MH/SUD.....Mental Health/Substance Use Disorder
MHP.....Mental Health Parity
MHPA.....Mental Health Provider, Adult

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

MHPAEA..... Mental Health Parity and Addiction Equity Act of 2008
MHPP.....Mental Health Provider, Pediatric
MMIS.....Medicaid Management Information System
MOU .....Memorandum of Understanding
M/S.....Medical/Surgical
NCPDP.....National Council for Prescription Drug Programs
NCQA .....National Committee for Quality Assurance
NEMT ..... Non-Emergent Medical Transportation
NPI.....National Provider Identifier
NQTL..... Non-Quantitative Treatment Limitation
OAR.....Oregon Administrative Rule
OB/GYN .....Obstetrics/Gynecology
OHA.....Oregon Health Authority
OHP.....Oregon Health Plan
OHPA.....Oral Health Provider, Adult
OHPP .....Oral Health Provider, Pediatric
OHSA.....Oral Health Specialist, Adult
OHSP .....Oral Health Specialist, Pediatric
OON.....Out-of-Network
OOS.....Out-of-State
OPPS..... Outpatient Prospective Payment System
PA..... Prior Authorization
PAHP ..... Prepaid Ambulatory Health Plan
PCD..... Primary Care Dentist
PCDA.....Primary Care Dentist, Adult
PCDP..... Primary Care Dentist, Pediatric
PCPCH.....Patient-Centered Primary Care Home
PCP..... Primary Care Provider
PCPA.....Primary Care Provider, Adult
PCPP .....Primary Care Provider, Pediatric
PFL.....Provider File Layout
PIHP.....Prepaid Inpatient Health Plan
PIP..... Performance Improvement Project
PMV ..... Performance Measure Validation
QA.....Quality Assurance
QAPI .....Quality Assessment and Performance Improvement

QI ..... Quality Improvement
QTL ..... Quantitative Treatment Limitation
RAPID ..... Relational Health, Academic, Psychological, Intellectual, Developmental
RHIP ..... Regional Health Improvement Plan
RR ..... Retrospective Review
RX ..... Pharmacy/Pharmacies
SAFE ..... Secure Access File Exchange
SDOH ..... Social Determinants of Health
SHCN ..... Special Health Care Needs
SPA ..... Specialty Practitioner, Adult
SPMI ..... Serious and Persistent Mental Illness
SPP ..... Specialty Practitioner, Pediatric
SUD ..... Substance Use Disorder
SUDPA ..... Substance Use Disorder Provider, Adult
SUDPP ..... Substance Use Disorder Provider, Pediatric
TA ..... Technical Assistance
THW ..... Traditional Health Worker
TPL ..... Third-Party Liability
TQS ..... Transformation Quality Strategy
UM ..... Utilization Management

1. Executive Summary

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 of, timeliness of, and access to care and services provided by each entity, as mandated by 42 Code of Federal Regulations (CFR) §438.364. To meet this requirement, the Oregon Health Authority (OHA) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), 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 five dental care organizations (DCOs) and 15 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).[1-1] The DCOs are accountable for providing OHP oral health care benefits to Medicaid members enrolled in the OHP open card program who are not enrolled in a CCO, whereas 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. In this report, the DCOs and CCOs are jointly referred to as "MCEs." Each MCE is responsible for ensuring that services are delivered in a manner that complies with legal, contractual, and regulatory obligations to provide effective care.

Scope of External Quality Review Activities

To conduct this assessment, HSAG used the results of mandatory external quality review (EQR) activities, as described in 42 CFR §438.358. The purpose of these activities is to provide valid and reliable data and information about the MCEs' performance. For the 2020 assessment, HSAG used findings from the following mandatory and optional EQR activities to derive conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by each MCE. Detailed information about each activity is provided in sections 3 through 8 of this report.

- Compliance monitoring reviews (CMRs) to determine MCE compliance with federal (42 CFR §438) and State standards that address requirements related to access, structure and operations, and quality measurement and improvement. CMR activities also included follow-up on the status of past CMR findings and related improvement plans (IPs) for the DCOs from calendar year (CY) 2019.
- Validation of performance improvement projects (PIPs) and focus studies.

[1-1] During 2020, Trillium Community Health Plan (TCHP) expanded into an additional service area in the Portland metropolitan region of the State of Oregon. This expansion was approved by OHA in September 2020, and the CCO was issued a separate contract for the new service area, TCHP-North. EQR activities for the new CCO will begin in 2021.

- Performance measure validation (PMV) of seven specific measures to evaluate the accuracy and validity of OHA's calculation of the performance measure rates for the State's 15 CCOs.
- Validation of network adequacy involving the comprehensive review of MCE Delivery System Network (DSN) Provider Capacity Reports and DSN Provider Narrative Reports regarding compliance in accordance with the State's standards for access to care, network adequacy to provide covered services to all members, and strengths and gaps regarding the DSN.
- An encounter data validation (EDV) study to evaluate CCO processes for collecting, maintaining, and submitting encounter data to OHA.
- A Mental Health Parity (MHP) Analysis to ensure that coverage and access to mental health/ substance use disorder (MH/SUD) benefits were provided in parity with medical/surgical (M/S) benefits.

High-Level Results and Conclusions

This technical report is a compilation of results from the 2020 EQR activities conducted using review tools, scoring strategies, and other processes consistent with the CMS EQR protocols.[1-2,1-3,1-4] Below are high-level summaries of results from the 2020 EQR activities with more complete summaries included in the following report sections. The EQR results by MCE are provided in Appendix A. CCO Profiles and Appendix B. DCO Profiles. HSAG comprehensively evaluated OHP's strengths and the MCEs' areas for improvement with respect to the quality, timeliness, and access to care, and documented aggregated conclusions in *Section 10. Assessment of Quality, Timeliness, and Access.*

Compliance Monitoring Review

In accordance with federal requirements,[1-5] CMR activities in 2020 consisted of conducting reviews of compliance for all MCEs. The CMR consisted of a series of technical assistance (TA) webinars for MCE staff members, a pre-"onsite" desk review of completed evaluation tools and submitted documentation to determine compliance, a webinar review that included interviews of key MCE staff members and record reviews, and a follow-up desk review of any additional documentation provided the day after the webinar review. MCE performance was evaluated on the five member-focused compliance standards listed below with more detailed results displayed in *Section 3. Compliance Monitoring Review* and on OHA's Quality Assurance website.

- Standard III—Coordination and Continuity of Care

[1-2] 2020 EQR activities leveraged the CMS EQR protocols from September 2012 and those published in October 2019 to the extent that the activities, tools, and methodology were not already underway by that release date.
[1-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols*, Version 2.0, September 2012.
[1-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, October 2019*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 16, 2021.
[1-5] 42 CFR §438.358; 42 CFR §438.204(g).

- Standard IV—Coverage and Authorization of Services
- Standard VII—Member Rights and Protections
- Standard X—Grievance and Appeal Systems
- Standard XV—Member Information

CCO Review Results

Compliance with Standard VII—Member Rights and Protections represented the greatest struggle for all CCOs with an average score of 83 percent. In contrast, the CCOs achieved their highest scores on Standard IV—Coverage and Authorization of Services with an average score of 94 percent.

The CCOs had a robust policy foundation for service authorizations and were knowledgeable and efficient at managing requests. They were also broadly compliant with time frames for decision making and member notification. Regarding areas for improvement, many of the CCOs were non-compliant with the State requirement to offer members all options for reporting a discrimination complaint. In addition, several CCOs did not provide evidence of implementing community education on advance directives as required by the State. The CMR raised concerns with regard to CCO oversight of delegates around ensuring appropriate oversight and consistent delivery of benefits within and across CCOs.

HSAG will begin reporting follow-up results of CCO IPs in 2021. Per OHA, CCO CMR efforts were delayed in 2020 due to the impacts of the coronavirus disease 2019 (COVID-19) pandemic on the health care delivery system in Oregon and resulting priority shifts. Further discussion on COVID-19 impacts can be found in *Section 2. Introduction*.

DCO Review Results

Compliance with Standard III—Coordination and Continuity of Care represented the greatest struggle for all DCOs with an average score of 44 percent. In contrast, the DCOs achieved their highest scores on Standard IV—Coverage and Authorization of Services with an average score of 91 percent.

The DCOs were well-versed on processing service authorizations and their performance on Standard IV—Coverage and Authorization of Services reflected this, particularly in timely and consistent clinical decision making and member communications. In contrast, while all DCOs had developed a policy foundation for the new contractual requirement regarding care coordination and continuity of care, most struggled to implement the policies and processes. Elements such as risk screenings, comprehensive assessments, identification of prioritized populations and ensuring their quick access to care, and completion and sharing of treatment plans were either not implemented or only partially implemented.

Most DCOs resolved the majority of any findings stemming from the 2019 CMR, which included two standards: Standard I—Access and Availability, and Standard X—Grievance and Appeal Systems. Any unresolved 2019 findings were carried over and incorporated into the 2020 IPs. Counts of resolved and unresolved findings for each DCO are provided in *Section 3. Compliance Monitoring Review*. Since the number of findings across DCOs varied considerably, resolution percentages cannot be meaningfully compared across DCOs.

Performance Improvement Projects

In 2020, HSAG validated the CCOs' statewide PIP design submissions and the DCOs' PIP design submissions. HSAG also conducted reviews of CCO-specific PIP focus study progress reports. In general, the CCOs' statewide PIP validation results and DCOs' PIP validation results demonstrated strong performance by the MCEs in developing and documenting methodologically sound project designs. The PIP design serves as the foundation of the project and will support progression to the Implementation phase, which includes reporting baseline measurement results and developing improvement strategies to address identified areas for improvement.

PIP Results

Only 13 of the 15 CCOs submitted the statewide PIP for validation. While 15 CCOs were operational in 2020, two of the CCOs were newly operational in January 2020 and were exempt from the January 31, 2020, statewide PIP submission requirement. For the 2020 statewide PIP validation, all 13 reporting CCOs received a *Met* overall validation status. Each of the 13 CCOs also received a *Met* score for all applicable evaluation elements. The PIPs were scored on the Design stage only, which included defining the topic, study question, study population, study indicator, and data collection process for the project.

After the statewide PIP validation was completed in April 2020, OHA identified the need to select a new PIP topic in response to the shifting health care needs of members and communities during the COVID-19 pandemic. As of the writing of this report, OHA has begun collaborating with the CCOs to identify a new statewide PIP topic. The CCOs are expected to submit the design of the new statewide PIP topic for validation in September 2021.

PIP validation results are described in *Section 4. Performance Improvement Projects*. Descriptions of CCO-specific PIP topics, strengths, and areas for improvement are provided in Appendix A. CCO Profiles. Descriptions of DCO-specific PIP topics, strengths, and areas for improvement are provided in Appendix B. DCO Profiles.

Performance Measure Validation

HSAG evaluated the accuracy and validity of OHA's calculation of the performance measure rates for the 15 CCOs. These measures represented Healthcare Effectiveness Data and Information Set (HEDIS) and OHA-developed measures and are listed in Table 1-1 below.

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

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

Performance Measure
Disparity Measure: ED Utilization Among Members With Mental Illness
Effective Contraceptive Use
Oral Evaluation for Adults With Diabetes

PMV Results

HSAG did not identify any issues or concerns with the accuracy or validity of OHA's calculation of the performance measure rates; however, HSAG noted that OHA's vendor, Providence Health & Services, Center for Outcomes Research and Education (CORE), had discrepancies between the rate review spreadsheet and the member-level detail file, identifying a need for implementation of a more enhanced quality assurance (QA) check when transferring data. All seven performance measures were compliant with the specifications and the rates were determined reportable.

Network Adequacy

MCEs are required to submit an annual integrated DSN report and analysis to OHA demonstrating the capacity to serve enrolled members in its service area in accordance with the State's standards for access to care. OHA requested HSAG provide a comprehensive review of the 2020 MCE DSN reports and document findings regarding compliance in accordance with standards for access to care and network adequacy to provide covered services to all members. HSAG compiled and presented results in two separate reports, a 2020 CCO Annual DSN Evaluation Report and a 2020 DCO Annual DSN Evaluation Report, including overall strengths, areas for improvement, and recommendations on how to improve compliance.

To additionally support federal and State network adequacy requirements, HSAG worked with OHA to begin a provider directory validation activity in 2020 to ensure members have appropriate access to provider information. Results of the provider directory validation will be reported in 2021.

2020 Network Adequacy Results

CCO Results

Overall, the CCOs received an average score of approximately 88.1 percent of the maximum points possible (26.0 points) in the DSN Provider Narrative Report categories. Three of the CCOs met the requirements of all DSN Provider Narrative Report categories. While most CCOs met the *Coordination of Care* and *Performance on Metrics* categories, two CCOs struggled to meet the possible points across all narrative categories.

As part of the DSN Provider Narrative Report, each CCO was required to demonstrate time and distance compliance by reporting the time and distance standards of minutes, miles, and percentage of overall member access for each geographic classification in its service area distance. The CCOs received an

average score of approximately 94.3 percent of the maximum points possible (14.0 points) in the DSN Provider Narrative Report—Time and Distance Standards category.

The DSN Provider Capacity Report provided an inventory of providers and facilities within the CCOs' provider networks. The CCO DSN Provider Capacity Report submissions illustrated improved quality, consistency, and accuracy with data elements, data field format/value, and data file layout validity and alignment with reporting specifications.

DCO Results

As 2020 was the first year DSN reporting was required of the DCOs, some of the lower scores likely represent a need for TA in proper reporting rather than operational failings.

Overall, the DCOs received an average score of approximately 77 percent of the maximum points possible (14.0 points) across aggregated DSN Provider Narrative Report categories. Two DCOs achieved a perfect score in at least one category, while all DCOs received at least a positive score in each categorical element. While all DCOs earned their lowest scores in the *Description of Members* category, all performed strongest in the *Additional Analysis of the DCO's Provider Network to Meet Member Needs* category. The DCOs achieved an average score of approximately 80 percent of the maximum points possible (5.0 points) across aggregated DSN Provider Narrative Report—Time and Distance Standards.

The DCO DSN Provider Capacity Report submissions illustrated many areas for improvement with regard to the quality, consistency, and accuracy of data field format/value and data file layout validity, and overall alignment with the reporting specifications.

Encounter Data Validation

The 2020 EDV study examined the extent to which OHA and the CCOs had appropriate system documentation and infrastructure to produce, process, and monitor encounter data. To ensure the collection of critical information, HSAG employed a three-stage review process that included an initial document review of encounter data requirements and policies, development and fielding of a customized encounter data questionnaire requiring supporting documentation, and follow-up interviews with key staff members when appropriate.

2020 EDV Evaluation Results

Based on encounter data questionnaire responses, the CCOs provided information demonstrating their capacity to collect, process, and transmit to OHA claims and encounter data meeting established quality specifications. While each CCO employed different strategies to facilitate accurate and timely encounter data submission, the CCOs pointed to centralized encounter data systems and data warehousing as key to their ability to develop adaptable data review processes that could promptly respond to quality issues identified by OHA. All CCOs described the role of internal personnel and departments, software systems, and/or external vendors employed for activities such as claims adjudication, provider and member

information verification, and management of third-party liability (TPL) information. When applicable, the CCOs described the systems/vendor oversight and data remediation activities they had in place to ensure the completeness and accuracy of data submitted to the CCO or processed on their behalf.

HSAG found that the CCOs had substantial autonomy regarding development and management of their encounter data systems and were required to submit complete and accurate encounter data in a timely manner; however, the limitation on the number of records that CCOs were allowed to submit for each transaction posed challenges in CCO encounter data submission, since additional steps had to be taken to comply with the number of record constraints. Although the CCOs reported the State's Medicaid Management Information System (MMIS) portal to be a generally useful tool, they cited examples that they perceived to be MMIS' limitations in reviewing some aspects of data quality that HSAG was not able to validate.

In cases where delegates were involved in encounter data submissions, HSAG found that validation was not consistently conducted at the CCO level prior to data submission to OHA. This both limited the ability of CCOs to oversee delegate encounter errors and rejections and increased the administrative burden on OHA. HSAG also found that, while CCOs and OHA described various activities to monitor completeness, accuracy, and timeliness of data, there was little or no evidence of validation via chart/medical record reviews by some CCOs or by OHA.

Mental Health Parity

HSAG conducted the 2020 MHP Analysis to determine whether limitations (e.g., day limits, prior authorization [PA] requirements, or network admission standards) applied to MH/SUD benefits were comparable to and applied no more stringently than those for M/S services provided under OHP managed care benefit packages. The analysis was conducted with OHA's 15 CCOs and OHP fee-for-service (FFS) to ensure continued compliance with MHP regulations in 42 CFR §438 Subpart K across all OHP managed care benefit packages. To conduct the 2020 MHP Analysis, HSAG developed review tools, provided TA to CCOs on analysis activity and submission details, conducted desk reviews of documentation submissions, analyzed utilization management (UM) and credentialing data, and held conference calls with CCOs and OHP FFS to further understand operations. HSAG reported analysis results in individual CCO and OHP FFS MHP Analysis reports as well as an aggregated summary report available on OHA's MHP website.[1-6]

2020 MHP Evaluation Results

Results of the 2020 MHP Analysis revealed that the CCOs' policies included integrated policies and processes that applied to both MH/SUD and M/S benefits, including UM and PA policies and service authorization handbooks. None of the CCOs had separate policies for the management of benefits based on benefit package, ensuring consistency across the packages in the analyses. The CCOs and OHP FFS

[1-6] Oregon Health Authority. Oregon Medicaid Mental Health Parity Analysis Website. Available at: https://www.oregon.gov/OHA/HSD/OHP/Pages/MH-Parity.aspx. Accessed on: Mar 17, 2021.

were generally compliant with MHP requirements, with four CCOs issued no findings and the remaining CCOs issued a minimal number of findings. The minimal number of findings were primarily due to operational differences in the CCO E and CCO G benefit packages where the CCOs managed MH/SUD benefits and OHP FFS managed M/S benefits.

Summary EQR Recommendations

HSAG used the results and conclusions drawn from its analyses and evaluations for each 2020 EQR activity to develop overarching recommendations for OHA to ensure alignment with Medicaid managed care regulations. A summary of the recommendations is included below, with the full list of detailed recommendations presented in *Section 11. 2020 EQR Recommendations to the State*. In addition, HSAG assessed OHA's quality strategy and provided recommendations pertaining to the State's intended quality strategy update to be conducted in 2021.

- **CMR:** OHA should ensure alignment of MCE contracts with Oregon Administrative Rules (OARs), provide TA to DCOs on 2021 DCO Health Care Services Contract requirements, clarify member rights language and context expectations to ensure consistency across MCEs, and consider the extraction of cultural competency training completion fields in provider directories to align with 2020 CFR revisions.
- **PIPs:** OHA should redesign the quarterly progress report to better align with CMS EQR protocols, ensure the new statewide PIP topic selection encompasses member needs and standardized performance measures, and promote enhanced CCO engagement in the statewide PIP topic selection and study design.
- **PMV:** OHA should ensure its vendor, CORE, implements a more enhanced QA check when transferring data.
- **Network Adequacy:** OHA should work to align category elements with requirements, establish standardized time and distance standards, more clearly define urban and rural geographic classifications, adjust reporting to be based on standardized health care provider taxonomy codes, evaluate member assignment to geographical areas, and provide additional TA to MCEs on reporting requirements.
- **EDV:** OHA should distribute a comprehensive operational edit list to CCOs, determine provider mapping data submission requirements, conduct medical record review validation, assess CCO data validation capacity, and require CCOs to submit all internal and delegate encounter data.
- **MHP:** OHA should ensure OHP FFS collaborates with CCOs on operational impacts that could affect parity, require CCOs to submit annual attestation of continued compliance with MHP requirements, develop material change criteria, conduct medical and provider records reviews, and analyze claims denial data for compliance with requirements.

HSAG additionally assessed OHA's quality strategy and related monitoring. Although OHA's quality strategy appeared to encompass all federally required elements with regular progress monitoring, HSAG identified a lack of clarity in how each project supported the federally required quality strategy elements listed in 42 CFR §438.340(b) and a few other discrepancies. HSAG provided recommendations for OHA's consideration when updating the quality strategy in 2021.

2. Introduction

Overview

States with Medicaid managed care delivery systems are required to annually provide an assessment of MCEs' performance related to the quality of, timeliness of, and access to care and services provided by each entity, as mandated by 42 CFR §438.364.[2-1] To meet this requirement, OHA contracted with HSAG as an EQRO to perform mandatory and optional EQR activities in 2020. HSAG conducted each activity and assessed the results to derive conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by contracted MCEs.

Under Oregon's 2017–2022 Section 1115(a) Medicaid Demonstration Waiver approved by CMS on January 12, 2017, OHA contracts with five DCOs and 15 CCOs to deliver managed care physical, behavioral, and oral health care benefits to members enrolled in the State Medicaid program, referred to as OHP.[2-2] The DCOs are accountable for providing OHP oral health care benefits to Medicaid members enrolled in the OHP open card program who are not enrolled in a CCO, whereas 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. In this report, the DCOs and CCOs are collectively referred to as "MCEs." Each MCE is responsible for ensuring that services are delivered in a manner that complies with legal, contractual, and regulatory obligations to provide effective care.

Scope of External Quality Review Activities

While quality, timeliness, and access are distinct aspects of care, most MCE activities and services cut across more than one area. Collectively, all MCE activities and services affect the quality, access, and timeliness of care delivered to members. As required by 42 CFR §438.364, this independent annual technical report summarizes conclusions drawn by HSAG related to MCE strengths and areas for improvement with respect to the quality and timeliness of, and access to the health care services furnished to Medicaid managed care members and includes:

- A description of the manner in which the data from all activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality and timeliness of, and access to the care furnished by the MCEs.

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 81, No. 88/Friday, May 6, 2016. 42 CFR Parts 431, 433, §438, et al. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule. Available at: https://www.govinfo.gov/content/pkg/CFR-2010-title42-vol4/pdf/CFR-2010-title42-vol4-sec438-364.pdf. Accessed on: Mar 17, 2021.

[2-2] During 2020, TCHP expanded into an additional service area in the Portland metropolitan region of the State of Oregon. This expansion was approved by OHA in September 2020, and the CCO was issued a separate contract for the new service area, TCHP-North. EQR activities for the new CCO will begin in 2021.

- For each EQR activity conducted in accordance with 42 CFR §438.358:
  - Statutory and contextual explanation of the activity ("Background").
  - The intent and specific goals of the activity ("Objectives").
  - Technical methods of data collection and analysis ("Methodology").
  - Description of data obtained, including validated performance measurement data for each activity conducted in accordance with 42 CFR §438.358(b)(1)(i) and (ii), as well as conclusions drawn from the data ("Results").
- An assessment of each MCE's strengths and areas for improvement for the quality of, timeliness of, and access to health care services furnished to Medicaid members.
- Recommendations to OHA for improving the quality of health care services furnished by MCEs to better support improvement in the quality of, timeliness of, and access to health care services furnished to Medicaid members.
- Methodologically appropriate, comparative information about all MCEs, consistent with guidance included in the CMS EQR protocols issued in accordance with 42 CFR §438.352(e).[2-3]
- An assessment of the degree to which each MCE has effectively addressed recommendations made by the EQRO during the previous year's EQR.

Review Activities

According to 42 CFR §438.358, the State Medicaid agency, an EQRO, or the State's agent that is not a Medicaid MCE, prepaid ambulatory health plan (PAHP), or prepaid inpatient health plan (PIHP) may perform the mandatory and optional EQR-related activities to obtain data to support production of the annual EQR in 42 CFR §438.350. OHA contracted with HSAG to carry out these activities in alignment with CMS guidance, which included:

- A review to determine MCE compliance with five member-focused standards from federal (42 CFR §438) and State requirements, which addressed requirements related to access, structure and operations, and quality measurement and improvement. This activity included follow-up on the status of compliance review findings from 2019 and related IPs for the DCOs.
- A review of the statewide PIPs, DCO PIPs, CCO PIPs, and CCO focus studies. Each quarter, the CCOs submitted information on the status and outcome of three ongoing PIPs and one focus study. This information was reviewed and evaluated by HSAG staff members and used to generate feedback to OHA regarding potential areas for improvement. The DCOs were evaluated on one annual PIP.
- PMV to assess the accuracy of a set of seven incentive performance measures reported and determine the extent to which the reported rates follow the measure specifications and reporting requirements.

[2-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, October 2019*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 17, 2021.

- Validation of network adequacy involving the evaluation of the DSN for MCEs through the comprehensive review of DSN Provider Capacity Reports and DSN Provider Narrative Reports regarding provider capacity compliance in accordance with the State's standards for access to care, network adequacy to provide covered services to all members, and strengths and gaps regarding the DSN.
- An EDV study to evaluate CCO processes for collecting, maintaining, and submitting encounter data to OHA.
- An MHP Analysis to ensure that coverage and access to MH/SUD services were provided in parity with services for M/S needs.

Oregon Managed Care

OHP is the source of health coverage for approximately 1,137,099 Oregonians,[2-4] approximately 1,031,249 of which were covered by a CCO in 2020. Care for OHP members is provided through FFS efforts, CCOs, and DCOs. The CCOs and DCOs fall under the purview of this annual technical report. Both are described below.

Coordinated Care Organizations

CCOs are the primary agents of health system transformation in Oregon. The CCOs are allowed to delegate certain functions and services contingent on appropriate oversight and reporting. The State's innovative CCO model has made progress on the triple aim of better health, better care, and lower costs, and Oregon continues to improve the model to meet these goals. There were 15 CCOs providing OHP services in Oregon in 2020 under new five-year contracts with Oregon beginning on January 1, 2020. One additional CCO was added in September 2020 to provide OHP services to members in the Portland metropolitan region of the State but will not begin participating in EQR activities until 2021.[2-5]

Table 2-1 displays the CCOs and their enrollment totals as of December 2020.[2-6] Numbers do not add up to 1,137,099 due to arrangements wherein some members are covered via the State's FFS program and not enrolled with any CCO. The numbers in the table were provided by OHA's Health Analytics Division and are considered preliminary at the time of this report.

[2-4] Oregon Health Authority. Oregon Health Plan: Monthly Medicaid Population Report. CCO, Managed Care, and Open Card—December 2020 (Preliminary). Available at: https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/December%202020%20Total%20CCO-Managed%20Care%20and%20FFS%20Enrollment.pdf. Accessed on: March 17, 2021.

[2-5] During 2020, TCHP expanded into an additional service area in the Portland metropolitan region of the State of Oregon. This expansion was approved by OHA in September 2020, and the CCO was issued a separate contract for the new service area, TCHP-North. EQR activities for the new CCO will begin in 2021.

[2-6] Oregon Health Authority. Oregon Health Plan: Monthly Medicaid Population Report. CCO, Managed Care, and Open Card—December 2020 (Preliminary). Available at: https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/December%202020%20Total%20CCO-Managed%20Care%20and%20FFS%20Enrollment.pdf. Accessed on: March 17, 2021.

Table 2-1—OHP Enrollment by CCO

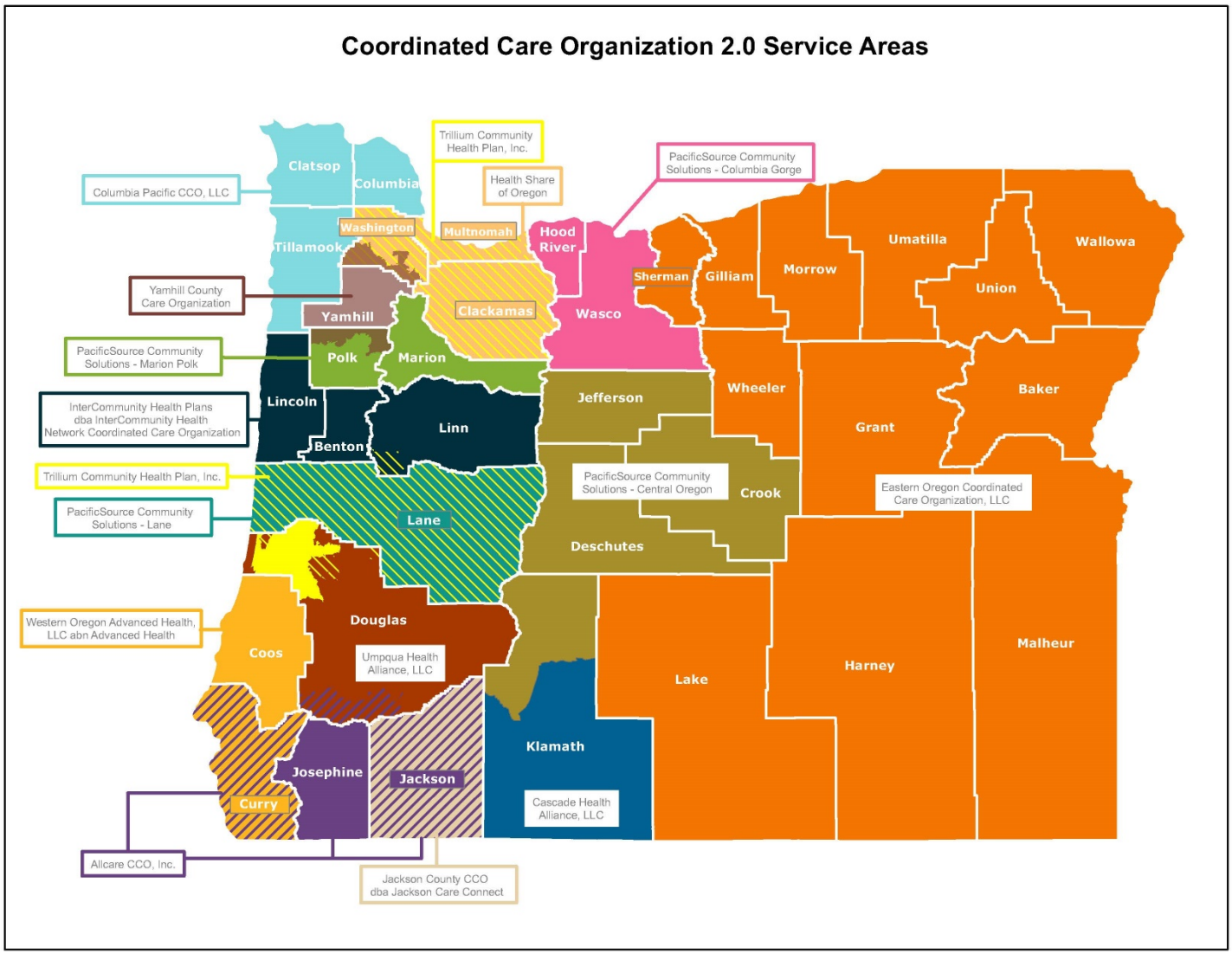
CCO	Total Members
Advanced Health (AH)	23,461
AllCare CCO, Inc. (AllCare)	51,981
Cascade Health Alliance, LLC (CHA)	21,496
Columbia Pacific CCO, LLC (CPCCO)	29,521
Eastern Oregon CCO, LLC (EOCCO)	58,426
Health Share of Oregon (Health Share)	367,799
InterCommunity Health Network (IHN)	65,099
Jackson Care Connect (JCC)	54,098
PacificSource Community Solutions—Central Oregon (PSCS-CO)	59,281
PacificSource Community Solutions—Columbia Gorge (PSCS-CG)	13,967
PacificSource Community Solutions—Lane (PSCS-Lane)	69,283
PacificSource Community Solutions—Marion Polk (PSCS-MP)	114,527
Trillium Community Health Plan, Inc. (TCHP)	41,185
Umpqua Health Alliance, LLC (UHA)	31,235
Yamhill Community Care Organization (YCCO)	29,890
Total Enrolled in a CCO	**1,031,249**

Several CCOs have notable operational relationships, which are key to understanding EQR activity documentation and performance:

- Health Share delegates all direct services and most administrative functions to various plan partners, which are additionally responsible for submitting claims directly to OHA. As such, each of Health Share's plan partners provided individual responses and supporting documentation for most of the EQR activities.
- PacificSource Community Solutions (PSCS) is the Medicaid line of business for PacificSource Health Plans, serving members through four separate CCOs in different regions of the State. Since these four CCOs fall under PSCS, they share centralized leadership and operations.
- CPCCO and JCC have a central administrative relationship with CareOregon for such things as policies, procedures, member appeals, and other centralized operations. As such, CareOregon provided the majority of the individual responses and supporting documentation for each EQR activity for the two CCOs.

Figure 2-1 shows the CCO service areas within Oregon since January 1, 2020. All counties in Oregon are served by at least one CCO.

Figure 2-1—Coordinated Care Organization Service Areas in Oregon[2-7]



[2-7] Oregon Health Authority. Coordinated Care Organization 2.0 Service Areas. Available at: https://www.oregon.gov/oha/OHPB/CCODocuments/Coordinated-Care-Organization-2.0-Service-Areas.pdf. Accessed on: Mar 17, 2021.

Dental Care Organizations

While most CCOs have delegated the management of members' oral health care benefits to dental provider networks, those members not enrolled with a CCO have their oral health care benefits directly managed by DCOs under direct contract with OHA. All DCO EQR activities in this report were reviewed in relation to members served under direct contract with OHA. The DCOs started new five-year contracts on January 1, 2020, concurrent with the CCOs. There were five DCOs operating in Oregon in 2020, providing direct-contract dental services to approximately 56,684 members. Two DCOs, Capitol Dental Care, Inc. (CDC) and Managed Dental Care of Oregon, Inc. (MDCO), are "sister" DCOs, sharing the same central staff members, leadership, administrative teams, policies, and procedures.

While some DCOs have contiguous service areas, most do not, and all DCOs contract with multiple providers outside of their main service areas. OHA had not produced a current DCO service area map at the time of this report. Table 2-2 displays the DCOs and their direct enrollment totals as of December 2020.[2-8] The numbers in the table were provided by OHA's Health Analytics Division and are considered preliminary at the time of this report.

Table 2-2—Members Served by DCO Direct Contract

DCO	Total Members
Advantage Dental Services, LLC (ADS)	21,124
Capitol Dental Care, Inc. (CDC)	15,322
Family Dental Care, Inc. (FDCi)	3,408
Managed Dental Care of Oregon, Inc. (MDCO)	3,361
ODS Community Dental (ODS)	13,469
Total Directly Enrolled in a DCO	**56,684**

Oregon Quality Strategy

Federal regulations under 42 CFR §438.340 require each state Medicaid agency contracting with managed care organizations (MCOs) to develop and implement a written quality strategy to assess and improve the quality of managed care services. The quality strategy should serve as a blueprint or road map for states and their contracted MCOs in assessing the quality of care Medicaid beneficiaries receive and set forth measurable goals and targets for improvement. Specifically, the quality strategy must include the following elements:

[2-8] Oregon Health Authority. Monthly Medicaid Population Report, CCO by Counties for Dental Health Plan Type—December 2020 (Preliminary). Available at: https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/December%202020%20Dental%20Health%20Service%20Delivery%20by%20County.pdf. Accessed on: Mar 17, 2021.

- A plan for improving quality of care and services.
- Standards for network adequacy and availability of services.
- A plan to identify and reduce health disparities.
- A transition of care policy.
- A plan to identify persons needing long-term services and supports (LTSS) or those with special health care needs (SHCN).

OHA's quality strategy was included as a component of Oregon's Section 1115(a) 2017–2022 Waiver and approved by CMS in May 2018.[2-9] The quality strategy is comprised of a number of different quality programs to accomplish OHA's mission to improve the lifelong health of Oregonians; increase the quality, reliability, and availability of care for all Oregonians; and lower or contain cost of care so it is affordable to everyone.

OHA's quality programs that make up the quality strategy include PIPs, performance monitoring through reviews of compliance with Medicaid managed care requirements and other focus areas (e.g., grievances and appeals; fraud, waste, and abuse; transitions of care, non-emergent medical transportation (NEMT) delivery, and network adequacy), and annual CCO transformation quality strategy (TQS) assessments aligned with the federally required quality strategy elements. More detail on OHA's quality strategy can be found in *Section 9. Quality Strategy Monitoring*.

Impact of COVID-19

In 2020, the COVID-19 pandemic greatly impacted Oregon's Medicaid population, operations, priorities, and EQR activities. Many EQR activities or EQR-related reporting requirements were altered, delayed, or waived by OHA in alignment with federal guidelines and State leadership directives in order to allow the State and its MCEs to prioritize resources and responses to the needs stemming from COVID-19. Oregon declared a "State of Emergency" due to COVID-19 on March 8, 2020, only three months into the newly redesigned "CCO 2.0"[2-10] contract period, with multiple organizational and administrative changes enacted statewide, including the transition of hundreds of thousands of members between CCOs. Leading up to the emergency declaration, OHP enrollment in 2020 had remained steady

[2-9] Department of Health & Human Services, Centers for Medicare & Medicaid Services, Project Number 21-W-00013/10 and 11-W-00160/10 Extension Approval, letter, January 12, 2017. Available at: https://www.oregon.gov/oha/HSD/Medicaid-Policy/Documents/Oregon%20Health%20Plan%20STCs_2017-2022.pdf. Accessed on: Mar 17, 2021.

[2-10] Oregon Health Authority. CCO 2.0: The Future of Coordinated Care. Available at: https://www.oregon.gov/oha/OHPB/Pages/cco-2-0.aspx. Accessed on: Mar 17, 2021.

at approximately 1 million members. However, between April 6, 2020, and December 21, 2020, average week-to-week enrollment increased by 15 percent to approximately 1.2 million members.[2-11]

In response to COVID-19 exigencies and federal relief legislation and guidance, OHA implemented multiple temporary policy changes intended to help existing OHP members retain their coverage during the epidemic and to simplify the application process for Oregonians that were newly eligible for OHP. These temporary policy actions included:

- Preventing benefits closures except for voluntary closure, deaths, incarcerations, or out-of-state residency.
- Accepting self-attestation of eligibility criteria without additional verification beyond citizenship or immigration status.
- Discounting federal stimulus payments and unemployment benefits when making income-based eligibility determinations.

Concurrently, MCEs made a plethora of administrative and operational adjustments to serve the Medicaid population and support State efforts, including such things as:

- Waiving all preauthorization requirements during the early stages of the pandemic.
- Investing in critical infrastructure, staffing, and communities.
- Automatically expediting reviews of grievances or appeals on member or provider request.
- Leveraging NEMT for wellness checks, social determinants of health (SDOH) needs, and natural disaster evacuation and relief efforts.
- Improving and expanding the availability of telehealth services.
- Automatically refilling necessary durable medical equipment (DME) and pharmacy prescriptions.
- Pooling electronic, staffing, economic, communication, data, and physical resources for COVID-19 prevention, relief, and vaccination efforts.

HSAG also made multiple adjustments to EQR activities to accommodate public health priorities and work schedules, including such things as holding onsite evaluations via webinar, adjusting review and reporting schedules, and modifying review methodologies while still meeting federal and State requirements and guidelines.

[2-11] Oregon Health Authority. Total Oregon Health Plan (OHP) Enrollment, OHP Weekly Enrollment Report, December 28, 2020. Available at: https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/snapshot122820.pdf. Accessed on: Mar 17, 2021.

3. Compliance Monitoring Review

Background

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the MCEs' compliance with standards set forth in 42 CFR §438—Managed Care Subpart D and the quality assessment and performance improvement (QAPI) requirements described in 42 CFR §438.330. With new MCE contracts beginning January 1, 2020, HSAG collaborated with OHA to design a CFR-compliant, three-year CMR cycle to mitigate the administrative burdens of having to review of all standards in a single year. Table 3-1 exemplifies the new three-year cycle ensuring standards target specific concentrations of health plan functions.

Table 3-1—Compliance Monitoring Review Standards Review by Year

Year	Standards
Year 1: 2020—Member-focused	• 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 XV—Member Information
Year 2: 2021—Provider-focused	• Standard I—Availability of Services • Standard II—Assurances of Adequate Capacity and Services • Standard V—Provider Selection • Standard VI—Subcontractual Relationships and Delegation • Standard XI—Practice Guidelines
Year 3: 2022—Operations-focused	• Standard VIII—Confidentiality • Standard IX—Enrollment and Disenrollment • Standard XII—Quality Assessment and Performance Improvement • Standard XIII—Health Information Systems • Standard XIV—Program Integrity

Objectives

The purpose of the 2020 CMR was to review each MCE's documentation to evaluate compliance with five member-focused standards to inform the State of MCE adherence to CFRs and associated OARs and contractual obligations, as well as to identify strengths and areas for improvement and TA. MCEs use the results to:

- Evaluate the quality and timeliness of and access to Medicaid managed care services furnished by the MCEs.
- Identify, implement, and monitor system interventions to improve quality.
- Evaluate current performance processes.
- Plan and initiate activities to sustain and enhance current performance processes.

Methodology

To initiate the 2020 CMR activity, HSAG invited MCEs to participate in a pre-onsite webinar to prepare them for document submission expectations and planned onsite reviews, including staff interviews and records reviews of care coordination, coverage and authorization, and grievance and appeal files. HSAG developed the 2020 CMR protocol and evaluation tools in alignment with CMS EQR protocols.[3-1]

HSAG developed and distributed the protocol, evaluation tools, and instructions for document submission using HSAG's Secure Access File Exchange (SAFE) website, as well as an attachment to elicit basic organizational and structural information including any delegated operations. The evaluation tools were intended to serve as a guide for the MCEs' submission of compliance documentation and preparation for onsite reviews and consisted of a comprehensive listing of elements to be reviewed. Documentation review periods were different based on the MCE; the CCOs' review period was from January 2020 through June 2020, and the DCOs' review period was from September 2019 through February 2020. The SAFE website was also used by the MCEs to submit completed tools and supporting documentation.

Prior to the onsite review, HSAG conducted desk reviews of all completed evaluation tools and associated documentation. For the record review component of the CMR, HSAG requested a comprehensive list of each CCO's intensive care coordination (ICC) members and each DCO's SHCN members, all service authorization requests, and all grievances and appeals prior to the webinar review. From the list provided, a random number generator was used to select a sample of 10 records from each category to be reviewed. The MCE was made aware of the randomly selected files prior to the onsite review to allow the MCEs time to prepare the records for display. While most CCOs delegate the management of members' oral health care benefits to dental provider networks, members not enrolled with a CCO have their oral health care benefits directly managed by the DCOs. The DCOs are accountable for non-CCO members' oral health care pursuant to the DCOs' direct contract with OHA.

Onsite reviews were planned as a component of the CMR to allow MCEs an opportunity to submit additional or clarifying documentation, navigate reviewers through relevant processes, and engage key staff members in bringing processes into greater focus. Due to the COVID-19 pandemic, HSAG was

[3-1] The compliance review protocols and review tools were consistent with the 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, October 2019*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 17, 2021.

limited to conducting the planned onsite reviews in a webinar format in order to comply with government-issued public health guidelines. The webinar review served to supplement HSAG's understanding of MCE processes and gather more evidence in support of MCE compliance.

HSAG reviewers used information from its desk reviews as well as additional information gathered during the webinar review to document observations and findings for each MCE in the CMR tool. HSAG then analyzed the information to determine whether each requirement in the tool was *Met*, *Partially Met*, or *Not Met* based on the information collected. The overall score for each of the nine standards was determined by totaling the number of *Met* (1 point), *Partially Met* (0.5 points), and *Not Met* (0 points) elements, then dividing the summed score by the total number of applicable elements for that standard. Table 3-2 provides a description of the scoring criteria applied to each requirement.

Table 3-2—CMR Scoring Methodology

Compliance Score	Point Value	Definition
Met	Value = 1.0 point	**Met** indicates full compliance defined as all of the following: • Documentation and data sources reviewed, including file reviews and systems demonstrations, were present and provided supportive evidence in accord with the regulatory provision. • Staff members were able to provide responses consistent with one another, with the data and documentation reviewed, and with the regulatory provisions.
Partially Met	Value = 0.5 points	**Partially Met** indicates partial compliance defined as a portion of any of the following: • Documentation and data sources reviewed, including file reviews and systems demonstrations, were present and provided supportive evidence in accord with the regulatory provision. • Staff members were able to provide responses consistent with one another, with the data and documentation reviewed, and with the regulatory provisions.
Not Met	Value = 0.0 points	**Not Met** indicates noncompliance defined as one or more of the following: • Documentation and data sources were not present and/or did not provide supportive evidence in accord with the regulatory provision. • Staff members demonstrated little or no knowledge of processes or issues addressed by the regulatory provisions.

For each MCE, HSAG provided an initial draft report of its findings to each MCE and OHA for review prior to issuing a final report. A summary of the 2020 CMR results is provided below.

Results

HSAG documented 2020 CMR results for each CCO and DCO in individualized reports. Each report identifies MCE strengths and areas for improvement pertaining to the standards reviewed, as well as findings and required actions for follow-up via the IP process. Overall, the CCOs and DCOs generally performed equivalently well in the CMR, with the exception of Standard III—Coordination and Continuity of Care. Table 3-3 presents a summary of the results for MCEs for each standard and overall performance. Average scores were rounded to the nearest tenth, and the average ratings were rounded to the nearest whole number. The aggregate CCO CMR score was 89 percent across all standards reviewed, whereas the DCO CMR aggregate score was 73 percent. Total possible scores for some standards varied between CCOs and DCOs due to the inapplicability of some elements to DCOs.

Table 3-3—Aggregated Scores and Ratings by Review Standard for MCEs

Review Standard	Average Score	Average Rating
CCO Scores and Ratings		
Standard III—Coordination and Continuity of Care	13.3/15	89%
Standard IV—Coverage and Authorization of Services	15.9/17	94%
Standard VII—Member Rights and Protections	7.5/9	83%
Standard X—Grievance and Appeal Systems	19.1/22	87%
Standard XV—Member Information	9.0/10	90%
Overall	**64.8/73**	**89%**
DCO Scores and Ratings		
Standard III—Coordination and Continuity of Care	4.0/9	44%
Standard IV—Coverage and Authorization of Services	10.9/12	91%
Standard VII—Member Rights and Protections	5.5/7	79%
Standard X—Grievance and Appeal Systems	17.2/22	78%
Standard XV—Member Information	11.9/18	66%
Overall	**49.5/68**	**73%**

Standard III—Coordination and Continuity of Care

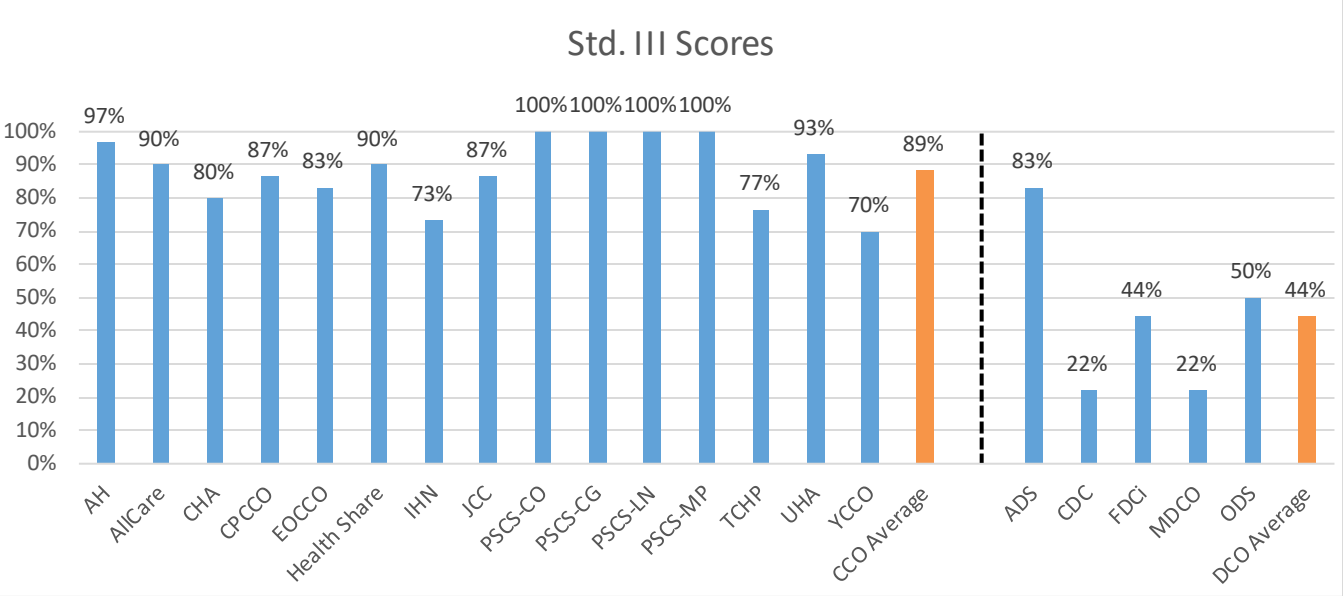
Standard III—Coordination and Continuity of Care processes were evaluated to ensure that each member has an ongoing source of appropriate care and that care and services are coordinated among MCEs, providers of all disciplines, and community and social supports. Pursuant to 42 CFR §438.208, applicable OARs, and contractual requirements, CMR evaluation criteria focused on CCO and DCO responsibility for the following requirements:

- Making a best effort to conduct an initial health risk screening of each member's needs.
- Prioritizing the screening of members receiving long-term care services and supports (LTCSS), designated as prioritized populations, and who have been referred for screening.

- Conducting a comprehensive assessment of needs for members eligible for ICC services.
- Sharing with the primary care provider (PCP), State, or other MCEs serving the member the results of any identification and assessment of the member's needs to prevent duplication of services.
- Developing an integrated treatment plan in alignment with federal and State rules for members enrolled in ICC services.
- Ensuring direct access to specialists for SHCN members.
- Providing needed supports and facilitating interdisciplinary communication to ensure successful and closely monitored transitions of care.

Figure 3-1 displays aggregated MCE scores for Standard III—Coordination and Continuity of Care. Overall, the CCOs had an average score of 89 percent, whereas the DCOs performed poorest on Standard III with an average score of 44 percent.

Figure 3-1—MCE Scores for Standard III—Coordination and Continuity of Care



Most DCOs lacked the resources for full implementation of the state-specific care coordination requirements, particularly with respect to conducting health risk assessments on prioritized populations, granting prioritized access, sharing identified needs with providers and other MCEs, and developing comprehensive treatment plans. Some DCOs expressed that their contract was too similar to the CCO contract and did not effectively consider the context of the administration of dental benefits. These DCOs also stated that the rapid turn-around time from the point of contract execution to the CMR represented a challenge in ensuring the contextual relevance of the contract for the services they provide within the scope of dental care. All DCO feedback was shared with OHA, prompting the State to provide TA, further scrutinize the contract for dental relevance, and apply modifications to expected corrective actions. In spite of the challenges faced in 2020, all DCOs generally displayed a solid foundation for successful implementation of most requirements.

In contrast, the CCOs performed better than the DCOs regarding compliance with Standard III requirements. Health risk screenings and comprehensive assessments were seamlessly implemented and, with the advantage of greater access to resources for staffing and software, the CCOs showcased streamlined workflows and diligent tracking of care coordination activities with the exception of a few CCOs that did not adequately track all required contact points. The CCOs were also proficient in demonstrating fully integrated, comprehensive care reflected in their treatment plans and documentation of contact points with members, providers, and community partners. For members not enrolled in ICC services, some CCOs did not clearly communicate the person or entity responsible for the member's care coordination. Another challenge for the CCOs was in regard to the State requirement to train providers and periodically communicate information on ICC services. HSAG additionally identified some concerns related to CCO delegate management of care coordination services for CCO members. Due to the organic construct of the CCO model, delegation continued to be an issue with respect to ensuring appropriate oversight and consistency in the delivery of benefits within and across CCOs.

Table 3-4 provides a summary of the most common coordination and continuity of care CMR findings by MCE.

Table 3-4—Most Common Standard III Findings

CCO Findings	DCO Findings
No formal designation or notification of person or entity responsible for care coordination.	No formal health risk screening implemented.
Inadequate tracking of care coordination activities.	Inadequate identification of and granting of access to prioritized populations.
Failure to provide adequate training and reminders to providers regarding the ICC program.	Lack of a mechanism to routinely share identified needs of prioritized populations with PCP or other MCEs.
Failure to accept responsibility for the overall care of members whenever mental health (MH) subcontractors provided care coordination.	Inadequate or no treatment plans for SHCN members.

Standard IV—Coverage and Authorization of Services

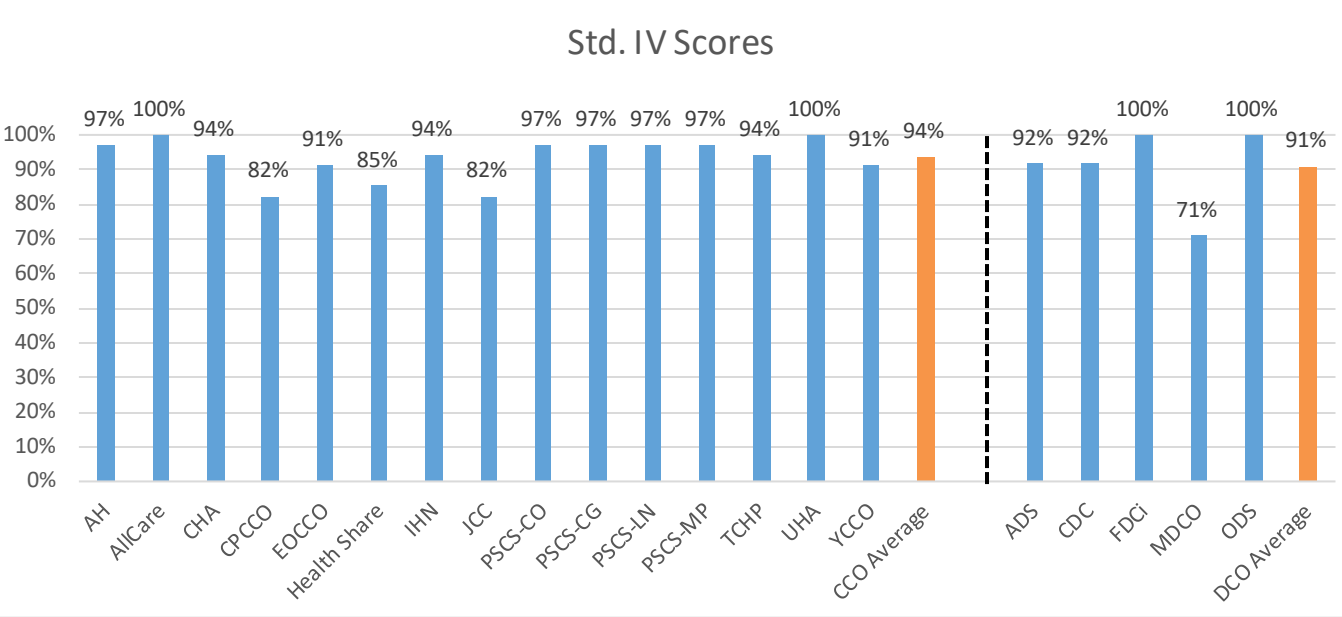
Standard IV—Coverage and Authorization of Services requirements were evaluated based on each MCE's authorization processes and mechanisms in place to ensure consistent application of review criteria for authorization decisions. Pursuant to 42 CFR §438.210, applicable OARs, and contractual requirements, CMR evaluation criteria focused on CCO and DCO responsibility for the following requirements:

- Having written policies and procedures for the processing of requests for initial and continuing authorization of services and providing notices of adverse benefit determination.
- Having processes for decisions and notification of members for standard and expedited authorization requests.

- Adhering to required time frames for authorization decisions and notification of members.
- Ensuring that decision makers have the appropriate level of expertise, as applicable.
- Ensuring compensation for UM does not provide incentives to deny, limit, or discontinue necessary services.

Figure 3-2 displays aggregated MCE scores for Standard IV—Coverage and Authorization of Services. The MCEs achieved their highest average scores on Standard IV, with the CCOs averaging 94 percent and the DCOs averaging 91 percent.

Figure 3-2—MCE Scores for Standard IV—Coverage and Authorization of Services



For both the CCOs and DCOs, the few findings for this standard were attributable to lack of detail in policies. Some DCOs did not address how they establish appropriate limitations or provide additional access to members with SHCN. Not all MCEs provided the needed level of specificity for processing service authorizations including the identification of time frames for determining validity or following up on pended requests. Some CCOs did not identify procedures for processing PA requests outside of normal business hours and some did not provide adequate oversight of subcontractor processes.

Table 3-5 provides a summary of the most common coverage and authorization of services CMR findings by MCE.

Table 3-5—Most Common Standard IV Findings

CCO Findings	DCO Findings
Policies did not address how the MCE conducts PA outside of normal business hours.	Policies did not address PA requests to support members with chronic conditions or those receiving LTCSS.
Policies did not address date and time-stamping authorizations or identifying time frames for processing authorization requests.	Policies did not address date and time-stamping authorizations or identifying time frames for processing authorization requests.
Inadequate oversight of subcontractor PA processes.	

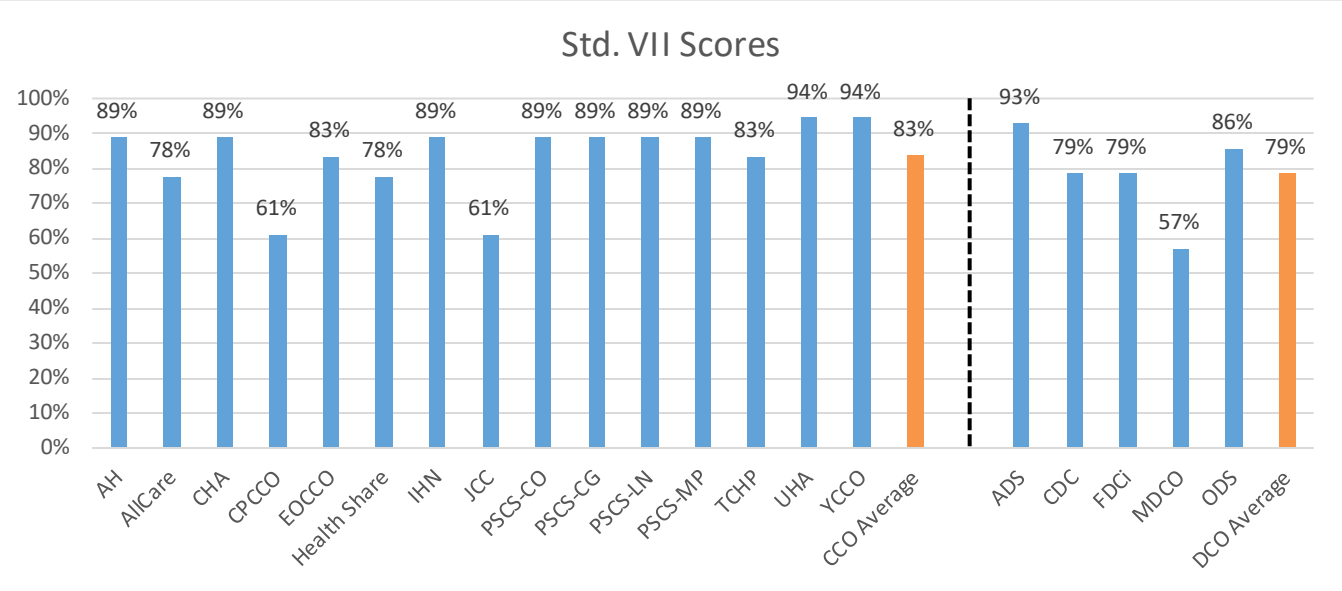
Standard VII—Member Rights and Protections

Standard VII—Member Rights and Protections was evaluated based on each MCE's processes for informing its members, subcontractors, and network providers of member rights and how it ensures that members' rights are respected and allowed to be exercised freely without affecting the way a member is treated. Pursuant to 42 CFR §438.100, applicable OARs, and contractual requirements, CMR evaluation criteria focused on CCO and DCO responsibility for the following requirements:

- Making interpreter services available free of charge, upon request, to each potential member and member.
- Ensuring members are free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation specified in federal regulations on the use of restraints and seclusion.
- Providing written notice to members of the MCE's nondiscrimination policy and complying with all federal and state nondiscrimination laws.
- Ensuring members receive information on available treatment options and alternatives presented in a manner appropriate to the member's condition, preferred language, and ability to understand.
- Allowing members to choose their own PCP from available participating providers and facilities to the extent possible and appropriate.
- Allowing members to be actively involved in the development of their treatment plans and to participate in decisions regarding their care, including the right to refuse treatment.

Figure 3-3 displays aggregated MCE scores for Standard VII—Member Rights and Protections. Overall, the CCOs achieved an average score of an 83 percent for Standard VII, whereas the DCOs achieved an average score of 79 percent.

Figure 3-3—MCE Scores for Standard VII—Member Rights and Protections



Regarding Standard VII—Member Rights and Protections, there were slight deficiencies such as omitting potential members from the scope of policies. Some DCOs did not obtain adequate assurances that providers would comply with members' rights to be free from restraint and seclusion, while some CCOs oversimplified member rights verbiage in the member handbook. Some MCEs failed to inform members that they may freely exercise all rights with no retribution from the MCE, provider, or State. Another common finding for all MCEs was the failure to provide members with contact information for four entities that accept discrimination complaints in compliance with the newly adopted State requirement.

Table 3-6 provides a summary of the most common member rights and protections CMR findings by MCE.

Table 3-6—Most Common Standard VII Findings

CCO Findings	DCO Findings
Failure to inform members that they may freely exercise their rights without adverse consequences.	Failure to inform members that they may freely exercise their rights without adverse consequences.
Failure to provide members with all four entities' contact information for filing a discrimination complaint.	Failure to provide members with all four entities' contact information for filing a discrimination complaint.
Policies did not address the right of potential members to access free interpretation services.	Policies did not address the right of potential members to access free interpretation services or that the services must be provided by a certified or qualified interpreter.
	Inadequate efforts to ensure providers agree to comply with DCO restraint and seclusion policies.

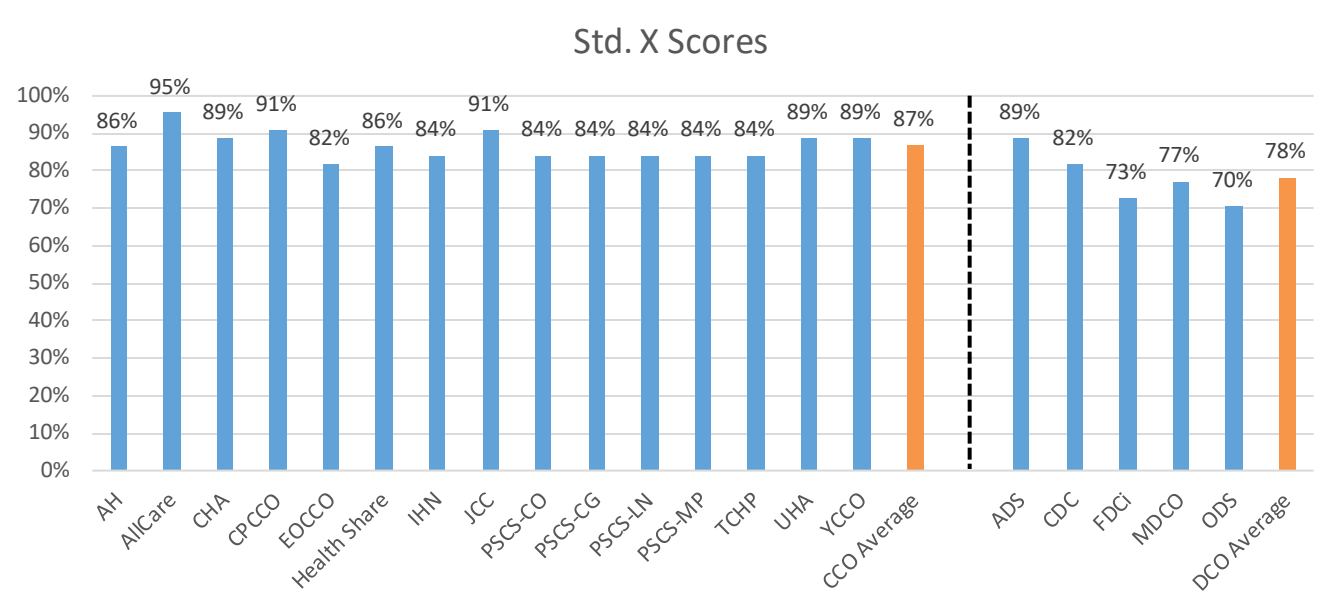
Standard X—Grievance and Appeal Systems

Standard X—Grievance and Appeal Systems requirements were evaluated by examining each MCE's compliance with grievance and appeal processes, provision of information to members and contracted providers, and adherence to time frame and notification requirements. Pursuant to 42 CFR §438.400-424, applicable OARs, and contractual requirements, CMR evaluation criteria focused on CCO and DCO responsibility for the following requirements:

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

Figure 3-4 displays aggregated MCE scores for Standard X—Grievance and Appeal Systems. Overall, the CCOs had an average score of 87 percent for Standard X, whereas the DCOs achieved an average score of 78 percent.

Figure 3-4—MCE Scores for Standard X—Grievance and Appeal Systems



While the fundamental elements of grievance and appeals systems were in place and the MCEs generally processed grievances and appeals efficiently, the MCEs collectively showed room for improvement in clearly communicating all required information in its policies, provider materials, and member materials. For example, some MCEs did not communicate detailed member rights information regarding the grievance and appeal process to members. For instance, many of the MCEs did not notify members that they may file a grievance directly with the State, not solely if they are dissatisfied with the MCE's resolution. Some MCEs did not clearly convey that a provider or authorized representative may file a grievance or appeal on a member's behalf if the member has given written consent. A few DCOs did not identify the 72-hour time frame for authorizing or providing disputed benefits after a final decision from the State. Lastly, many MCEs failed to notify members that, if the MCE does not meet required time frames for appeals, members may request a contested case hearing.

Table 3-7 provides a summary of the most common grievance and appeal systems CMR findings by MCE.

Table 3-7—Most Common Standard X Findings

CCO Findings	DCO Findings
Member materials did not include the option of filing a grievance directly with the State but rather if the member is dissatisfied with the MCE's resolution.	Member materials did not include the option of filing a grievance directly with the State but rather if the member is dissatisfied with the MCE's resolution.
Members were not informed that a representative (including their provider) may file a grievance or appeal on their behalf with written consent.	Members were not informed that a representative (including their provider) may file a grievance or appeal on their behalf with written consent.
Members were not informed that, if the MCE fails to meet time frames processing standard/extended appeals, the member is deemed to have exhausted the appeal process and may initiate a contested case hearing.	Members were not informed that, if the MCE fails to meet time frames processing standard/extended appeals, the member is deemed to have exhausted the appeal process and may initiate a contested case hearing.
Providers were not informed that the MCE would not take punitive action against a provider who requests an expedited resolution or supports a member's grievance or appeal.	Policies did not address the requirement that MCEs will authorize or provide disputed services no later than 72 hours from the date the MCE receives notice of a final decision.

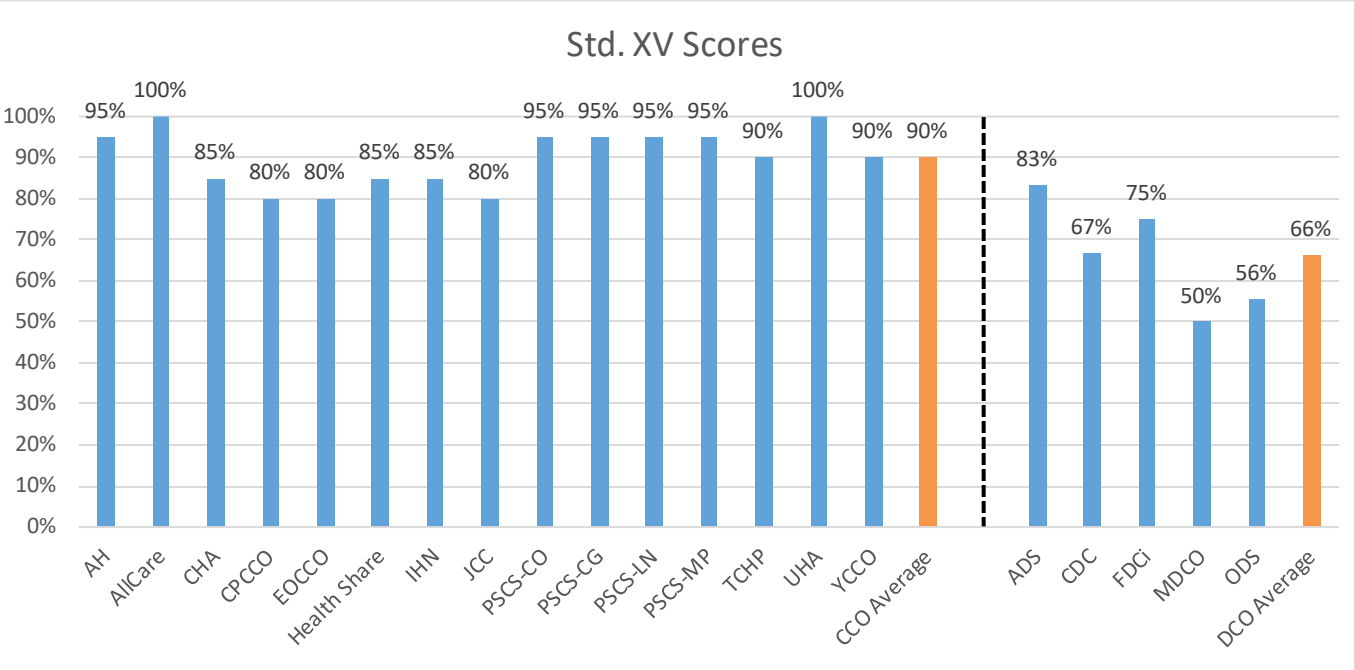
Standard XV—Member Information

Standard XV—Member Information requirements were evaluated based on how each MCE provides information to its members, ensuring ease of access, readability, and the provision of materials in alternative formats and languages. Pursuant to 42 CFR §438.10, applicable OARs, and contractual requirements, CMR evaluation criteria focused on CCO and DCO responsibility for the following requirements:

- Providing written materials that are critical to obtaining services to all members and potential members and making these materials available in the prevalent non-English languages in its service area.
- Providing information in easily understood language and format in a font size no smaller than 12 point with taglines in large font (18 point) informing individuals how to request auxiliary aids and services, including the provision of materials in alternative formats.
- Adhering to required time frames for provision of required information, including provision of the member handbook within 14 days after receiving notification of the member's enrollment.
- Adhering to content requirements for the member handbook and the provider directory.

Figure 3-5 displays aggregated MCE scores for Standard XV—Member Information. The CCOs achieved an average score of 90 percent for Standard XV, whereas the DCOs achieved an average score of 66 percent.

Figure 3-5—MCE Scores for Standard XV—Member Information



HSAG's review of Standard XV—Member Information showed that the DCOs grappled with budgetary restrictions related to mass mailings to newly enrolled members as well as annual notifications of the availability of information. For the DCOs, the review also revealed little to no member education on the risks of tobacco use and member materials did not consistently meet readability requirements. In response to this pervasive challenge, HSAG collaborated with OHA to develop a readability assessment guidance tool inclusive of allowable language exclusions and to provide TA for all MCEs on readability.

For the CCOs, member education subject matter was extensive but CCOs lacked a foundational basis for developing and providing health education. Few CCOs had a process addressing criteria for selecting member education topics or the modality or frequency for which health education would be delivered. Insufficient provider directory information was a common theme for all MCEs particularly in regard to physical accessibility, provider websites, and provider completion of cultural competency training.[3-2] The provision of member notifications and electronically accessible member handbooks were widely available in Spanish; however, some CCOs with a prevalent Spanish-speaking member population failed to offer an electronically accessible provider directory in Spanish.

Table 3-8 provides a summary of the most common member information CMR findings by MCE.

Table 3-8—Most Common Standard XV Findings

CCO Findings	DCO Findings
There were no written policies or procedures about provision of member education.	Member education material did not include the risks of tobacco use.
Electronic provider directory not available in Spanish.	Member materials did not consistently meet readability standards.
Annual reminders of availability of information did not identify the provider directory as being available on the website.	Critical member materials were accessible on the website, but no mailings or annual reminders were sent to inform members of this.
Provider directory was missing information such as websites and provider cultural competency training completion status.	Provider directory was missing information such as Americans with Disabilities Act (ADA) accessibility, websites, and provider cultural competency training completion status.

Improvement Plan Implementation

In accordance with CFR §438.364(a)(5), this technical report includes an assessment of the degree to which each health plan effectively addressed the recommendations for quality improvement (QI) made by the EQRO during the previous year's EQR. As previously mentioned, HSAG worked with OHA to redesign the process for more frequent and timelier follow-up of CMR findings to better track and ensure MCE performance. The new process began in 2020 with MCEs required to submit IPs within 30 days of receipt of CMR findings and quarterly follow-up conducted by HSAG on each MCE's implementation of the IPs. For each CMR finding, MCEs were required to identify the following:

- Interventions planned by the MCE to achieve full compliance.
- Individual(s) responsible for ensuring that the planned interventions are completed.

[3-2] Effective November 2020, CMS no longer requires provider directories to include provider cultural competency training completion status. However, the OARs still contain the requirement.

- Proposed timeline for completing each planned intervention with the understanding that most corrective actions/interventions can be completed within three months and no longer than six months. Corrective actions/interventions requiring additional time will need to include specific information to determine the appropriateness of the extended time frame.

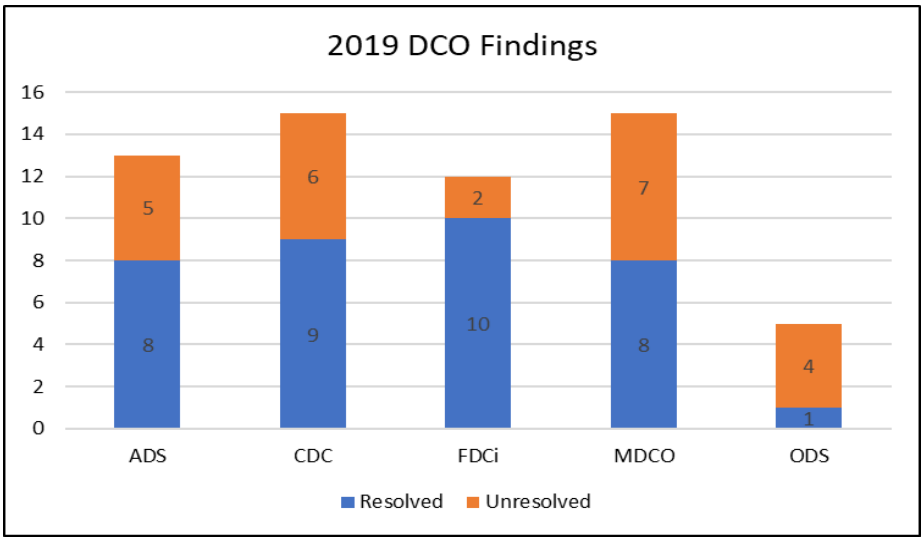
HSAG reviewed IPs using the following criteria to evaluate the sufficiency of each corrective action/intervention identified in the IP to bring performance into compliance:

- Completeness of the IP document in addressing each finding and identifying a responsible individual, a timeline/completion date, and specific corrective actions/interventions that the MCE will take.
- Degree to which the planned corrective actions/interventions are anticipated to bring the MCE into compliance with CMR requirements.
- Appropriateness of the timeline for the corrective actions/interventions given the nature of the finding.

Once reviewed, HSAG communicated to the MCE whether the IP was approved. If any corrective actions/interventions were determined to not meet the requirements related to correlating findings, HSAG identified the discrepancies and required resubmission of the IP until it was approved by HSAG in collaboration with OHA. Quarterly reviews of IP progress are conducted with each MCE via desk reviews and conference calls as necessary to ensure that all planned activities and interventions are completed.

The MCEs did not have active IPs in place during 2020 due to the new review cycle beginning January 1, 2020. Due to COVID-19 priorities, OHA modified the deliverables reporting schedule such that IP implementation evidence for the 2020 CMR activities was not due until early 2021. The DCOs had active IPs from 2019 CMR activities, the year in which CMRs were first conducted with the DCOs with a review of two standards: Standard I—Access and Availability, and Standard X—Grievance and Appeal Systems. The remaining unresolved findings from the 2019 CMR were incorporated into each DCO's IP reported in the individual 2020 DCO CMR reports. Figure 3-6 identifies the number of findings resolved from the 2019 CMR results. More details on the 2020 DCO CMR findings and resulting IPs, including implementation details, are available in the individual 2020 DCO CMR reports available on OHA's website. The review of DCO implementation of the 2020 IPs is underway as of the writing of this report.

Figure 3-6—Resolution of 2019 DCO Findings



The DCOs made good progress toward resolution of the 2019 EQR findings. Policies, agreements, and member notifications have been updated and remaining findings are pending resolution based on evidence of implementation. One of the DCOs faced challenges in implementing site visits to audit physical accessibility of provider offices due to COVID-19 social distancing restrictions. HSAG and OHA have worked with the DCO toward a mutually agreeable solution with the caveat that oversight will be more strictly enforced upon containment of the pandemic.

4. Performance Improvement Projects

Background

PIPs allow MCEs the opportunity to identify areas of concern affecting their membership and strategize ways to improve care. Designed to assess and improve health care processes, the purpose of a PIP is to impact health care delivery and the outcomes of care. For such projects to achieve real improvements in care, and to ensure confidence in reported improvements, PIPs must be designed, conducted, and reported in a methodologically sound manner that meets all State and federal requirements. OHA is contracted with HSAG to review and validate MCE PIPs in accordance with federal requirements set forth in 42 CFR §438.240(b)(1).

CCO PIPs

The CCO 2.0 contract requires each CCO to conduct three PIPs and one focus study designed to improve care in at least four of the eight QI focus areas:

1. Reducing preventable rehospitalizations.
2. Addressing population health issues (e.g., diabetes, hypertension, and asthma) within a specific geographic area by harnessing and coordinating a broad set of resources, including community workers, public health services, and aligned federal and State programs.
3. Deploying care teams to improve care and reduce preventable or unnecessarily costly utilization by super-utilizers.
4. Integration of health: physical health, behavioral health, and oral health care.
5. Ensuring appropriate care is delivered in appropriate settings.
6. Improving perinatal and maternity care.
7. Improving primary care for all populations through increased adoption of the patient-centered primary care home (PCPCH) model of care.
8. Addressing SDOH.

One of the three PIPs was required to address the statewide PIP topic. As part of the CMS 1115 waiver foundational to Oregon's Medicaid system, CCOs are required to participate in the OHA statewide PIP. The CCOs collaborated with OHA throughout 2019 to develop the statewide PIP topic and design. The statewide PIP topic focused on improving acute opioid safety, building on improvement strategies and successes conducted by the CCOs for the previous statewide PIP topic, which focused on chronic high-dose opioid reduction. The areas for improvement related to acute opioid prescribing align with OHA's goals to further the Oregon Opioid Initiative, which brings communities and stakeholders together to

reduce harms, overdoses, and deaths from prescription opioids.[4-1] The CCOs submitted the statewide PIP design for validation on January 31, 2020.

After the statewide PIP validation was completed in April 2020, OHA determined a need to shift to a new statewide PIP topic in response to new needs and priorities as a result of the COVID-19 pandemic. Consequently, quarterly PIP progress reporting requirements were waived by OHA for the first and second quarters of 2020 to reduce administrative burden during the initial COVID-19 response. The CCOs resumed regular quarterly PIP progress reporting in 2021. OHA began to explore new statewide PIP topics in late 2020 and as of early 2021 is working collaboratively with the CCOs and other stakeholders to define a new statewide PIP design in 2021.

For the remaining PIPs and/or focus study, the CCOs selected a topic required to target improving care within the eight QI focus areas listed above. All selected topics were expected to align with the CCO's Transformation Quality Strategies and OHA quality and incentive requirements. Each CCO submitted status updates and outcome measure results at the end of the third quarter of 2020.

DCO PIPs

The OHA contract requires each DCO to conduct one PIP, submitted annually for validation. The PIP topic must address one of the following focus areas:

1. Prevention.
2. Addressing special populations' health issues.
3. Access and utilization.
4. Community.

The DCOs submitted the selected PIP topic for approval to OHA in late 2019. After receiving approval of the PIP topic, the DCOs developed the PIP study design and submitted the PIP design for validation on July 31, 2020.

Objectives

The purpose of PIPs is to achieve significant improvement sustained over time in both clinical and nonclinical areas through ongoing measurements and interventions. For the projects to achieve real improvements in care and for interested parties to have confidence in the reported improvements, the PIPs must be designed, conducted, and reported using sound methodology and must be completed in a

[4-1] Oregon Health Authority, Public Health Division. Opioids: Resources for Health Care Professionals and CCOs. Available at: https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Pages/providers.aspx. Accessed on: Mar 17, 2021.

reasonable time. The primary objective of PIP validation is to determine a health plan's compliance with the requirements of 42 CFR §438.330(d)(2), including:

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

Table 4-1 identifies each of the PIPs validated in 2020 with their specific objectives.

Table 4-1—PIP-Specific Objectives

PIP Topic	Objective
Statewide CCO PIP	
Acute Opioid Safety: Improving Acute Opioid Prescribing Practices	To reduce excessive supply of opioids in the first prescription for previously opioid naïve members.
DCO PIPs	
Implementation of a Customer Relationship Management (CRM) System for Improved Member Engagement	To increase the percentage of members 0–18 years of age who receive a dental service.
Implementation of a Customer Relationship Management (CRM) System for Improved Member Engagement	To increase the percentage of members 0–18 years of age who receive a dental service.
Increasing Dental Care Utilization During Pregnancy	To increase the percentage of pregnant members who receive a dental service during pregnancy.
Reduction of No-Shows to Improve Access	To reduce the percentage of dental appointments that are not attended or cancelled/rescheduled with at least 24 hours advance notice.
Targeted Outreach for Members Not Engaged in Regular Dental Care	To increase the percentage of members 0–14 years of age who receive a dental service.

Methodology

CCO and DCO PIP Validation

The MCEs submitted PIPs in the Design phase for validation in 2020. The CCOs submitted the statewide PIP study design to OHA on January 31, 2020. HSAG received the statewide PIP submissions for validation from OHA in early February and validated the CCOs' statewide PIP submissions from

February through April 2020. The DCOs submitted DCO-specific PIP study designs to OHA on July 31, 2020. HSAG received the DCOs' PIP study designs for validation from OHA in early August and validated the DCOs' PIP submissions from August through October 2020.

The goal of HSAG's PIP validation was to ensure that OHA and other key stakeholders can have confidence that any reported improvement in outcomes is related and can reasonably be linked to the QI strategies and activities conducted during the PIP.

The 2020 PIP validation activities were initiated prior to the release of the most recent EQR protocols in October 2019. HSAG used the Department of Health and Human Services, CMS publication *EQR Protocol 1: Assessment of Compliance With Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012[4-2] to guide the annual PIP validation. HSAG's validation of PIPs included two key components of the QI process:

1. Evaluation of the technical structure of the PIP. This step ensured that the MCEs designed, conducted, and reported PIPs in a methodologically sound manner, meeting all State and federal requirements. HSAG's validation determined whether the PIP design (e.g., study question, population, study indicator(s), sampling techniques, and data collection methodology/processes) were based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensured that reported PIP results were accurate and capable of measuring sustained improvement.

2. Evaluation of the implementation of the PIP. Once a PIP is designed, its 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 MCEs improved rates through the implementation of effective processes (i.e., evaluation of outcomes, barrier analyses, and interventions).

HSAG's methodology for PIP validation provided a consistent, structured process and a mechanism for providing the MCEs with specific feedback and recommendations. HSAG used a standardized PIP Submission Form, completed by each MCE, to collect information on the PIP design and completed PIP activities. HSAG evaluated the documentation provided in the PIP Submission Form to conduct the annual validation. Using its 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 (NA)*. HSAG designated some of the evaluation elements pivotal to the PIP process as "critical elements." For a PIP to produce valid and reliable results, all the critical elements needed to achieve a *Met* score.

[4-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-1.pdf. Accessed on: Mar 17, 2021.

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*. Table 4-2 identifies the scoring criteria used in the PIP validation.

Table 4-2—PIP Scoring Criteria

Rating	Scoring Description
Met	High confidence/confidence in the reported findings.
Partially Met	Low confidence in the reported findings.
Not Met	Reported findings are not credible.

PIPs that accurately addressed CMS EQR protocol 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 no longer credible.

CCO-Specific PIP Progress Reviews

OHA required each CCO to provide a progress report on three additional projects targeting focus areas defined by OHA. The CCOs were required to submit the progress report on October 31, 2020. Due to competing priorities of the COVID-19 pandemic, OHA waived other quarterly progress report requirements that were scheduled to occur on April 30 and July 31 in 2020. Throughout November 2020, HSAG reviewed and documented its observations and findings for each CCO in a standardized PIP Progress Review Tool. HSAG analyzed the information to prepare a listing of TA needs associated with each PIP element and CCO, including the identification of high-priority CCOs and PIPs in need of TA. Based on the PIP review findings, HSAG provided individual PIP Progress Review Tools, a summary of all CCO-specific PIP topics, and a TA needs summary to OHA in December 2020. OHA used HSAG to conduct follow-up TA with CCOs as needed.

General PIP Technical Assistance

Group TA sessions were provided to the MCEs in 2019 to provide an overview of HSAG's PIP validation process, documentation requirements, and scoring methodologies. In 2020, HSAG offered one-on-one TA to the MCEs after providing initial validation findings with written feedback in the PIP Validation Tool. The MCEs had the opportunity to schedule TA phone calls and/or webinars with HSAG and OHA staff members to discuss how to address the initial feedback prior to resubmitting the PIP for the final validation.

Results

In 2020, HSAG validated the CCOs' statewide PIP design submissions and the DCOs' PIP design submissions. The CCOs and DCOs used HSAG's standardized PIP Submission Form to document the topic, study question, study population, study indicator, and data collection process to describe the design for each PIP. All CCO statewide PIP submissions and four of five DCO PIP submissions received a *Met* score for all applicable evaluation elements and a *Met* overall validation status for the Design phase. The PIP validation results suggested that, in general, the MCEs developed a methodologically sound design for each PIP, establishing a strong foundation for objectively measuring and evaluating performance as the PIP progresses to the Implementation stage, reporting baseline measurement results, conducting causal/barrier analyses, and developing interventions to drive improvement.

Statewide PIP

In 2020, HSAG validated 13 CCO statewide PIP submissions. While 15 CCOs were operational in 2020, two of the CCOs, PSCS-Lane and PSCS-MP, were newly operational in January 2020 and were exempt from the January 31, 2020, statewide PIP submission requirement. Table 4-3 displays the validation scores and overall validation status HSAG assigned to each CCO's PIP submission. This table illustrates the CCOs' performance on accurately documenting the design components for the statewide PIP. The validation results included the percentage of applicable evaluation elements that received a *Met* score and the overall validation status HSAG assigned to each CCO's PIP submission. This was the first year HSAG validated the CCOs' *Acute Opioid Safety* PIPs and all CCOs fully met the evaluation and critical elements.

Table 4-3—2020 Statewide PIP Design Validation Results by CCO

CCO Name	Percentage of Evaluation Elements Scored *Met*	Percentage of Critical Elements Scored *Met*	Overall Validation Status
AH	100% (8/8)	100% (5/5)	*Met*
AllCare	100% (8/8)	100% (5/5)	*Met*
CHA	100% (8/8)	100% (5/5)	*Met*
CPCCO	100% (8/8)	100% (5/5)	*Met*
EOCCO	100% (8/8)	100% (5/5)	*Met*
Health Share	100% (8/8)	100% (5/5)	*Met*

CCO Name	Percentage of Evaluation Elements Scored *Met*	Percentage of Critical Elements Scored *Met*	Overall Validation Status
IHN	100% (8/8)	100% (5/5)	*Met*
JCC	100% (8/8)	100% (5/5)	*Met*
PSCS-CO	100% (8/8)	100% (5/5)	*Met*
PSCS-CG	100% (8/8)	100% (5/5)	*Met*
TCHP	100% (8/8)	100% (5/5)	*Met*
UHA	100% (8/8)	100% (5/5)	*Met*
YCCO	100% (8/8)	100% (5/5)	*Met*

The validation results suggested that the CCOs accurately defined and reported the study design for the statewide PIP. The study design was developed collaboratively among the CCOs and OHA; OHA made final decisions on the design components to ensure that each CCO's PIP focused on improving outcomes for the same metric among comparable populations. All 13 CCOs received a *Met* score for all applicable evaluation elements and a *Met* overall validation status for their PIP submissions.

CCO-Specific PIPs

All 15 CCOs submitted CCO-specific PIP progress reports in 2020. Figure 4-1 summarizes the CCO-specific PIP topics included in the PIP progress reports for the third quarter of 2020, which addressed various issues of health care access, timeliness, and quality. The color-coded column headers at the top of the table identify seven of the eight focus areas defined by OHA. The eighth focus area, *integration of health: physical health, behavioral health, and/or oral health care* was addressed by the statewide PIPs focusing on the topic of *Acute Opioid Safety*. HSAG completed the 2020 validation of the statewide PIP in April 2020. The CCOs were exempted from the statewide PIP progress report requirement in 2020 because OHA determined a need to select a new statewide PIP topic in response to shifting priorities resulting from the pandemic. The CCO-specific project titles falling under each focus title are grouped under the corresponding focus area addressed. PIP topics addressed by each CCO are also included in the individual CCO profiles in *Appendix A. CCO Profiles*. The identification of "P" (PIP) vs. "F" (Focus Study) in Figure 4-1 is based on the CCOs' documentation provided in quarterly progress reports. Very few CCOs identified one of their projects as a focus study. If "focus study" was not specified in the progress report, the project was labelled "P" by default.

Figure 4-1—CCO-Specific PIP Topic Summary

	Reducing Preventable Re-Hospitalizations		Population Health							Reduce Utilization by "super-utilizers"			Appropriate Care/ Appropriate Setting						Perinatal/ Maternity Care			Improving Primary Care		Addressing SDOH					CCO Subtotal
	Reduce Re-hospitalization	Pharmalogical Management of Chronic Obstructive Pulmonary Disease (COPD)	Hepatitis C Screening and Treatment	Colorectal Cancer Screening	Improve Type II Diabetes Poor Control	Oral Health Care for Patients with Diabetes	Childhood Immunization Status	Adolescent HPV Immunization Rates	Tobacco Cessation	Expanding Access to MAT for Opioid Use Disorder	Reducing ED utilization among high-frequency Users	Reducing ED utilization among members with Mental Illness	Oral Health Care Access across All Ages	Reducing Preventable ED Utilization	Adolescent Well Child Visits	Increasing Access to Traditional Health Worker Services	Pediatric Asthma Management	Childhood Immunization Status	Maternity Case Management	Oral Health Care during Pregnancy	Prenatal/Postnatal Care Incentive	Improving Foster Care RAPID Assessment Process	Increase Access to Medication-Assisted Treatment (MAT) in Primary Care	SDOH Screening and Follow-Up	Health Complexity	Health Equity - Increase access to Primary Care among African American members	Reducing Housing Instability	Behavioral Support Services and Care Coordination for Children 0-5 years of age with high social complexity	
Advanced Health						P								P							P								3
AllCare					P												P									P			3
Cascade Health Alliance											P		P												P				3
Columbia Pacific									P		P		P																3
Eastern Oregon					P		P					P																	3
Health Share										P						P						P							3
Intercommunity Health					P										P				P										3
Jackson Care Connect					P																		P	P					3
PS Central Oregon								F												P				P					3
PS Columbia Gorge								F												P				P					3
PS Lane								F												P				P					3
PS Marion-Polk								F												P				P					3
Trillium		P		P														P											3
Umpqua	P											P							P									P	4
Yamhill Community Care			P											P													P		3
Subtotal	1	1	1	1	4	1	1	4	1	1	2	2	2	2	1	1	1	1	2	4	1	1	1	5	1	1	1	1	46
TOTAL	**2**		**13**							**5**			**8**						**7**			**2**		**9**					**46**

* The CCOs were not required to submit a Quarter 3 2020 report for the statewide PIP. Annual validation for the statewide PIP was completed in April 2020 and OHA is selecting a new statewide PIP topic to address post-pandemic priorities.

DCO-Specific PIPs

HSAG validated five DCO PIP submissions in 2020, which was the first year in which DCO PIPs were validated. Each DCO submitted one PIP for validation. Table 4-4 displays the validation scores and overall validation status HSAG assigned to each DCO's PIP submission. This table illustrates the DCOs' performance on developing a methodologically sound PIP design. The validation results include the percentage of applicable evaluation elements that received a *Met* score and the overall validation status HSAG assigned to each DCO's PIP submission.

Table 4-4—2020 PIP Design Validation Results by DCO

DCO	PIP Topic	Percentage of Evaluation Elements Scored *Met*	Percentage of Critical Elements Scored *Met*	Overall Validation Status
ADS	*Increasing Dental Care Utilization During Pregnancy*	100% (8/8)	100% (5/5)	*Met*
CDC	*Implementation of a Customer Relationship Management (CRM) System for Improved Member Engagement*	100% (8/8)	100% (5/5)	*Met*
FDCi	*Reduction of No-Shows to Improve Access*	63% (5/8)	40% (2/5)	*Partially Met*
MDCO	*Implementation of a Customer Relationship Management (CRM) System for Improved Member Engagement*	100% (8/8)	100% (5/5)	*Met*
ODS	*Targeted Outreach for Members Not Engaged in Regular Dental Care*	100% (8/8)	100% (5/5)	*Met*

Four of the five DCOs received a *Met* score for all applicable evaluation and critical elements reviewed, and a *Met* overall validation status for their PIP design submissions. These validation results suggested that the four DCOs developed a methodologically sound PIP design to support valid and reliable measurement and analysis of PIP indicator results to support improvement efforts and evaluation of progress toward achieving improvement as the PIPs progress to the Implementation and Outcomes phases. One DCO, FDCi, received a *Partially Met* overall validation status for the PIP design submission. HSAG identified methodological issues with the data collection process, study population definition, and study indicator definition. HSAG provided feedback on these issues in the PIP Validation Tool and recommended additional TA to FDCi to address these issues prior to completion of baseline data collection for the next annual PIP validation submission.

5. Performance Measure Validation

Background

In accordance with 42 CFR §438.330(c), states must require MCEs to submit performance measurement data as part of their QAPI programs. The validation of performance measures is one of the mandatory EQR activities that the state Medicaid agencies are required to perform.[5-1] OHA selected HSAG to evaluate the accuracy and validity of OHA's calculation of seven performance measure rates for the 15 CCOs under contract in 2019 in accordance with CMS *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity, October 2019.*[5-2] Table 5-1 lists the performance measure indicators that HSAG evaluated.

Table 5-1—2020 Performance Measures Validated

PMV Measures
Adolescent Well-Care Visits
Ambulatory Care: Emergency Department (ED) Utilization
Dental Sealants on Permanent Molars for Children
Developmental Screening in the First Three Years of Life
Disparity Measure: ED Utilization Among Members With Mental Illness
Effective Contraceptive Use
Oral Evaluation for Adults With Diabetes

Objectives

As set forth in 42 CFR §438.358, the validation of performance measures calculated by the State during the preceding 12 months was one of the mandatory EQR activities. The primary objectives of the PMV activities were to:

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

[5-1] 42 CFR §438.358(b)(2).

[5-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity, October 2019.* Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 16, 2021.

Methodology

The CMS PMV protocol identifies key types of data that should be reviewed as part of the validation process. These include the Information Systems Capabilities Assessment Tool (ISCAT); 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. HSAG utilized an ISCAT to obtain information from OHA regarding its information systems capabilities and supporting documentation, and additionally obtained performance measure specifications and source code for the validation activity.

After completing a desk review of the information and data obtained, HSAG conducted a virtual audit review with OHA. The virtual audit review included interviews with key staff members, system demonstration, review of data output files, primary source verification, observation of data processing, and review of data reports. Since OHA subcontracted essential functions and reporting requirements to another entity, CORE, OHA maintained and provided detailed files documenting work performed by the subcontractor. HSAG queried OHA staff members to confirm that appropriate documentation and processes were in place to oversee all processes related to the calculation of performance measures.

OHA's rate calculations for measures in the scope of HSAG's validation were based on administrative data only (i.e., enrollment and claims/encounters) for the CY 2019 measurement period. The CCOs under contract in 2019 differed slightly from the CCOs contracted in 2020 due to the new health care services contract excluding two previous CCOs and adding two new regions. Integral to the PMV, HSAG employed several crucial validation components in the calculation of performance indicator data. These include data integration, data control, and documentation of performance measure calculations. The sections below describe how each validation component was employed in the validation activity, including the resulting findings. Consistent with the CMS PMV protocol, 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 5-2. 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.

Table 5-2—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.

Results

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. The results of this analysis and the

virtual audit review are documented below. Although OHA received no findings, HSAG noted during the virtual audit review that OHA's vendor, CORE, had discrepancies between the rate review spreadsheet and the member-level detail file. HSAG recommends that CORE follow through with its implementation of a more enhanced QA check when transferring data. Additional QA checks can consist of multi-level reviews, comparison between data output files, review of source documents, and comparison to historical data.

Data Integration

Accurate data integration is essential to calculating valid performance measure data. The steps used to combine various data sources (including claim/encounter, eligibility, and other administrative data) must be carefully controlled and validated. HSAG validated the data integration process used by OHA, which included a comparison of source data to warehouse files and a review of file consolidations or extracts, data integration documentation, source code, production activity logs, and linking mechanisms. By evaluating linking mechanisms, HSAG was able to determine how different data sources (i.e., claims data and membership data) interacted with one another and how certain elements were consolidated readily and used efficiently. It was noted during the review that various quality checks were in place by OHA's vendor, CORE, which included comparative data analysis, managerial reviews, and eligibility checks. If any issues were identified, CORE notified OHA and resolved the issues.

Overall, HSAG determined that the data integration processes used by OHA were:

☒ Acceptable

☐ Not acceptable

Data Control

The organizational infrastructure of OHA must support all necessary information systems. Each QA practice and backup procedure must be sound to ensure timely and accurate processing of data, as well as provide data protection in the event of a disaster. HSAG validated the data control processes used by OHA, which included a review of disaster recovery procedures, data backup protocols, and related policies and procedures.

It was noted during the review that multiple backups were in place with daily storage backups maintained and stored off site. OHA had a secure email setup to accept incoming data from the CCOs and data were finalized weekly. OHA and CORE also had a secure file transfer protocol site set up to properly exchange sensitive data to restricted personnel monthly. In addition, various security checks were done in order to appropriately provide access to data, which included role identification and privileges. An annual review of roles was conducted to ensure staff members had the proper access to data.

Overall, HSAG determined that the data control processes in place at OHA were:

☒ Acceptable

☐ Not acceptable

Performance Measure Documentation

Complete and sufficient documentation is necessary to support validation activities. While interviews and system demonstrations provided supplementary information, the majority of the validation review findings were based on documentation provided by OHA. HSAG reviewed all related documentation, which included the completed ISCAT, job logs, computer programming code, output files, workflow diagrams, narrative descriptions of performance measure calculations, and other related documentation. It was noted during the review that OHA's source code captured the appropriate fields from its raw data to calculate the rates for the seven performance measures. Source code was reviewed and approved, and a live system demonstration was provided by OHA to validate member compliance for each measure.

Overall, HSAG determined that the documentation of performance measure data collection and calculations by OHA were:

☒ Acceptable
☐ Not acceptable

Performance Measures

Based on all validation activities, HSAG determined results for each performance measure indicator. For the measures selected for PMV, HSAG did not identify any issues or concerns with the accuracy or validity of the calculation of the performance measure rates by OHA. In summary, all seven performance measure indicators in the scope of HSAG's PMV activities for CY 2019 were given a validation result of "R," indicating that the measures were compliant with the measure specifications and the rates can be reported.

Table 5-3 shows the seven performance measure indicators and comparisons to the prior years' rates.

Table 5-3—Summary of Performance Measure Indicators

CCO	Measure Rates						
	Adolescent Well-Care Visits	*Ambulatory Care: Emergency Department (ED) Utilization—Total Ages (Visits/1,000 Member Months)**	*Dental Sealants on Permanent Molars for Children*	*Developmental Screening in the First Three Years of Life—Screening Totals*	*Disparity Measure: ED Utilization Among Members With Mental Illness*	*Effective Contraceptive Use*	*Oral Evaluation for Adults With Diabetes*
AH	58.99%	57.93	31.66%	83.76%	11.06%	54.13%	22.70%
AllCare	43.85%	39.96	25.74%	74.13%	8.54%	54.66%	27.71%
CHA	47.52%	46.16	30.04%	82.33%	9.80%	49.35%	27.33%
CPCCO	49.74%	45.95	27.32%	69.91%	9.01%	48.93%	25.86%
EOCCO	44.71%	54.09	25.91%	70.09%	11.39%	54.16%	25.12%

CCO	Measure Rates						
	Adolescent Well-Care Visits	*Ambulatory Care: Emergency Department (ED) Utilization—Total Ages (Visits/1,000 Member Months)**	*Dental Sealants on Permanent Molars for Children*	*Developmental Screening in the First Three Years of Life—Screening Totals*	*Disparity Measure: ED Utilization Among Members With Mental Illness*	*Effective Contraceptive Use*	*Oral Evaluation for Adults With Diabetes*
Health Share	56.36%	45.91	26.98%	73.57%	9.88%	43.97%	34.55%
IHN	46.03%	50.38	24.87%	75.59%	9.86%	59.49%	27.30%
JCC	43.23%	42.47	27.70%	71.38%	8.97%	48.81%	30.55%
PSCS-CO	53.49%	44.41	26.76%	78.43%	9.85%	55.97%	31.78%
PSCS-CG	63.33%	42.70	29.99%	85.21%	9.51%	55.00%	31.95%
Primary Health of Josephine County	45.27%	37.00	25.52%	82.93%	8.41%	49.01%	27.25%
TCHP	43.57%	51.72	26.48%	76.98%	10.36%	52.81%	29.66%
UHA	55.46%	51.58	31.17%	83.61%	9.88%	54.83%	27.87%
Willamette Valley Community Health	56.00%	43.14	25.69%	73.53%	9.65%	50.92%	29.63%
YCCO	61.65%	56.43	27.29%	79.01%	11.42%	54.45%	29.29%
2019 Benchmark	65.20%	43.10	26.80%	80.00%	8.77%**	53.90%	27.10%
2019 Statewide Average	52.35%	46.99	26.83%	75.03%	9.92%	49.85%	30.67%
2018 Statewide Average	49.74%	46.41	24.82%	72.44%	NA	46.78%	NA
2017 Statewide Average	49.41%	46.73	24.07%	68.98%	NA	45.74%	NA

** Rates shown for this measure are not a percentage.*
*** Due to being a Utilization measure, HSAG recommends comparison to a benchmark be considered with caution.*
NA indicates that the measure was not validated in the fiscal year.

The 2019 statewide average improved for all five indicators that could be compared to prior years. Additionally, four out of the seven indicators exceeded the 2019 benchmark. Conversely, the *Adolescent Well-Care Visits* statewide average was lower than the benchmark by greater than 10 percent.

Validation

Table 5-4 lists the validation result for each performance measure indicator for OHA.

Table 5-4—Summary of Validation Results

Performance Measure	Validation Result
Adolescent Well-Care Visits	**R**
Ambulatory Care: Emergency Department (ED) Utilization	**R**
Dental Sealants on Permanent Molars for Children	**R**
Developmental Screening in the First Three Years of Life	**R**
Disparity Measure: ED Utilization Among Members With Mental Illness	**R**
Effective Contraceptive Use	**R**
Oral Evaluation for Adults With Diabetes	**R**

All seven performance measure indicators in the scope of HSAG's PMV activities for CY 2019 were compliant with the measure specification. The rates can therefore be reported and were given a validation result of "R."

6. Network Adequacy

Background

Federal and State regulations require each MCE to maintain a network of appropriate health care providers to ensure adequate access to all services covered under the Medicaid contract. As of December 2020, CMS has not published the validation of network adequacy protocol referenced in federal regulations for managed care.[6-1] To support federal and State network adequacy requirements, the MCEs are contractually required to develop and submit DSN reports that consist of two components, an annual DSN Provider Narrative Report and quarterly DSN Provider Capacity Reports, that crosswalk to the network standards in the MCEs' contracts with the State, the 2021 OHP CCO Health Plan Services Contract and the 2021 DCO Health Plan Services Contract.

In 2020, HSAG worked with OHA to conduct a comprehensive review of the MCEs' DSN reports to evaluate provider capacity compliance in accordance with standards for access to care, network adequacy to provide covered services to all members, and strengths and gaps regarding the DSN. HSAG presented aggregated results in two separate detailed reports, a 2020 CCO Annual DSN Evaluation Report and a 2020 DCO Annual DSN Evaluation Report.

To additionally support federal and State network adequacy requirements, HSAG began a provider directory validation activity to ensure members have appropriate access to provider information. For the provider directory validation, HSAG will compare key elements published in the online provider directories with the data in the provider capacity reports and will confirm each MCE's website meets the federal requirements in 42 CFR §438.10(h), OAR 410-141-3585, and relevant State contractual requirements. Results of the provider directory validation will be reported in 2021.

Objectives

The objective of the DSN evaluation was to evaluate provider capacity compliance in accordance with standards for access to care, network adequacy to provide covered services to all members, and strengths and gaps regarding the DSN. For the network adequacy analysis currently underway, the objective is to evaluate the network of Medicaid providers available both within and across MCE service areas for their ability to serve enrolled members in accordance with federal, State, and contractual standards for access to care.

Methodology

HSAG developed and distributed a 2020 DSN evaluation protocol outlining reporting requirements and methods for the submission of documentation from each MCE and on the evaluated components for which each MCE's capacity to serve enrolled members in accordance with the federal and State

[6-1] 42 CFR §438.358(b)(1)(iv) and 42 CFR §438.604(a)(5).

standards for access to care was to be assessed.[6-2] The protocol was accompanied by DSN Provider Narrative Report and DSN Provider Capacity Report templates and instructions containing specifications for the completion of each report. TA was provided to MCEs via webinar to provide an overview of reporting requirements and specifications, as well as an opportunity for questions and answers. To conduct the annual DSN evaluation, HSAG leveraged the September 1, 2020, DSN Provider Narrative Reports and October 1, 2020, DSN Provider Capacity Reports.

DSN Provider Narrative Assessment

HSAG reviewed each MCE's DSN Provider Narrative Report and scored the elements based on the Narrative Response Specifications identified in the *2020 Annual CCO DSN Provider Narrative Report Instructions*, *2020 Quarterly CCO DSN Provider Capacity Report Instructions*, and scoring criteria defined in Table 6-1. Elements received a score ranging from 0 (*Not Met*) to 1 (*Met*) with a score of 0.5 for elements receiving a rating of *Partially Met*. All element scores were then aggregated into a category score and overall summary score.

Table 6-1—DSN Provider Narrative Report Scoring Criteria

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

Table 6-2 identifies the five DSN Provider Narrative Report categories, the number of reporting elements associated with each category, and the maximum number of points possible for scoring the MCEs' compliance with the elements.

Table 6-2—DSN Provider Narrative Report Categories

Category Number	Categories	Points Possible
	CCOs	
1	Description of the Delivery Network and Adequacy	12.0
2	Description of Enrollees (Members)	3.0
3	Additional Analysis of the CCO's Provider Network to Meet Enrollee (Member) Needs	4.0
4	Coordination of Care	5.0
5	Performance on Metrics	2.0
	Totals	**26.0**

[6-2] See 42 CFR §438.206 and §438.207; OAR 410-141-3515, CCO and DCO Health Care Services Contracts, Exhibit G.

Category Number	Categories	Points Possible
	DCOs	
1	Description of the Delivery Network and Adequacy	6.0
2	Description of Enrollees (Members)	3.0
3	Additional Analysis of the CCO's Provider Network to Meet Enrollee (Member) Needs	5.0
	Totals	**14.0**

As a component of the DSN Provider Narrative Reports, MCEs were additionally required to report provider time and distance data including minutes, miles, and percentage of overall member access for each geographic classification in each MCE's service area to determine compliance based on the following three OHA-defined time and distance standards:[6-3]

- In urban areas, not exceeding 30 miles, 30 minutes.
- In rural areas, not exceeding 60 miles, 60 minutes.
- A minimum of 90 percent of members in each service area accessing care within the respective routine travel time or distance listed above.

HSAG scored MCE time and distance data by applying scoring ranging from 0 (*Not Met*) to 1 (*Met*) with a score of 0.5 for elements receiving a rating of *Partially Met*. Table 6-3 defines the rating and scoring criteria applied. All element scores were then aggregated into category scores and an overall summary score.

Table 6-3—DSN Time and Distance Report Scoring Criteria

Score	Rating	Rating Description
1.0	*Met*	Submission included all time and distance reporting and met all of the three OHA-defined time and distance standards.
0.5	*Partially Met*	Submission included one, but not all time and distance reporting (minutes, miles, and percent of overall member access).
		Submission included all time and distance reporting but did not meet all of the three OHA-defined time and distance standards.
0.0	*Not Met*	Submission did not include any time and distance reporting.

DSN Provider Capacity Analysis

In order to ensure data quality, HSAG conducted a one-time Targeted DSN Provider Capacity Report Review and provided feedback to each MCE to allow data corrections to be made prior to the October 1,

[6-3] Contract standards are detailed in OAR 410-141-3515. Available at: https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=275046.

2020, DSN Provider Capacity Report submission. For the one-time and annual analyses, HSAG processed, cleaned, and evaluated the MCEs' DSN Provider Capacity Report data to evaluate the general capacity of each MCE's compliance with the required provider file layout (PFL) as outlined in the *2020 Quarterly CCO DSN Provider Capacity Report Instructions* and *2020 Quarterly DCO DSN Provider Capacity Report Instructions*. Specifically, HSAG evaluated each MCE's DSN Provider Capacity Report according to key measures in four domains as identified in Table 6-4.

Table 6-4—DSN Provider Capacity Domains and Measures

Domain	Description	Key Measures
Quality of DSN Provider Capacity Reporting	The MCE's ability to provide complete and accurate provider network data in the required format.	• Percent Present—The percent of key data fields that are populated. • Percent Valid Format—The percent of key fields where data are submitted in the required format (e.g., date elements are populated with formatted dates). • Percent Valid Values—The percent of key data fields containing allowable data values.
Provider Network Capacity	The underlying infrastructure of the MCEs' DSNs, including whether or not health services are available to members through a sufficient supply and variety of providers.	• Provider Counts—The number and percent of providers by key stratifications (e.g., provider specialty/category, pediatric/adult provider, panel status, network status, and contract status).
Provider Accessibility	The degree to which contracted services are accessible to the MCEs' member populations.	• Percent Accepting New Patients—The number and percent of providers accepting new patients by key stratifications (e.g., provider specialty/category, county, network status, and contract status). • Percent Non-English Language—The number and percent of providers that support non-English languages by key stratifications (e.g., provider specialty/category, county, network status, and contract status).
Geographic Distribution	The geographic distribution of providers relative to member populations, assessing whether not the location of providers is spread proportionately across the member population.	• Provider Count by Geography—The number and percent of providers by county (or ZIP Code) by provider specialty/category. • Provider Coverage Maps—A visual presentation of coverage area provided by each MCE's DSN based on pre-defined time and distance thresholds, by provider specialty/category.

Results

Most CCOs incorporated the required response specifications outlined in the *2020 Annual CCO DSN Provider Narrative Instructions* in their narrative responses. CCO responses and analysis improved from previous years and included more comprehensive descriptions demonstrating how each CCO ensured, monitored, and evaluated adequate provider capacity and member access to health care services. Answers included geographic location of network providers and members, considering distance, travel time, member needs, coordination of care, and performance metrics.

CY 2020 represented the first year DSN Provider Narrative Reports were required of the DCOs. The DCOs performed well in the *Additional Analysis of the DCO's Provider Network to Meet Member Needs* category but earned their lowest scores in the *Description of Members* category. The lower scores likely represented a need for TA in proper reporting rather than operational deficiencies.

CCO 2020 Annual DSN Evaluation Results

DSN Provider Narrative Assessment Results—CCOs

In aggregate, the CCOs received an average score of 22.9 points across DSN Provider Narrative Report categories, or approximately 88.1 percent of the maximum points possible (26.0 points), as shown in Table 6-5. Three of the 15 CCOs met the requirements across all DSN Provider Narrative Report categories. While most CCOs met the *Coordination of Care* and *Performance on Metrics* categories, two CCOs struggled to meet the possible points across all narrative categories.

Table 6-5—DSN Provider Narrative Report Evaluation Results

CCO	DSN Provider Narrative Report Categories					Total CCO Score
	Description of the Delivery Network and Adequacy	Description of Members	Additional Analysis of the CCO's Provider Network to Meet Member Needs	Coordination of Care	Performance on Metrics	
AH	12.0	3.0	4.0	5.0	2.0	26.0
AllCare	8.0	3.0	3.5	4.5	2.0	21.0
CHA	5.0	1.5	3.5	5.0	0.5	15.5
CPCCO	12.0	3.0	4.0	5.0	2.0	26.0
EOCCO	10.0	3.0	4.0	5.0	2.0	24.0
Health Share	11.0	3.0	4.0	5.0	2.0	25.0
IHN	10.0	2.5	3.0	4.0	2.0	21.5
JCC	12.0	3.0	4.0	5.0	2.0	26.0

CCO	DSN Provider Narrative Report Categories					Total CCO Score
	Description of the Delivery Network and Adequacy	Description of Members	Additional Analysis of the CCO's Provider Network to Meet Member Needs	Coordination of Care	Performance on Metrics	
PSCS-CO	11.0	3.0	4.0	5.0	2.0	25.0
PSCS-CG	11.0	3.0	4.0	5.0	2.0	25.0
PSCS-Lane	11.0	3.0	4.0	5.0	2.0	25.0
PSCS-MP	11.0	3.0	4.0	5.0	2.0	25.0
TCHP	11.0	2.5	3.5	4.5	1.5	23.0
UHA	7.5	2.0	3.5	3.5	2.0	18.5
YCCO	7.5	2.0	3.0	3.5	1.5	17.5
Statewide Average Scores	**10.0**	**2.7**	**3.7**	**4.7**	**1.8**	**22.9**
Points Possible	**12.0**	**3.0**	**4.0**	**5.0**	**2.0**	**26.0**

Description of the Delivery Network and Adequacy

Three CCOs met all of the elements in the *Description of the Delivery Network and Adequacy* narrative category. Most CCOs included the required geographic distribution description and analysis for all providers (including delegated providers) compared to the distribution of members. Thirteen CCOs' narrative responses described how traditional health workers (THWs) are incorporated into the DSN by type and analyzed whether the CCO considers member access to these services as adequate.

Most CCOs described using a specific geocoding software package, primarily Quest Analytics, to conduct geographic distribution analyses and time and distance standards. Two CCOs did not specify which geocoding application or software was used to conduct analysis. Although the *2020 Annual CCO DSN Provider Narrative Instructions* outlined specifications for calculating time and distance standards, there were still inconsistencies with the CCOs' calculation methodologies. Four CCOs calculated time and distance standards by using a member and provider's address ZIP Code, or "central point," instead of the precise locations of both groups. Measuring with the ZIP Code or "central point" of a member to the closest provider within the same ZIP Code or "central point" produces an inaccurate estimate of the routine travel time and distance.

Description of Members

Ten CCOs met all the elements in the *Description of Members* narrative category. Most CCOs had some mechanism for analyzing the characteristics of its members to ensure that the cultural, language, disability, and special health care needs are met. Eleven CCOs described processes for considering

member characteristics when making provider assignments and included analysis, demonstrating the categorization of members by characteristics for the purpose of ensuring that the assigned PCP can best address each member's needs. Two CCOs described different tools and data sources used to identify member characteristics and needs; however, the narrative responses did not specifically address processes and/or procedures for conducting analysis. Three CCOs also did not submit analyses to demonstrate the characteristics of its membership's cultural, language, disability, and special health care needs were incorporated in the narrative responses or as supplemental data.

Every CCO described how member needs for continuity of care and transition between levels of care are assessed by conducting a needs assessment to identify risks and/or determine each member's appropriate level of care at the time of the transition.

Additional Analysis of the CCO's Provider Network to Meet Member Needs

Nine CCOs met all the elements in the *Additional Analysis of the CCO's Provider Network to Meet Member Needs* narrative category. Six CCOs did not meet the requirement for the CCOs to incorporate member feedback into network adequacy decisions. Two CCOs addressed how they incorporated member feedback obtained from MH surveys, complaints and grievances, and Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results; however, neither incorporated an example or scenario demonstrating how member feedback from surveys impacted a network adequacy decision. Three CCOs reported they had an established community advisory council (CAC); however, two of three did not describe a process and/or procedure for how input from the CAC was used to support and influence network adequacy and/or network capacity, and none of the three CCOs incorporated an example or scenario demonstrating how CAC input impacted a network adequacy decision. To effectively monitor network adequacy and to identify issues with network capacity, timely access to care, and provider-specific deficiencies, CCOs should have mechanisms to collect and use member and community feedback.

Every CCO described how technology is used to deliver team-based care and support other innovations. All CCOs expanded access to telehealth and telemedicine services in alignment with the directive and guidelines set by the Health Systems Division (HSD) and CMS in response to the COVID-19 pandemic.

Coordination of Care

Ten CCOs met all the elements in the *Coordination of Care* narrative category. Most CCO narratives provided descriptions of their contractual relationships with local Aging and Persons with Disabilities (APD) offices, public health authorities, and MH authorities that facilitate the coordination of care. Most CCOs described how interdisciplinary care teams and coordination supports are used across each member's continuum of care. The CCO narrative responses demonstrated an integrated approach across the spectrum of physical, behavioral, and oral health care.

Most CCOs submitted narrative responses with thorough descriptions and, in some instances, supporting documentation, to demonstrate all the elements in this category. All CCOs described how internal and external platforms of electronic health records (EHRs) are used to coordinate health care, including

preventive health care, for all members across the continuum of care. Multiple CCOs described using the Collective Platform, also known as Pre-Manage, a medical platform tool, to share real-time hospital/emergency department (ED) event information; member-level data and preventive gaps in care; and member-specific information for the purpose of coordinating physical, behavioral, and oral health care between provider offices, hospitals, and community partners. For example, various CCOs explained leveraging real-time notifications to identify members' needs and proactively coordinate care and offering members additional support post-ED visits and coordination of care prior to hospital discharges.

Most CCOs described how interdisciplinary care teams and coordination supports are used across each member's continuum of care. The CCO narrative responses demonstrated an integrated approach across the spectrum of physical, behavioral, and oral health care.

Performance on Metrics

Twelve CCOs met all the elements in the *Performance on Metrics* narrative category. The CCO narratives described regular internal monitoring of performance metrics through oversight committees whose objectives included improving performance measure rates by creating action plans, executing both provider and member QI initiatives, and implementing changes to the DSN. Several CCOs had developed or invested in population management software and tools to create actionable and visual data reports, which are distributed to providers and/or individual offices in an effort to improve performance on metrics related to member access and ED utilization.

Most CCOs described a methodology for analyzing and monitoring underutilization and overutilization, including using claims data and other analytic tools. CCO narratives described implementing workgroups that included community partners, provider-specific corrective action plans (CAPs), alternative payment models (APMs), disease-specific case management programs, and member education as some of the actions taken to address patterns of both overutilization and underutilization.

Time and Distance Standards Reporting

The CCOs reported compliance with time and distance access standards in either routine time or distance (i.e., minutes and miles) and with the percentage of members in the service area that could access health care from the network. HSAG scored this section based on the CCOs' ability to report values within the standard for their geographic classification for all required service categories.

The time and distance analysis resulted in an average CCO score of 13.2 points across aggregated DSN Provider Narrative Report—Time and Distance Standards, or approximately 94.3 percent of the maximum points possible (14.0 points), as displayed in Table 6-6. While 11 CCOs achieved the maximum points possible, four CCOs received scores ranging from seven to 13.5 points.

Table 6-6—DSN Provider Narrative Report—Time and Distance Evaluation Results

CCO	DSN Provider Narrative Report—Time and Distance Standards														Total CCO Score
	PCPA	PCPP	PCPCH	OB/GYN	MHPA	MHPP	SUDPA	SUDPP	HOSP	RX	OHPA	OHPP	SPA	SPP	
AH	1	1	1	1	1	1	1	1	1	1	1	1	1	1	14.0
AllCare	1	1	1	1	1	1	1	1	1	1	1	1	1	1	14.0
CHA	1	1	1	1	1	1	1	1	1	1	1	1	1	1	14.0
CPCCO	1	1	1	1	1	1	1	1	1	1	1	1	1	1	14.0
EOCCO	1	0.5	1	1	1	1	1	1	1	1	1	1	1	1	13.5
Health Share	1	1	1	1	1	1	1	1	1	1	1	1	1	1	14.0
IHN	1	1	1	0	1	1	1	1	1	0	0	0	1	1	10.0
JCC	1	1	1	1	1	1	1	1	1	1	1	1	1	1	14.0
PSCS-CO	1	1	1	1	1	1	1	1	1	1	1	1	1	1	14.0
PSCS-CG	1	1	1	1	1	1	1	1	1	1	1	1	1	1	14.0
PSCS-Lane	1	1	1	1	1	1	1	1	1	1	1	1	1	1	14.0
PSCS-MP	1	1	1	1	1	1	1	1	1	1	1	1	1	1	14.0
TCHP	1	1	1	1	1	1	1	1	1	1	1	1	1	1	14.0
UHA	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	7.0
YCCO	1	0.5	1	1	1	1	1	1	1	1	1	1	1	1	13.5
Statewide Average Scores	**1.0**	**0.9**	**1.0**	**0.9**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**0.9**	**0.9**	**0.9**	**1.0**	**1.0**	**13.2**
Points Possible	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**14.0**

Definitions for the provider service categories referenced in this table: PCPA—Primary Care Provider, Adult; PCPP—Primary Care Provider, Pediatric; PCPCH—Patient-Centered Primary Care Home; OB/GYN—Obstetrics/Gynecology; MHPA—Mental Health Provider, Adult; MHPP—Mental Health Provider, Pediatric; SUDPA—Substance Use Disorder Provider, Adult; SUDPP—Substance Use Disorder Provider, Pediatric; HOSP—Hospital; RX—Pharmacy/Pharmacies; OHPA—Oral Health Provider, Adult; OHPP—Oral Health Provider, Pediatric; SPA—Specialty Practitioner, Adult; SPP—Specialty Practitioner, Pediatric

Twelve CCOs met all the elements in the Time and Distance Standards Reporting section of the narrative. Of these 12 CCOs, six CCOs reported their routine time or distance standard as 30 and/or 60 miles and minutes across every service category without any variation; however, these CCOs reported variations in percentages to demonstrate calculations of members with access in their service areas. Five of the 12 CCOs provided detailed time and distance standards with variations in minutes, miles, and percentages, demonstrating the CCOs calculated member travel time and distance, and percentage of members with access in their service area. The remaining CCO reported its routine time and distance as the standard requirement with no variation across all service categories.

Of the remaining three CCOs that did not meet all elements in the Time and Distance Standards Reporting section, one CCO only reported the percentage of members with access in its service area with no variation, across all service categories. Another CCO reported its routine time or distance standard but was non-compliant with the 73.40 percent of pediatric members having access to PCPP. The remaining CCO reported detailed time and distance standards but did not report standards for OB/GYN, RX, OHPA, and OHPP.

DSN Provider Capacity Analysis Results—CCOs

HSAG analyzed the CCOs' DSN Provider Capacity Reports in each of the four domains. The following text provides aggregated results.

Quality of DSN Provider Capacity Reporting

HSAG's analysis of the third quarter DSN Provider Capacity Reports illustrated most CCOs rectified quality, consistency, and accuracy issues identified during the one-time Targeted DSN Provider Capacity Report Review, resulting in improved data elements, data field format/value, and data file layout validity and alignment with the specifications in the *2020 Quarterly CCO DSN Provider Capacity Report Instructions* and *2020 Quarterly DCO DSN Provider Capacity Report Instructions.* HSAG identified two exceptions to these general improvements in DSN provider capacity reporting quality:

- Two CCOs submitted data records with invalid values populated in the Provider Service Category data fields (e.g., DSPA, DSPP, MMPA).
- One CCO's DSN Provider Capacity Report interchanged two data fields.

Provider Network Capacity

HSAG processed, cleaned, deduplicated, and analyzed each CCO's third quarter DSN Provider Capacity Report, identifying the number and percentage of individual practitioners, facilities, businesses, and services by key stratifications (e.g., provider/service category, pediatric/adult provider, panel status, network status, contract status, and geographic distribution). HSAG identified three areas for improvement in provider network counts:

- One CCO submitted its DSN Provider Capacity Report with no data records identifying the Provider Category Description of Facility or Business or Healthcare Services.
- After deduplication by National Provider Identifier (NPI), two of the CCOs were assessed as having no contracted and in-network substance use disorder (SUD) practitioners rendering care to pediatric members.
- None of the CCOs submitted DSN Provider Capacity Reports with populated data records for all nine individual practitioner service categories.

Provider Accessibility

HSAG analyzed CCO provider accessibility, identifying the total number of PCPs (e.g., PCPA, PCPP, and PCPCH) accepting new members. Table 6-7 shows data results stratified by contracted, in-network providers and contracted, out-of-network providers. HSAG identified four areas for improvement in provider accessibility:

- One CCO's DSN Provider Capacity Report interchanged two data fields, reporting values for "# of Members Assigned to PCP" in the "Accepting New Medicaid Members" data field, resulting in no PCPs accepting new members.
- Seven CCOs were assessed with less than 80 percent of the total number of contracted, in-network PCPs accepting new members.
- Eight CCOs were assessed with less than 70 percent of the total number of contracted, in-network PCPs accepting new members.
- Six CCOs demonstrated widespread access to contracted, out-of-network PCPs accepting new members.

Table 6-7—Number and Percentage of PCPs Accepting New Patients, by CCO

	All Providers			Contracted, In-Network Providers			Contracted, Out-of-Network Providers		
CCO[1]	Number Accepting New Patients	Total Number of PCPs	Percent	Number Accepting New Patients	Total Number of PCPs	Percent	Number Accepting New Patients	Total Number of PCPs	Percent[2]
AH	89	89	100.0%	89	89	100.0%	0	0	0.0%
AllCare	90	401	22.4%	90	401	22.4%	0	0	0.0%
CHA	68	191	35.6%	68	139	48.9%	0	0	0.0%
CPCCO	1,306	6,904	18.9%	135	349	38.7%	1,171	6,555	17.9%
EOCCO	769	1,000	76.9%	283	289	97.9%	486	711	68.4%
Health Share	7,085	7,085	100.0%	5,388	5,388	100.0%	1,697	1,697	100.0%
IHN	267	278	96.0%	218	224	97.3%	49	54	90.7%
JCC	1,366	6,944	19.7%	185	682	27.1%	1,181	6,262	18.9%
PSCS-CO	199	286	69.6%	199	286	69.6%	0	0	0.0%
PSCS-CG	85	93	91.4%	85	93	91.4%	0	0	0.0%

	All Providers			Contracted, In-Network Providers			Contracted, Out-of-Network Providers		
CCO[1]	Number Accepting New Patients	Total Number of PCPs	Percent	Number Accepting New Patients	Total Number of PCPs	Percent	Number Accepting New Patients	Total Number of PCPs	Percent[2]
PSCS-Lane	334	511	65.4%	334	493	67.7%	0	0	0.0%
PSCS-MP	302	437	69.1%	302	437	69.1%	0	0	0.0%
TCHP	360	360	100.0%	259	259	100.0%	101	101	100.0%
UHA	124	154	80.5%	124	154	80.5%	0	0	0.0%
YCCO	0	1,308	0.0%	0	1,308	0.0%	0	0	0.0%

[1] Limited to providers in Oregon.

[2] '0' indicates that both the numerator and denominator are zero; therefore, a percentage cannot be calculated.

Geographic Distribution

The geographic distribution of providers relative to member populations assessed whether the providers were spread proportionately across the member population. HSAG conducted access analyses using the provider service categories listed in the Time and Distance section of the DSN Provider Narrative Report and made the following observations:

- Seven CCOs were assessed with no deficiencies, validating that at least 90 percent of both adult and pediatric members had sufficient access to all required provider service categories within each CCO's service area and corresponding ZIP Codes.
- Six CCOs had a geographic distribution of PCPCH practitioners and facilities compared to their memberships that was not sufficient to cover each CCO's service area based on the OHA pre-defined time and distance thresholds. HSAG's analysis identified no PCPCH practitioners and facilities reported by each CCO, validating that 100 percent of all members were without access to PCPCHs.
- Two CCOs had a geographic distribution of PCPs compared to their memberships that was not sufficient to cover each CCO's service area based on the OHA pre-defined time and distance thresholds. Both CCOs were assessed as having less than 90 percent of adult and pediatric members with sufficient access to PCPA and PCPP services in both rural and urban areas.
- Three CCOs had a geographic distribution of SUD providers, compared to their pediatric members, that was not sufficient to cover each CCO's service area based on the OHA pre-defined time and distance thresholds. HSAG's analysis identified no SUD providers reported by CCOs, validating that 100 percent of all pediatric members in those CCOs were without SUD access.
- One CCO had a geographic distribution of SPPs compared to its pediatric members that was not sufficient to cover each CCO's service area based on the OHA pre-defined time and distance thresholds.
- All 15 CCOs were assessed to have membership residing in counties and ZIP Codes that did not align with their assigned CCO's geographic service area.

DCO 2020 Annual DSN Evaluation Results

DSN Provider Narrative Assessment Results—DCOs

The DCOs received an average score of 10.8 points across aggregated DSN Provider Narrative Report categories, or approximately 77 percent of the maximum points possible (14.0 points), as shown in Table 6-8. Two DCOs achieved a perfect score in at least one category. All DCOs received at least a positive score in each category.

Table 6-8—DSN Provider Narrative Report Evaluation Results

DCO Name	DSN Provider Narrative Report Categories			Total DCO Score
	Description of the Delivery Network and Adequacy	Description of Members	Additional Analysis of the DCO's Provider Network to Meet Member Needs	
ADS	3.0	2.0	4.0	9
CDC	4.0	2.5	4.5	11
FDCi	4.0	1.0	5.0	10
MDCO	4.0	2.5	4.5	11
ODS	6.0	2.0	5.0	13
Statewide Average Scores	**4.2**	**2.0**	**4.6**	**10.8**
Points Possible	**6.0**	**3.0**	**5.0**	**14.0**

Description of the Delivery Network and Adequacy

One DCO met all the elements in the *Description of the Delivery Network and Adequacy* narrative category, being the only DCO that fully identified the geocoding application or software (Facets and Quest Analytics) used in its network analysis. Four of the five DCOs calculated time and distance standards in a way that did not explicitly use the precise physical address of both the member and provider or did not fully describe their methodology. Measuring with non-precise locations (e.g., ZIP Codes or counties) produces inaccurate estimates of routine travel time and distance.

All DCOs exhibited a strength in the category in terms of monitoring member access to care and ensuring provision of appropriate urgent, emergency, crisis, and triage services 24 hours a day, seven days a week. Oregon's DCOs were uniformly committed to and capable of providing appropriate dental care to members when they needed it.

Description of Members

The *Description of Members* category yielded low scores for all DCOs, representing the worst category for four out of five DCOs. No DCO submitted a cultural, language, disability, and special health care needs analysis demonstrating characteristics of its membership, nor described using such characteristics

as part of its membership analysis processes. Some DCOs described analyzing their membership population in terms of language, but not the other characteristics. Most DCOs reported relying on their member services or care coordination team/care coordinator(s) for the purposes of helping members find a "best fit" member/provider assignment. One DCO described assigning members by ZIP Code and providing members with a "provider search tool," but did not describe the process further, how it benefited members, or how it considered the needs of members in making assignments.

Additional Analysis of the DCO's Provider Network to Meet Member Needs

All DCOs turned in their strongest or tied-for-strongest performance in the *Additional Analysis of the DCO's Provider Network to Meet Member Needs* category. Two DCOs earned a perfect score in the category, and all DCOs showcased one or more major and innovative strengths in the category, including such approaches as technology use, development, and investment; health equity training and analysis; sophisticated and dedicated member outreach and care coordination; and community investment or program pilots. The main failing for the DCOs in this category was in submitting narratives that did not contain full responses, detailed examples, and/or relevant supporting documentation, all of which points to a likely need for TA in appropriate reporting rather than shortcomings in their respective networks. The most common finding for the DCOs was not including concrete examples of incorporating member feedback when making network decisions and assessing adequacy.

Time and Distance Standards Reporting

The DCOs reported compliance with time and distance access standards in either routine time or distance (i.e., minutes and miles) and with the percentage of members in the service area that can access health care from the network. HSAG scored this section solely based on the CCOs' ability to report values within the standard for their geographic classification for all required service categories. Additionally, the *2020 Quarterly DCO DSN Provider Capacity Report Instructions* included expanded practice dental hygienist (EPDH) as an all-inclusive provider service category; however, the Annual 2020 MCE DSN Provider Narrative Report Template time and distance reporting included EPDH stratified for adults and children. Upon discussing with OHA, it was decided after the instructions were dispersed that this service category would not be stratified and all reporting for EPDH would be comprehensive.

Overall, the DCOs received an average score of 4.0 points across aggregated DSN Provider Narrative Report—Time and Distance Standards, or approximately 80 percent of the maximum points possible (5.0 points), as shown in Table 6-9.

Table 6-9—DSN Provider Narrative Report—Time and Distance Evaluation Results

DCO Name	DSN Provider Narrative Report—Time and Distance Standards					Total DCO Score
	PCDA	PCDP	EPDH	OHSA	OHSP	
ADS	1.0	1.0	1.0	1.0	1.0	5.0
CDC	1.0	1.0	1.0	1.0	1.0	5.0

DCO Name	DSN Provider Narrative Report—Time and Distance Standards					Total DCO Score
	PCDA	PCDP	EPDH	OHSA	OHSP	
FDCi	0.0	0.0	0.0	0.0	0.0	0.0
MDCO	1.0	1.0	1.0	1.0	1.0	5.0
ODS	1.0	1.0	1.0	1.0	1.0	5.0
Statewide Average Scores	**0.8**	**0.8**	**0.8**	**0.8**	**0.8**	**4.0**
Points Possible	**1.0**	**1.0**	**1.0**	**1.0**	**1.0**	**5.0**

Definitions for the provider service categories referenced in this table: PCDA—Primary Care Dentist, Adult; PCDA—Primary Care Dentist, Pediatric; EPDH—Expanded Practice Dental Hygienist; OHSA—Oral Health Specialist, Adult; OHSP—Oral Health Specialist, Pediatric

Four DCOs met all the elements in the Time and Distance Standards Reporting section of the narrative. One of the four DCOs that met all standards for the section provided detailed time and distance standards with variations in minutes, miles, and percentages, demonstrating the DCOs calculated member travel time and distance, and percentage of members with access in their service area. Two of the four DCOs reported their distance and access standards as, "No difference from OAR standards." The remaining DCO reported its routine time and distance in the standard fashion.

As for the one DCO that did not meet any of the time and distance standards, only the average driving distance was reported for PCDA and PCDP in miles. The DCO also did not specify whether the standard was for the rural or urban geographic classification. Finally, the DCO stated that the "ratio of EPDHs to members changes depending on the specific clinic's staffing mix" as a response to the time, distance, and percentage of members with access reporting prompt.

DSN Provider Capacity Analysis Results—DCOs

HSAG analyzed the DCO DSN Provider Capacity Reports in each of the four domains. The following text provides aggregated results.

Quality of DSN Provider Capacity Reporting

HSAG's analysis of the October 1, 2020, DSN Provider Capacity Reports illustrated that most DCOs did not rectify quality, consistency, and accuracy issues identified as part of the one-time Targeted DSN Provider Capacity Report Review. Below are the observed reporting exceptions:

- Three DCOs submitted a DSN Provider Capacity Report that did not remedy key quality reporting issues identified in the one-time Targeted DSN Provider Capacity Report Review. All three DCOs resubmitted a DSN Provider Capacity Report with no data records identified as Provider Category Description of Facility or Business or Healthcare Services.
- Two DCOs' DSN Provider Capacity Reports demonstrated more complete and accurate provider network data; however, deficiencies with data field values and format were still observed.

Provider Network Capacity

HSAG processed, cleaned, deduplicated, and assessed each DCO's third quarter DSN Provider Capacity Report, identifying the number and percent of oral health practitioners, facilities, businesses, and services by key stratifications (e.g., provider/service category, pediatric/adult provider, panel status, network status, contract status, and geographic distribution). Findings from the analysis included:

- Three DCOs submitted their DSN Provider Capacity Reports with no data records identifying the Provider Category Description of Facility or Business or Healthcare Services.
- After deduplication by NPI, two DCOs were assessed as having less than 25 percent of their contracted and in-network primary care dentists (PCDs) rendering care to pediatric members.
- None of the DCOs submitted DSN Provider Capacity Reports with populated data records for all oral health practitioner service categories.

Provider Accessibility

HSAG analyzed the provider accessibility of each DCO, identifying the total number of PCDs (e.g., PCDA and PCDP) accepting new members. Table 6-10 exhibits deduplication of PCDs by NPI and results stratified by contract and network status.

- Three DCOs were assessed as having greater than 95 percent of their total number of PCDs accepting new members.
- One DCO was evaluated as having 941 unique PCDs within its network, with only 59.2 percent of the providers accepting new members.
- One DCO was evaluated as having 761 unique PCDs within its network, with only 15.6 percent of the providers accepting new members.
- When comparing contracted, in-network PCDs accepting new members across all five DCOs, 1,034 out of 2,065 PCDs resulted in 50.1 percent accepting new members.

Table 6-10—Number and Percent of PCDs Accepting New Patients, by DCO

DCO[1]	All Providers			Contracted, In-Network PCDs		
	Number Accepting New Patients	Total Number of PCDs	Percent	Number Accepting New Patients	Total Number of PCDs	Percent
ADS	119	761	15.6%	119	761	15.6%
CDC	241	244	98.8%	241	244	98.8%
FDCi	57	57	100.0%	56	56	100.0%
MDCO	61	63	96.8%	61	63	96.8%
ODS	557	941	59.2%	557	941	59.2%

[1] Limited to providers in Oregon.

Geographic Distribution

The geographic distribution of providers relative to member populations assessed whether the oral health practitioners were spread proportionately across the member population. HSAG conducted access analysis using the provider service categories listed in the Time and Distance section of the DSN Provider Narrative Report. The analysis had the following findings:

- Three DCOs were assessed with no deficiencies, validating that at least 90 percent of both adult and pediatric members had sufficient access to all required provider service categories within each DCO's service area and corresponding ZIP Codes.
- Two DCOs' geographic distribution of EPDHs compared to their memberships were not sufficient to cover each DCO's service area based on the OHA pre-defined time and distance thresholds. HSAG's analysis of both DCOs' DSN Provider Capacity Reports identified that neither report included any data records for EPDHs, validating that 100 percent of both DCOs' memberships were without access.
- Four DCOs were assessed to have membership residing in counties and ZIP Codes that did not align with the OHA-defined geographic service areas.

7. Encounter Data Validation

Background

Federal regulations under 42 CFR §438.242[7-1] require OHA to ensure that each of its MCEs 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 MCEs to ensure that these data are a complete and accurate representation of the services provided to its Medicaid members.

OHA had previously addressed these federal requirements for the CCOs via a comprehensive Information Systems Capabilities Assessment (ISCA) every two years. In 2019, HSAG examined the results from the 2018 ISCA, 2019 Readiness Review Health Information Systems evaluations, and the 2019 PMV activity. Based on these efforts and in consultation with OHA, HSAG determined that the ISCA could be streamlined toward an EDV process in 2020. HSAG also recommended to OHA that the EDV be conducted as a sequential and collaborative process that incorporated CCO accountability for claims validation.

The EDV assessment, in alignment with the CMS EQR protocol[7-2] for validating encounter data, included an evaluation of the CCOs' processes for collecting, maintaining, and submitting encounter data to OHA. The evaluation provided information on the strengths and limitations of the CCOs' information systems in promoting and maintaining quality encounter data. HSAG also evaluated OHA's processes for collecting and managing the CCO-submitted encounter data.

Objectives

The objective of the CY 2020 EDV study was to examine the extent to which OHA and the CCOs had the appropriate system documentation and infrastructure to produce, process, and monitor encounter data. 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 provide complete and accurate utilization information.

[7-1] 42 CFR §438.242.

[7-2] 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, October 2019*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 17, 2021.

Methodology

HSAG designed a three-stage EDV assessment process that included a document review, development and fielding of a customized encounter data questionnaire, and follow-up interviews with key OHA and CCO staff members. The EDV activity was initiated by HSAG conducting a thorough desk review of existing documents related to OHA encounter data initiatives/validation activities. Documentation included but was not limited to data dictionaries, information system schema, processing diagrams, file/table layouts, full encounter system edit/audit, encounter data re-adjudication processing cycle, sample rejection reports, and encounter data submission requirements and standards. The information obtained from this initial review, in conjunction with previous ISCAs and PMV findings, informed the development of a targeted questionnaire to address specific topics of interest for OHA.

The targeted questionnaire was designed to assist HSAG in understanding the information systems and data processing procedures used by the CCOs and OHA. Based in part on the ISCA, the questionnaire was designed to identify current processes and procedures that impact encounter data processing, as well as other identified areas of interest. The questionnaire also gathered information on the claims adjudication processes in use by the CCOs, including claims validation processes. Where applicable, the questionnaire also included a review of supplemental documentation regarding other data systems, including enrollment and providers. HSAG produced two versions of the questionnaire: one specific to OHA, and one specific to the CCOs. Table 7-1 displays the four areas assessed in the targeted questionnaire.

Table 7-1—2020 Targeted Questionnaire Assessment Areas

2020 Targeted Questionnaire Assessment Areas
Encounter Data Sources and Systems
Data Exchange Policies and Procedures
Management of Encounter Data: Collection, Storage, and Processing
Encounter Data Quality Monitoring and Reporting

The OHA questionnaire had similar domains but focused on OHA's data exchange with the CCOs. All questionnaire responses were self-reported, and HSAG did not validate the responses for accuracy. After reviewing the completed questionnaires from OHA and the CCOs, HSAG conducted further follow-up communications with key OHA and CCO information technology (IT) personnel to clarify any questionnaire responses as necessary. The focused information system and data processing reviews allowed HSAG to document current processes and develop a thematic process map identifying critical points that impacted the submission of quality encounter data.

Results

Representatives from all 15 CCOs completed OHA-approved questionnaires supplied by HSAG. HSAG identified follow-up questions based on the CCOs' original questionnaire responses, and the CCOs

responded to these CCO-specific questions. To support their questionnaire responses, the CCOs submitted a wide range of documents with varying formats and levels of detail. HSAG finalized a single aggregate report in February 2021, which contained key findings for OHA as well as aggregate and CCO-specific summary of findings and recommendations. This section provides high-level results from the four key domains described in the methodology.

Encounter Data Sources and Systems

The claims/encounter process began when a member received a health care service from a provider; the providers then usually submitted claims electronically or via paper to a clearinghouse responsible for aggregating and formatting claims for submission to the claims processor. In some cases, providers submitted the claims directly to the CCO for claims processing. Next, the claim was processed, and the data were submitted to the CCO's encounter data system. If the claim was processed by a third party, that vendor submitted the claim information to the CCO through its encounter data system. The CCO or its vendor was responsible for ensuring that encounter data are accurate, complete, and formatted correctly for submission to OHA, using 837 P/D/I or National Council for Prescription Drug Programs (NCPDP) D.0 files.

Depending on how providers and vendors submitted data to the CCO, these data files were either passed directly to OHA, or the vendor submitted the data to OHA on behalf of the CCO (i.e., pass-through arrangements). Once the required files were submitted to OHA, OHA provided the response files for the data submission. The CCO or its vendor reviewed the response files and resubmitted data, if needed. If the rejected data were originally provided to the CCO by a vendor, the CCO required the vendor to correct the data and resubmit the files to the CCO. This data framework contained extensive opportunities for variation at nearly every stage based on the CCO's contractual arrangements with health care providers and provider networks, other CCOs, and trading partners (e.g., vendors for claims preprocessing and/or processing, or provision of selected services).

Encounter data submitted by the CCOs were checked to determine if the providers on the claim are actively enrolled into MMIS for the date(s) of service. Based on OHA's questionnaire response, it appeared that MMIS was adjudicating both claims and encounters submitted by the plans, based on the FFS provider enrollment. State provider mapping was identified by the CCOs as one of their challenges to the submission of complete and timely encounters to OHA.

Data Exchange Policies and Procedures

The CCOs' encounter data implementation process began with reviewing contractual requirements and data submission requirements, such as companion guides and OHA-specific edits. In general, all CCOs prepared their file submissions based on OHA's guidelines. Policies and procedures documents, as well as the encounter data flow documents, were submitted by each CCO to HSAG as supporting documentation with the completed questionnaires. The policy and procedure documents showed that the CCOs employed encounter file generation and review processes that had been tailored to meet OHA's encounter submission contractual requirements and specifications.

Management of Encounter Data: Collection, Storage, and Processing

The OHA-approved questionnaire elements in this area focused primarily on the CCOs' collection of payment-related data fields. Because the encounter data submission did not include a payment methodology field, some variation in pricing methodology existed among the CCOs with regard to their pricing methodology for outpatient, inpatient, and pharmacy encounters. For outpatient encounters, nearly all the CCOs used percent billed methodology as one of their claim payment strategies. While nearly all CCOs employed this methodology for outpatient encounters, some CCOs used other methods such as line by line, fee schedule, capitated, and CMS Outpatient Prospective Payment System (OPPS) rules. For inpatient encounters, nearly all CCOs used the diagnosis-related group (DRG) or percent billed methodology for pricing. Nearly all CCOs employed similar claim payment strategies for pharmacy claims, using negotiated rates (based on ingredient costs and administrative/dispensing fees) methodology to price pharmacy claims.

All CCOs collected TPL data for their managed care members, although information was processed at different points in their adjudication processes. The CCOs collected TPL data from various data sources to track other insurance coverage for their members, including the daily 834 eligibility file, the coordination of benefit information provided by OHA, member contact, and provider or billing office contacts. The CCOs considered TPL data before finalizing their claims adjudication.

Encounter Data Quality Monitoring and Reporting

To submit accurate, complete, and timely encounter data to OHA, CCOs must ensure oversight of data submitted by their vendors or subcontractors. Therefore, the CCOs responded to the questionnaires with descriptions of how they monitor completeness, accuracy, and timeliness of claims and encounter data submitted by their vendors or subcontractors. In addition to the business rule edits and Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance checks executed by their claims processing systems, the CCOs conducted various validation activities, such as calculating amount billed based on the State submission tracker and claim count validation reports; evaluating each monthly submission claim; reviewing data submission and utilization trends; and tracking date of pharmacy claim reports.

The completeness and accuracy of claims data submitted from providers and clearinghouses were generally verified through data validation checks that were incorporated into the CCOs and/or their vendors'/subcontractors' processes. These validation checks verified that claims were not missing values for vital fields and that missing values were reasonable (e.g., valid International Classification of Diseases, Tenth Revision, Clinical Modification [ICD-10-CM] diagnosis codes or valid NPI values). Additionally, these checks verified HIPAA compliance and that claims data met OHA's specifications for file transactions.

Based on HSAG's review, all CCOs appeared to have processes both to track encounters sent to OHA and then process the response files back such that CCOs could monitor the rejections/pends and handle necessary corrections and resubmissions. All CCOs processed the following files received from OHA:

- 999—Used to determine if a file was received and accepted into OHA's Electronic Data Interchange (EDI) translator.
- 835—Claims payment/remittance file, used to ensure what was submitted and if it was successfully processed by OHA.
- Status file—Used to determine pended claims and ensure that pended claims are corrected.
- NCPDP response file—Used to identify issues with NCPDP file submissions.

To evaluate the quality of CCO monthly encounter submissions, OHA's Claim and Encounter Data Services Unit (CEDSU) used various receipt and validity editing, review, and reporting. OHA ensured the accuracy and completeness of encounter data by using MMIS edits, historical data, and error reports. The metrics used were based on contract requirements. OHA also noted that it has reports that monitor each requirement in the contract and follows the contractual requirements for submission to be able to enforce any corrective action.

To monitor the timeliness of encounter data submitted by the CCOs, OHA used the contract requirement that no more than 5 percent of encounter data can be sent more than 45 days past the date of adjudication for a service month. Timeliness monitoring was conducted weekly by the liaison within CEDSU. However, OHA did not have performance standards beyond what was described in the CCO contract requirements regarding submission, accuracy, and timeliness of encounter data.

Additionally, CCOs were required to submit a report detailing the number and dollar amount submitted as part of the encounter data submission activities. If the report information did not match what was processed, CCOs were required to research the cause and respond. Pended encounter claims sent to the CCOs were also required to be corrected by the CCOs and were monitored to ensure correction within the 63 days allowed in the contract.

While CCOs and OHA described various activities conducted to monitor completeness, accuracy, and timeliness, there appeared to be a lack of validation via chart/medical record reviews by some CCOs and by OHA.

8. Mental Health Parity

Background

MHP regulations are intended to ensure that coverage and access to services for the treatment of MH/SUD conditions are provided in parity with treatments provided for M/S needs. The required analysis of MH/SUD benefits is governed by federal regulations. 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 are comparable to and applied no more stringently than the limitations applied to M/S benefits. Provisions of the MHPAEA became applicable to the OHP in October 2017 when the Medicaid Parity Final Rule (42 CFR §438 Subpart K) went into effect. The rule requires parity in 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 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.

To meet the requirements, OHA conducted an initial MHP Analysis of OHP's full delivery system in 2018. OHA's 15 CCOs and OHP FFS participated in the initial MHP Analysis, which included an inventory of all MH/SUD and M/S benefits offered to OHP members and the limitations applied to those benefits to ensure that limitations (e.g., day limits, PA requirements, or network admission standards) for MH/SUD services were comparable to and applied no more stringently than those for M/S services provided under OHP. In 2020, OHA contracted with HSAG to conduct a follow-up analysis across the CCOs and OHP FFS to determine continued compliance with MHP regulations.

Objectives

The objective of the MHP activity in 2020 was to ensure that coverage and access to services for the treatment of MH/SUD conditions across all organizations for OHP managed care benefit packages were provided in parity with treatments provided for M/S needs, in compliance with MHP regulations in 42 CFR §438 Subpart K.

Methodology

In accordance with 42 CFR §438 Subpart K, MHP applied to all OHP benefits delivered through OHA's managed care delivery system, including those delivered through a combination of managed care and FFS delivery systems. HSAG developed a protocol and tools to carry out the analysis activity based on the initial 2018 MHP Analysis and in alignment with guidance outlined in the toolkit provided by CMS: *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*.[8-1] The 2020 MHP Analysis also referenced Oregon's Mapping Guide[8-2] that assigned benefits to MH/SUD and M/S groupings based on International Classification of Diseases, Tenth Revision (ICD-10) diagnoses and mapped into four prescribed classifications: Inpatient, Outpatient, Prescription Drug, and Emergency Care.[8-3]

Table 8-1 identifies the four OHP benefit packages evaluated in the 2020 MHP Analysis. Since each benefit package involved the delivery of Medicaid essential health benefits covered by both CCOs and OHP FFS, HSAG conducted an analysis of each CCO's NQTLs, and then against the OHP FFS NQTLs.

Table 8-1—OHP Benefit Packages

Benefit Package	Benefit Types Covered	Evaluation
CCO A	Physical Health, Behavioral Health, Oral Health	CCO MH/SUD and FFS MH/SUD compared to CCO M/S
CCO B	Physical Health, Behavioral Health	
CCO E	Behavioral Health	CCO MH/SUD and FFS MH/SUD compared to FFS M/S
CCO G	Behavioral Health, Oral Health	

Since OHP benefits do not require financial limitations or quantitative limitations (e.g., day or visit limits), the 2020 MHP Analysis focused on NQTLs such as PA and provider admission processes. HSAG analyzed CCO and OHP FFS policies and operations to ensure that limitations applied to MH/SUD benefits were comparable to and applied no more stringently to M/S benefits provided under each benefit package in the NQTL categories listed and described in Table 8-2.

[8-1] The CMS *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs* and additional CMS resources related to MHP can be accessed at: https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/parity/index.html.

[8-2] The Oregon Mapping Guide includes definitions, links, and resources important for the MHP Analysis. It also maps all Oregon Medicaid benefits to the classifications required for the MHP Analysis. It can be accessed on OHA's MHP webpage at: https://www.oregon.gov/OHA/HSD/OHP/Pages/MH-Parity.aspx.

[8-3] Federal Register. Volume 81, No. 61/Wednesday, March 30, 2016. Available at: https://www.govinfo.gov/content/pkg/FR-2016-03-30/pdf/FR-2016-03-30.pdf. Accessed on: Mar 17, 2021.

Table 8-2—MHP Analysis NQTL Categories

Category	Category Title	Description
I	**Utilization Management Limits Applied to Inpatient Services**	UM processes implemented through PA, concurrent review (CR), and retrospective review (RR) that may also be used to ensure medical necessity for MH/SUD and M/S services.
II	**Utilization Management Limits Applied to Outpatient Services**	UM processes applied to Outpatient MH/SUD and M/S services through PA, CR, and RR to ensure medical necessity.
III	**Prior Authorization for Prescription Drug Limits**	PA as a means of determining whether particular medications will be dispensed. PA of prescription drugs limits the availability of specific medications.
IV	**Provider Admission—Closed Network**	Closed networks as they impose limits to providers seeking to join a panel of approved providers.
V	**Provider Admission—Network Credentialing**	Network enrollment/credentialing requirements imposed, including provider admission requirements such as state licensing requirements and exclusions of specific provider types, that may result in limitations.
VI	**Out-of-Network/Out-of-State Limits**	Out-of-network (OON) and out-of-state (OOS) limits that affect how members access OON and OOS providers and address how OHA and the CCOs ensure necessary access to providers not eligible to be reimbursed or not in a CCO's network.

Additional MHP requirements related to the availability of criteria for medical necessity determinations and the reason for denial of reimbursement or payment for MH/SUD benefits were also analyzed.

The 2020 MHP Analysis activities included:

1. **Protocol and Tool Development and Dissemination:** HSAG developed and disseminated an MHP Analysis Protocol that presented details and guidance to OHA and the CCOs on the analysis process and included tools in which to conduct the 2020 MHP Analysis activity. The tools utilized for the analysis, identified below, were based on OHA's initial analysis of MHP and were developed using 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*.
   - **MHP Evaluation Questionnaire**—Questions referencing the six NQTL categories, to identify changes that may impact parity.
   - **MHP Reporting Template**—Documentation of changes and additions to NQTLs previously reported in 2018, organized by the six NQTL categories.
   - **MHP Required Documentation Template**—UM and credentialing data across MH/SUD and M/S benefits and providers.

2. **Pre-Analysis Webinar:** HSAG conducted a pre-analysis webinar on July 15, 2020, with OHA and the CCOs to provide an overview of MHP regulations, details of the protocol and tools, specifics of the analysis timeline, and examples of MHP scenarios for reference.
3. **Documentation Submission:** OHA and the CCOs were required to submit documentation that included responses to the MHP Evaluation Questionnaire and completed templates, along with supporting documentation, by August 31, 2020.
4. **Desk Review:** HSAG conducted a desk review of all submitted MHP Evaluation Questionnaires, the MHP Reporting Template, and required and supporting documentation (e.g., policies and procedures, benefit schedules, and delegate agreements) to analyze policies and operational practices that impact MHP and determine preliminary analysis findings.
5. **Conference Calls:** HSAG conducted conference calls to discuss preliminary analysis findings and areas in need of clarification. Additional information and documentation were requested at that time, as necessary to support the MHP Analysis.
6. **Reporting:** HSAG compiled analysis results and documented MHP determinations for each CCO and as compared to OHP FFS, identifying areas in which MHP had not been achieved and corrective actions were required to ensure future parity. OHA and each CCO had an opportunity to review report drafts prior to finalizing the reports.
7. **Corrective Action Planning and Implementation:** HSAG will work with OHA and the CCOs to develop and implement CAPs to achieve compliance with MHP requirements.

HSAG reviewers conducted a desk review of submitted MHP Analysis tools and supporting documentation to further clarify reported changes and additions to previously reported NQTLs from the initial MHP Analysis conducted in 2018. More specifically, HSAG evaluated responses to the MHP Evaluation Questionnaire to identify changes to benefits design and operations within OHA and each CCO that may impact MHP, cross-referenced questionnaire responses with changes and additions reported in the MHP Reporting Template, and reviewed supporting documentation submitted by OHA and the CCOs. Supporting documentation included, but was not limited to, UM policies, workflow diagrams, program descriptions, prescription drug formularies, and network admission/credentialing policies. HSAG conducted the 2020 MHP Analysis based on this information to determine compliance with parity guidelines, including ensuring that policies followed standard industry practice, allowed for little to no exception or variation, incorporated established State definitions and guidelines, included staff members qualified to make the decisions and complete the tasks assigned, and had appropriate oversight.

Information obtained via scheduled conference calls was also evaluated in relation to changes and additions reported. Differences in how limits were applied to MH/SUD services as compared to M/S services, in relation to comparability and stringency standards displayed in Table 8-3, were evaluated across the six NQTL categories for continued compliance with MHP regulations. Each CCO's NQTLs were additionally evaluated against OHP FFS MH/SUD and M/S NQTLs based on the structure of OHP benefit packages.

Table 8-3—Comparability and Stringency Standards

Comparability and Stringency Standard	Question Description
Benefits in Which NQTLs Apply	**1. To which benefits is an NQTL assigned?** *Purpose: To describe the NQTL assigned to MH/SUD and M/S benefits (e.g., PA, scope of services, and time frames).*
Comparability of Strategy	**2. Why is the NQTL assigned to these benefits?** *Purpose: To describe for what reasons or purpose the NQTL is assigned (e.g., ensure medical necessity, prevent overutilization, and comply with State and federal requirements).*
Comparability of Evidentiary Standard	**3. What evidence supports the rationale for the assignment?** *Purpose: To describe the evidence to support the rationale (e.g., benchmarks, standards that form the basis of the rationale, and State and federal requirements).*
Comparability of Processes	**4. What are the NQTL procedures?** *Purpose: To describe the NQTL process and evidence needed to support NQTL determinations (e.g., documentation requirements, timelines, and steps for the CCO and members/providers).*
Stringency of Strategy	**5. How frequently or strictly is the NQTL applied?** *Purpose: To describe the frequency of application, frequency of medical necessity and appropriateness reviews, level of discretion in how the NQTL is applied, triggers for review and re-review, etc.*
Stringency of Evidentiary Standard	**6. What standard supports the frequency or rigor with which the NQTL is applied?** *Purpose: To describe standards that the CCO uses to determine the frequency or rigor of NQTL procedures.*

Results of the MHP Analysis were reported individually to OHP FFS and each CCO with limitations or other operational processes found to impact parity reported as findings. Required actions were also presented to each organization to support future compliance with MHP requirements as applicable.

Results

Results of the 2020 MHP Analysis revealed that CCO policies included standardized processes that applied to both MH/SUD and M/S benefits, including UM and PA policies and service authorization handbooks. None of the CCOs had separate policies for the management of benefits based on benefit package, ensuring consistency across the packages in the analyses. The CCOs and OHP FFS were generally compliant with MHP requirements, as four CCOs issued no findings and the remaining CCOs

issued a minimal number of findings. The minimal number of findings was primarily due to operational differences in the CCO E and CCO G packages where the CCOs managed MH/SUD benefits and OHP FFS managed M/S benefits. These differences created greater stringency in the CCOs' application of NQTLs.

All CCOs achieved parity for benefit packages CCO A and CCO B where they had full control over UM processes across both benefit types. However, many CCOs received findings for benefit packages CCO E and CCO G, where M/S benefits were being managed by OHP FFS. During 2019, OHP FFS established a 90-day RR period for PA requests and an interrater reliability (IRR) process inclusive of an 80 percent testing standard. CCOs without an RR review period or a period of less than 90 days allowable for RR were issued findings of non-parity due to having more stringent processes for MH/SUD benefit authorizations as compared to M/S benefit authorizations administered by OHP FFS. Similarly, CCOs without an IRR process or a testing standard less than 80 percent were issued findings of non-parity related to the application of authorization decisions for Inpatient and Outpatient MH/SUD benefits, which impacted the stringency of the application of NQTLs in that the method to promote consistency of Inpatient and Outpatient MH/SUD medical necessity determinations was not sufficiently structured as compared to Inpatient and Outpatient M/S processes.

Overall MHP Analysis results by organization are provided in Table 8-4. Detailed findings and observations by organization were provided in the MHP reports developed for each organization.

Table 8-4—Overall MHP Analysis Results—Comparability and Stringency

C = Comparability; **S** = Stringency; √ = Compliant; X = Non-Compliant

Organization	Category I—UM Limits Applied to Inpatient Services		Category II—UM Limits Applied to Outpatient Services		Category III—Prior Authorization for Prescription Drug Limits		Category IV—Provider Admission—Closed Network		Category V—Provider Admission—Network Credentialing		Category VI—Out-of-Network/Out-of-State Limits	
	C	S	C	S	C	S	C	S	C	S	C	S
AH	√	X	√	X	√	√	√	√	√	√	√	√
AllCare	√	X	√	X	√	√	√	√	√	X	√	√
CHA	√	X	√	X	√	√	√	√	√	√	√	√
CPCCO	√	√	√	√	√	X	√	X	√	√	√	√
EOCCO	√	√	√	√	√	√	√	√	√	√	√	√
Health Share	√	√	√	√	√	√	√	√	√	√	√	√
IHN	√	√	√	√	√	√	√	√	√	√	√	√
JCC	√	√	√	√	√	X	√	X	√	√	√	√
PSCS-CG	√	X	√	X	√	√	√	√	√	√	√	√
PSCS-CO	√	X	√	X	√	√	√	√	√	√	√	√
PSCS-Lane	√t	X	√	X	√	√	√	√	√	√	√	√
PSCS-MP	√	√	√	X	√	√	√	√	√	√	√	√
TCHP	√	√	√	X	√	√	√	√	√	√	√	√
UHA	√	√	√	√	√	√	√	√	√	√	√	√
YCCO	√	√	√	√	√	√	√	√	√	√	√	√
OHP FFS	√	X	√	X	√	√	N/A	N/A	N/A	N/A	√	√

9. Quality Strategy Monitoring

Overview

Federal regulations under 42 CFR §438.340 require each state Medicaid agency contracting with MCOs to develop and implement a written quality strategy to assess and improve the quality of managed care services. The quality strategy should serve as a blueprint or road map for states and their contracted MCOs in assessing the quality of care Medicaid beneficiaries receive and set forth measurable goals and targets for improvement. Specifically, the quality strategy must include the following elements:

- A plan for improving quality of care and services.
- Standards for network adequacy and availability of services.
- A plan to identify and reduce health disparities.
- A transition of care policy.
- A plan to identify persons needing LTSS or those with SHCN.

OHA's quality strategy was included as component of Oregon's Section 1115(a) 2017–2022 Waiver and approved by CMS in May 2018.[9-1] The quality strategy is comprised of a number of different QAPI programs to accomplish OHA's mission to improve the lifelong health of Oregonians; increase the quality, reliability, and availability of care for all Oregonians; and lower or contain cost of care so it is affordable to everyone. OHA's framework for quality includes the following eight focus areas:

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

OHA's QAPI programs that make up the quality strategy include PIPs, performance monitoring through reviews of compliance with Medicaid managed care requirements and other focus areas (e.g., grievances

[9-1] Department of Health & Human Services, Centers for Medicare & Medicaid Services, Project Number 21-W-00013/10 and 11-W-00160/10 Extension Approval, letter, January 12, 2017. Available at: https://www.oregon.gov/oha/HSD/Medicaid-Policy/Documents/Oregon%20Health%20Plan%20STCs_2017-2022.pdf. Accessed on: Mar 17, 2021.

and appeals; fraud, waste, and abuse; transitions of care, and network adequacy), and annual CCO TQS assessments. TQS submissions document CCO health transformation activities aligning with the federally required quality strategy elements and coordinating internal CCO health transformation and quality initiatives in support of the goals and objectives of OHA's quality strategy in the eight focus areas.

Monitoring Quality

OHA regularly monitors its quality strategy based on CCO performance; stakeholder input and feedback; achievement of goals; changes resulting from legislative, State, federal, or other regulatory authority; and/or significant changes to the programmatic structure of the Medicaid program. OHA's Quality Council and agency leadership are responsible for guiding quality strategy monitoring. Internal and external stakeholders are engaged across all spectrums of the delivery of health care to assist with monitoring quality programs through continuous QI practices and robust data systems, as well as assessing CCO adherence to quality metric standards and contract compliance. Such stakeholders include:

- Addictions and Mental Health Planning and Advisory Council*
- CCO Medical Directors
- Health Equity Committee*
- Health Evidence Review Committee*
- Health Policy and Analytics Management Team
- HSD Executive Team
- FFS Contractors
- CCO Quality Management Coordinators
- Local Government Advisory Committee*
- Managed Care and CCO Collaborative
- Medicaid Advisory Committee*
- Oregon Health Policy Board*
- Quality and Health Outcomes Committee*
- OHA Executive Leadership
- Quality Management Program & Contract Compliance

** Committees including consumer representatives.*

Due to the COVID-19 pandemic, quality meetings internally and externally were either canceled and/or re-focused on pandemic response in the community and health system partners in 2020. Significant factors in Oregon's quality strategy in 2020 were COVID-19 response and coordination; behavioral

health initiatives; and focused TA in metrics, TQS, DSNs, and Prometheus (a utilization review technology tool to support care delivery assessment).

Despite the refocused quality activities, OHA was able to monitor the quality strategy with respect to ensuring PIP validation and reviews of compliance with Medicaid managed care requirements for each MCE through EQR activities and adopting an equity measure to "achieve meaningful access to health care services for all CCO members through quality communication, language access services, and the delivery of culturally responsive care." In addition, OHA implemented a transitions of care policy, formed an internal network adequacy workgroup to further develop access to care standards, evaluated MCE grievance and appeals systems, developed an NEMT Quality Assurance Monitoring Report, and assessed TQS progress. These additional efforts are further defined below:

Transitions of Care Policy Development

Over the last three years OHA has held workgroups with its CCOs to support federal and State requirements for transitions of care meant to ensure continued access to services to prevent serious detriment to health or reduce the risk of hospitalization/institutionalization, which includes the transfer of historical utilization data and medical records.[9-2] The workgroups have focused on the adherence and implementation of technology related to Transition of Care including:

- Defining and identifying eligible member populations.
- Standardizing claims and other relevant member data critical to support transitions of care.
- Establishing a data exchange system for the CCOs to exchange data.
- Establishing ongoing workgroups to help resolve and collaborate on successful transitions of care.

Network Adequacy Workgroup

OHA convened an internal workgroup to develop minimum quantitative network adequacy standards (i.e., metrics) to ensure there are no gaps in access to and availability of services for OHP members enrolled in an MCE. The network adequacy workgroup is continuing work to develop a methodology that will be used to conduct a needs assessment identifying member needs, provider supply, and network capacity; establish access standards; and monitor access.

Grievance and Appeals System Evaluation

In 2020, to address the findings related to appeals and grievances, OHA evaluated and approved CCO appeal and grievance policies, procedures, and member notice templates. OHA also evaluated quarterly grievance and appeals data submitted by CCOs ensuring the data were accurate and complete. OHA reviewed a sample of NOABDs and respective PA documentation based on criteria in 21 areas of

[9-2] 42 CFR 438.62 and OAR 410-141-3061.

compliance. Upon completion of the grievance and appeals system evaluations, OHA provided each CCO with evaluation results identifying areas requiring corrective action. To address findings, CCOs were required to submit an IP for OHA approval. In addition, OHA issued guidance to reiterate CCO contract and State rule requirements regarding verbal requests for appeal, grievance, and hearing processes.

NEMT Quality Assurance Monitoring Report

Due to multiple OHP member grievances around NEMT, OHA established a quarterly NEMT reporting requirement for MCEs in order to monitor the quality of NEMT services provided to OHP members across all service areas. The quarterly NEMT reports are required to include information related to service delivery events, network availability, call-center, and reimbursement information.

TQS Progress Assessment

Each year since 2018, OHA has disseminated a TQS template to be completed and submitted by each CCO. The TQS template and CCO TQS submissions can be accessed on OHA's *Transformation and Quality Strategy Technical Assistance* website.[9-3] OHA provides annual TA on TQS template requirements and written assessments of progress for each CCO's TQS. The TQS assessments include pre-defined assessment components and scoring determined by whether each component was: fully relevant, fully detailed, and feasible (3 points); somewhat relevant, somewhat to very limited detail and feasibility (2 points); or very limited relevance, very limited to not detailed and feasible (1 point). In 2020, OHA evaluated TQS submissions identifying a total of 156 projects, with 48 percent of the projects reported as new. Table 9-1 provides an aggregate summary of combined TQS submission assessment results by assessment component, identifying an average score of 2.07 across all CCO TQS projects.

Table 9-1—2020 TQS Assessment Results

Assessment Component	Average Score
Access: Cultural Considerations	1.75
Access: Quality and Adequacy	1.75
Access: Timely	1.80
Behavioral Health Integration	2.33
Culturally and Linguistically Appropriate Services (CLAS) Standards	2.23
Grievances and Appeals	2.27
Health Equity: Cultural Responsiveness	2.03
Health Equity: Data	2.37

[9-3] OHA's *Transformation and Quality Strategy Technical Assistance* website is available at: https://www.oregon.gov/oha/HPA/dsi-tc/Pages/Transformation-Quality-Strategy-Tech-Assist.aspx.

Assessment Component	Average Score
Oral Health Integration	1.90
PCPCH	2.23
Serious and Persistent Mental Illness (SPMI)	2.71
SDOH	1.69
SHCN	1.85
Utilization Review	2.10
Average Score	**2.07**

Based on the 2020 TQS assessment results, OHA implemented the following changes for 2021 TQS submissions and subsequent assessments:

- Adjusted TQS submission elements and assessment details to allow for reporting of rationale for discontinuing TQS projects and quality management, enhance tracking of PCPCH tier advancement and member assignment, include focused assessments of prior year analyses vs. project rationale and progress to allow for further analysis of component assessment to drive to project implementation for the coming year.
- Aligned SHCN projects with initiatives pertaining to dual-eligible members in Oregon.
- Conducted timely TQS TA webinars on the TQS components of SDOH, SHCN, Health Equity, CLAS, SPMI, and Access.[9-4]
- Developed a database capturing evaluation results, lessons learned, alignment of projects across CCOs to other upstream areas with public health, and health policy enhancements that allow for comprehensive analysis in support of quality strategy monitoring and adjustment.

Updating the Quality Strategy

In 2020, OHA began to meet internally and with the Medicaid Advisory Committee on quality strategy monitoring activity results and to discuss future updates to the quality strategy. OHA intends to make updates to the quality strategy in May 2021, which will include:

- Inclusion of OHA's 10-year goal to eliminate health inequities by 2030.
- Alignment of strategies to coordinated care model priorities.
- Alignment of strategies to the 2020–2024 State Health Improvement Plan.
- Alignment with November 2021 CFR updates.
- Alignment to quality payment programs (e.g., value-based purchasing and the CCO quality pool).

[9-4] The TQS TA webinar schedule is available at: https://www.oregon.gov/oha/HPA/dsi-tc/Documents/2021-TQS-technical-assistance-schedule.pdf.

Assessment of the Quality Strategy

OHA's quality strategy appeared to encompass all federally required elements with regular progress monitoring, including a plan to update the comprehensive quality strategy in 2020. HSAG's review of OHA's quality strategy and associated efforts identified that OHA has the mechanisms in place to allow the State to address quality comprehensively, combining the strategies of its Medicaid MCOs via their own quality plans and by ensuring stakeholder input in continuous improvement. While OHA's eight focus areas and the details of the quality programs appeared to support the overall quality strategy and align with federally required elements, HSAG did not identify clear goals and objectives in support of the quality strategy. More specifically, the activities were not clearly documented as to how each of the quality strategy programs and assessment activities aligned with the federally required elements.

10. Assessment of Quality, Timeliness, and Access

Overview

Based on the results of each EQR activity conducted in 2020 in accordance with 42 CFR §438.358, HSAG evaluated MCE strengths and areas for improvement with respect to the quality, timeliness, and access to care, and documented aggregated conclusions in this section. The evaluation was based on the following definitions of the quality, timeliness, and access domains:

- **Quality**—The CFR indicates that quality, as it pertains to EQR, means the degree to which an MCO, PIHP, or PAHP increases the likelihood of desired outcomes of its members through:
  - Its structural and operational characteristics.
  - The provision of services that are consistent with current professional, evidence-based knowledge.
  - Interventions for performance improvement.
- **Timeliness**—The National Committee for Quality Assurance (NCQA) defines timeliness relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[10-1] NCQA further discusses the intent of this domain as being to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to members and that require timely response by the MCE (e.g., processing expedited appeals and providing timely follow-up care). The Agency for Healthcare Research and Quality (AHRQ) indicates that "timeliness is the health care system's capacity to provide health care quickly after a need is recognized."[10-2] Timeliness includes the interval between identifying a need for specific tests and treatments and receiving those services.[10-3]
- **Access**—The CFR indicates that access, as it pertains to EQR, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under 42 CFR §438.68 (network adequacy standards) and 42 CFR §438.206 (availability of services).

While quality, timeliness, and access are distinct aspects of care, most MCE activities and services cut across more than one area. Collectively, all MCE activities and services affect the quality, timeliness, and access to care delivered to Medicaid managed care members.

10-1 National Committee for Quality Assurance. 2006 Standards and Guidelines for MBHOs and MCOs.
10-2 Agency for Healthcare Research and Quality. *National Healthcare Quality Report*, 2007. AHRQ Publication No. 08-0040. February 2008.
10-3 Ibid.

Assessment Results

The following narratives provide HSAG's conclusions drawn as to MCE performance related to the quality and timeliness of, and access to care furnished to members. The information is intended to be representative and should not be considered an all-inclusive list. *Section 11. 2020 EQR Recommendations to the State* provides overarching recommendations by each EQR activity. While quality, timeliness, and access are distinct aspects of care, most MCE activities and services cut across more than one area. Collectively, all MCE activities and services affect the quality, timeliness, and access to health care delivered to members.

Quality

OHA worked closely with its MCEs, partners, and stakeholders on quality for OHP members. This was primarily done through the engagement of internal and external committees to support quality and access monitoring, the requirement for MCEs to annually maintain a TQS to ensure robust and streamlined quality programs, and statewide and MCE-specific PIPs and focus studies. Despite redirected efforts to manage the COVID-19 pandemic, OHA and the CCOs continued to make QIs in a number of areas and performed well.

All MCEs began new health care services contracts with OHA on January 1, 2020, with the DCO contracts including requirements more closely aligned with CCO contracts and federal Medicaid managed care regulations. While the CCOs achieved improved compliance from past performance reviews, delegation continues to be an issue with respect to not only ensuring appropriate oversight, but also ensuring consistency in the delivery of benefits within and across CCOs. The DCOs struggled with the implementation of new requirements, with the DCOs expressing concern regarding unanticipated administrative resource needs and that some requirements did not pertain in the oral health context.

All the MCEs were coordinating care at some level and most of them had dedicated care managers that work with members identified as needing ICC. The CCOs had robust care coordination policies and operations, while the DCOs displayed a solid foundation for successful implementation of most care coordination requirements. While health risk screenings were evident among CCOs, the DCOs were in the beginning stages of implementing these screenings for members with most of them screening only at the time of the members' first appointment. Treatment plans were consistently implemented across CCO membership, but not among the DCOs. Every CCO described how member needs for continuity of care and transition between levels of care are assessed by conducting a needs assessment to identify risks and/or determine each member's appropriate level of care at the time of the transition. The MCEs also had sound processes for grievances and appeals; however, not all required grievance and appeal information was clearly communicated in provider and member materials.

Most CCOs had a methodology for analyzing and monitoring underutilization and overutilization, including using claims data and other analytic tools. HSAG's evaluation of CCO DSN Provider Narrative Reports identified CCO workgroups including community partners, provider-specific CAPs,

APMs, disease-specific case management programs, and member education as some of the actions taken to address patterns of both overutilization and underutilization.

OHA continued to address QI with its managed care entities. Although OHA has since abandoned the *Acute Opioid Safety* PIP validated in 2020, validation results suggested that, in general, MCEs developed a methodologically sound design for each PIP, establishing a strong foundation for objectively measuring and evaluating performance as the PIP progresses to the implementation stage, reporting baseline measurement results, conducting causal/barrier analyses, and developing interventions to drive improvement. OHA has refocused the statewide PIP to address behavioral health concerns in the delivery system and is currently working with HSAG and stakeholders to develop the new PIP topic with stakeholders. The CCOs are additionally required to have three CCO-specific PIPs that are validated quarterly with minimal concerns, and the DCOs are now required to submit PIPs, which are primarily related to access to care.

To evaluate CCO and DCO performance, OHA calculated performance measures based on CCO data submissions. HSAG's validation of performance measures determined data integration, data control, and supporting documentation were adequate. While the measures were validated as reportable, HSAG noted that OHA's vendor, CORE, had discrepancies between the rate review spreadsheet and the member-level detail file, indicating a need for additional QA checks.

Regarding CCO data quality, HSAG's review of CCO EDV revealed that CCOs employed encounter file generation and review processes tailored to meet OHA's encounter submission contractual requirements and specifications; however, both CCOs and their associated vendors were responsible for ensuring that encounter data are accurate, complete, and formatted correctly for submission to OHA. The CCOs passed data files directly to OHA, but some CCO vendors submitted data to OHA on behalf of the CCO (i.e., pass-through arrangements). If rejected data were originally provided to the CCO by a vendor, the CCO required the vendor to correct the data and resubmit the files to the CCO. This framework contained extensive opportunities for variation at nearly every stage based on the CCO's contractual arrangements with health care providers and provider networks, other CCOs, and trading partners (e.g., vendors for claims preprocessing and/or processing, or provision of selected services). While the CCOs and OHA described various activities that were conducted to monitor completeness, accuracy, and timeliness, there appeared to be a lack of validation via chart/medical record reviews by some CCOs and by OHA.

Results of the 2020 MHP Analysis revealed that CCO policies included integrated operational processes that applied to both MH/SUD and M/S benefits, including UM and PA policies and service authorization handbooks. None of the CCOs had separate policies for the management of benefits based on benefit package, ensuring consistency across the packages in the analyses. The CCOs and OHP FFS were generally compliant with MHP requirements, with four CCOs issued no findings and the remaining CCOs issued a minimal number of findings. The minimal number of findings were primarily due to operational differences in the CCO E and CCO G packages where the CCOs managed MH/SUD benefits and OHP FFS managed M/S benefits. These differences created greater stringency in the CCOs' application of NQTLs.

Timeliness

The MCEs generally met the requirements specified in 42 CFR §438 and established standards for timely access to care and services, considering the urgency of members' need for services. Overall, HSAG's reviews of MCE compliance revealed that policies, procedures, and programs described appropriate coverage and authorization of service activities and supported timely access to care and services. Policies and procedures addressed the time frames for standard and expedited service authorizations with processes to ensure that authorization decisions and notices to members for both types of decisions were provided in a timely manner. Not all MCEs provided the needed level of specificity for processing service authorizations including identification of time frames for determining validity or following up on pended requests. Some CCOs did not identify procedures for processing PA requests outside of normal business hours and some did not provide adequate oversight of subcontractor processes.

All CCOs used the Emergency Department Information Exchange (EDIE) system to alert CCO staff to member ED visits. Multiple CCOs were using the Collective Platform, also known as Pre-Manage, which is a medical platform tool that allows the sharing of real-time hospital/ED event information; member-level data and preventive gaps in care; and member-specific information for the purpose of coordinating physical, behavioral, and oral health care between provider offices, hospitals, and community partners. For example, various CCOs leveraged real-time notifications to identify members' needs, proactively coordinate care, and offer members additional post-ED support visits. Using these two technology platforms in concert enabled CCOs to timely coordinate care and discharge planning.

Access

All MCEs made efforts to ensure appropriate access to care for Medicaid members by employing mechanisms to assess provider networks, evaluate member needs, explore grievance and appeal data, and minimize network closures. While HSAG identified some areas for improvement in reporting and network adequacy gaps to be further explored, the MCEs had policies and procedures, reporting mechanisms, and committee structures to manage provider networks and address concerns with access to care.

Member rights and information are imperative to access to appropriate care. Although the MCEs had all necessary fundamental member information and materials, ensuring members had information regarding accessibility of OHP benefits and providers, HSAG identified the following areas for improvement:

- Omittance of member rights requirements in MCE policies, creating an artificial barrier to members seeking care. This included seclusion and restraint details, nondiscrimination information, and providing members with contact information for entities that accept discrimination complaints.
- Many MCEs failed to notify members that if the MCE does not meet required time frames for appeals, members may request a contested case hearing.
- Readability (as specified in OARs) of member materials was a consistent concern for the DCOs, prompting further OHA guidance.

- Few CCOs had a process addressing criteria for selecting member education topics or the modality or frequency for which education would be delivered.
- While provider directories included the necessary information in which to locate and access provider types, many MCE directories lacked availability in prevalent languages and information on provider ADA accessibility and cultural competency training. While CMS had revised the CFRs to omit the cultural competency training requirement in directories, OHA adhered to an OAR requiring that information to be documented. OHA plans to conduct an assessment as to whether to maintain the OAR cultural competency training requirement for provider directories.

Also supporting access to care, the DCO-specific PIPs were focused on improved member engagement, dental care utilization during pregnancy, and reduction of no-shows to improve access to care. HSAG's validation of these PIPs revealed that four of the five DCOs met all applicable evaluation elements and overall validation status for their 2020 PIP design submissions. For the other DCO, HSAG identified methodological issues with the data collection process, study population definition, and study indicator definition, which is being addressed.

Network adequacy activities assessed member access by reviewing provider capacity and compliance with time and distance standards. While HSAG's analyses of self-reported MCE provider data identified adequate capacity based on limited capacity standards, the MCEs, particularly DCOs, struggled with reporting accurate and complete provider data. Most CCOs reported required geographic distribution descriptions and analysis for all providers (including delegated providers) compared to the distribution of members. HSAG's analysis of CCO time and distance data revealed that only four CCOs did not meet all time and distance requirements, identifying inconsistencies with the CCO descriptions of the methodologies used to calculate those standards.

All DCOs exhibited a strength in terms of monitoring member access to care and ensuring provision of appropriate urgent, emergency, and triage services 24 hours a day, seven days a week. Oregon's DCOs were uniformly committed to and capable of providing appropriate oral health care to members when they needed it; however, the DCOs did not conduct cultural, language, disability, and special health care needs analyses demonstrating characteristics of its membership, and some DCOs did not address how they establish appropriate limitations or provide additional access to members with SHCN.

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

Every CCO described how technology is used to deliver team-based care and support other innovations. All CCOs expanded access to telehealth and telemedicine services in alignment with the directive and guidelines set by HSD and CMS in response to the COVID-19 pandemic.

Community partnerships and the inclusion of the member's voice are paramount to providing access to culturally competent care. Staff training and community outreach were conducted by all MCEs, with one CCO facilitating listening sessions that highlighted the voices and perspectives of members of diverse cultural and ethnic groups (e.g., Native American and SPMI populations). The MCEs include member participation in community partnerships and committees that offer forums for member perspectives to be heard. While the MCEs addressed cultural competency through interpretation and translation services, there were missed opportunities to broaden cultural competency and look beyond race and ethnicity for other cultural considerations. Many of the MCEs acknowledged the need to provide culturally sensitive care to the lesbian, gay, bisexual, transgender, queer, and intersex (LGBTQI) community; those living in poverty; and those experiencing homelessness.

11. 2020 EQR Recommendations to the State

HSAG used the results and conclusions drawn from its analyses and evaluations for each 2020 EQR activity identified in sections 3 through 8 of this report to develop overarching recommendations for OHA to ensure alignment with Medicaid managed care regulations. While some of the 2020 recommendations outlined below repeat the recommendations made to the State in relation to 2019 activities, there are additional recommended actions to improve quality, timeliness, and access to care for Medicaid members in Oregon. *Appendix C. 2019 EQR Recommendations Follow-Up* provides an account of 2019 overarching recommendations and actions taken by OHA during 2020. Overall strengths and areas for improvement for each MCE are presented in Appendix A. CCO Profiles and Appendix B. DCO Profiles.

2020 EQR Activity Recommendations

Table 11-1 provides aggregate EQR recommendations by EQR activity. The recommendations were developed to be addressed at the State level, rather than by each individual MCE. MCEs were issued findings and corrective actions in separate EQR activity reports as referred to in each of the activity sections, sections 3 through 8, as applicable.

Table 11-1—2020 EQR Recommendation Follow-Up

#	2020 EQR Recommendations
EQR CMR Recommendations	
1.	**Alignment of MCE Contracts With OARs:** OHA should ensure alignment of verbiage between MCE contracts and relevant OARs. For example, there were differences in the definition of which populations are encompassed by the term "prioritized populations."
2.	**TA for the 2021 DCO Contract:** OHA should provide TA to DCOs on how to operationalize the adjustments made to the DCO contract in 2020 and 2021 as a result of DCO feedback. For example, OHA could work with the DCOs to develop a framework for oral health risk screenings and treatment plans. Furthermore, OHA should consider providing TA on how to identify prioritized populations, including SHCN members, and how to share that information with other MCEs and the State.
3.	**Member Rights Clarification:** OHA should clarify the language and context of members' rights to both CCOs and DCOs with regard to the member handbook. The MCE contract contained descriptions of member rights that were not identified in the OARs. The language of the member rights both in the contract and the OARs was not written at a sixth-grade reading level. While it is presently the responsibility of the MCEs to communicate information to members in an accessible manner, OHA should provide guidance on member rights language to ensure consistency and accuracy across MCEs. Additionally, some member rights appeared to be specific to physical and behavioral health and it was unclear whether the DCOs should identify those rights (e.g., women's health) to members in the context of oral care.
4.	**Provider Directory:** Effective November 2020, CMS no longer requires the provider directory to include cultural competency training completion status. With licensing boards now requiring provider training on cultural competency, OHA should consider removing this requirement from the OARs to

#	2020 EQR Recommendations
	reduce ongoing administrative burden. In addition, the DCOs could benefit from guidance on inclusion of provider websites and inclusion of specialists, which some DCOs intentionally omitted to avoid overwhelming specialists with member requests when a referral is needed to initiate care.
EQR PIP Recommendations	
1.	**Quarterly Progress Report Redesign:** HSAG recommends that OHA consider a redesign of the quarterly PIP Progress Report Template to better align with CMS' EQR protocols,[11-1] support clearer documentation of PIP activities by the CCOs and facilitate more effective TA.
2.	**New Statewide PIP Topic Selection:** As OHA collaborates with the CCOs and other stakeholders to define the new statewide PIP topic, OHA should ensure the topic meets the requirements of CMS' EQR protocols. OHA and its partners should conduct comprehensive analyses of member needs and consider statewide performance on existing standardized measures, such as CMS Child and Adult Core Set Measures[11-2,11-3] and/or NCQA's HEDIS measures. In addition, OHA should consider the National Quality Strategy,[11-4] which focuses on better care for individuals and families, improved community-level and population-level health, and affordable care.
3.	**Promote Efficient CCO Engagement in Statewide PIP Topic Selection and Study Design:** HSAG recommends that OHA examine processes that may promote a balance of CCO engagement with efficient progress in PIP activities. OHA should consider staffing, planning, and scheduling needs that may support the timely progression of PIP activities.
EQR PMV Recommendations	
1.	**Implement Additional QA Checks:** HSAG noted during the virtual audit review that OHA's vendor, CORE, had discrepancies between the rate review spreadsheet and the member-level detail file. HSAG recommends that CORE follow through with its implementation of a more enhanced QA check when transferring data. Additional QA checks can consist of multi-level reviews, comparison between data output files, review of source documents, and comparison to historical data.

11-1 Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf. Accessed on: Mar 17, 2021.

11-2 Centers for Medicare & Medicaid Services. Children's Health Care Quality Measures. Available at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/childrens-health-care-quality-measures/index.html. Accessed on: Mar 17, 2021.

11-3 Centers for Medicare & Medicaid Services. Adult Health Care Quality Measures. Available at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures/adult-health-care-quality-measures/index.html. Accessed on: Mar 17, 2021.

11-4 Agency for Healthcare Research and Quality. About the National Quality Strategy. Available at: https://www.ahrq.gov/workingforquality/about/index.html. Accessed on: Mar 17, 2021.

#	2020 EQR Recommendations
EQR Network Adequacy Recommendations	
Provider Narrative Recommendations	
1.	**Align Category Elements With Requirements:** OHA should reevaluate the elements within the categories outlined in the Annual 2020 MCE DSN Provider Narrative Report Template to ensure alignment with both the network adequacy standards established in accordance with 42 CFR §438.206 and §438.207; the OHA 2020 MCE 2.0 Health Plan Services Contract, Exhibit G(2)(a); and OAR 410-141-3515, creating clear and concise elements that describe what is required of the MCE. This recommendation was upheld from 2019 for the CCOs but new for the DCOs in 2020.
2.	**Establish Standardized Time and Distance Standards:** OHA should reevaluate the time and distance standard elements outlined in the Annual 2020 MCE DSN Provider Narrative Report Template to ensure alignment with both the routine travel time and distance standards established in accordance with 42 CFR §438.206 and §438.207; the OHA 2020 MCE 2.0 Health Plan Services Contract, Exhibit G(2)(a); and OAR 410-141-3515, creating clear and concise elements that describe what is required of the MCE. This recommendation was upheld from 2019 for the CCOs but new for the DCOs in 2020.
3.	**Define Urban and Rural Geographic Classifications:** OHA should reevaluate the definitions of "urban" and "rural" geographic area classifications in the Annual 2020 MCE DSN Provider Narrative Template to ensure alignment with both the routine travel time and distance standards in accordance with 42 CFR §438.206 and §438.207; the OHA 2020 MCE 2.0 Health Plan Services Contract, Exhibit G(2)(a); and OAR 410-141-3515, creating clear and concise elements that describe what is required of the MCE.
4.	**Eliminate Independent Time and Distance Standards Reporting:** OHA should reevaluate whether the independent time and distance standard reporting section incorporated in the Annual 2020 MCE DSN Provider Narrative Report Template can be eliminated, instead expanding the time and distance standards reporting for the relevant *Description of the Delivery Network and Adequacy* category elements, eliminating duplicate efforts.
5.	**TA to DCOs:** OHA should promote and provide TA to the DCOs on expectations for DSN Provider Narrative Report response submissions and associated data analysis.
Provider Capacity Recommendations	
1.	**Utilize the Standardized Healthcare Provider Taxonomy Code Set:** OHA should implement the adoption of the Healthcare Provider Taxonomy Code Set and eliminate the use of historical OHA provider type and specialty type codes. The Healthcare Provider Taxonomy Code Set is a HIPAA standard code set designed to categorize the type, classification, and/or specialization of health care providers and facilities. All providers and facilities are required to select the taxonomy code(s) that most closely describes the health care provider's type/classification/specialization when applying for an NPI. This recommendation was upheld from 2019 for the CCOs but new for the DCOs in 2020.
2.	**Revise Standardized PFL and Instructions:** OHA should implement a revised standardized PFL, accompanied by Provider Network Data Submission Instructions that reflect any revisions and/or updates. The instruction manual should include detailed guidance on proper completion of the PFL, standard naming conventions, a data dictionary that categorizes provider types (e.g., primary care, physician specialty, MH, and oral health care providers), program-specific definitions, standardized

#	2020 EQR Recommendations
	provider and facility type specifications, and a sample PFL template. This recommendation was upheld from 2019 for the CCOs and new for the DCOs in 2020.
3.	**Conduct MCE Training on DSN Provider Capacity Reporting Changes:** OHA should conduct training for all MCEs and provide detailed guidance that reflects any revisions and/or updates on appropriate methods for submitting provider capacity information and review the requirements for submitting provider capacity network data. This recommendation was upheld from 2019 for the CCOs but new for the DCOs in 2020.
4.	**Expand the DSN Provider Capacity Report for Broader Use:** OHA should revise the standardized Annual MCE DSN Provider Capacity Report Template to be used by OHA for other provider-related reporting and ad hoc analysis (e.g., cross-referencing provider types across MCEs, provider directory validation, evaluation of appointment availability timeliness). This recommendation was upheld from 2019 for the CCOs but new for the DCOs in 2020.
5.	**Evaluate MCE Member Assignment:** OHA should evaluate members that appear to reside in counties and ZIP Codes outside of their assigned MCE's geographic service area.
6.	**TA for the DCOs:** OHA should promote and provide TA to the DCOs on expectations for DSN Provider Capacity Report submissions and associated data analysis.
EQR EDV Recommendations	
1.	**Distribute Comprehensive Operational Edit List:** HSAG recommends that OHA consider developing and distributing a comprehensive list of operational edits associated with the error categories identified in the feedback/response files. Some CCOs indicated that resubmission of rejected encounters by the CCO is challenging when reasons for the rejection are not clearly detailed. Distributing an updated, comprehensive list describing the nature of the errors and providing TA sessions would allow the CCOs to 1) have a better understanding of which claim-related elements are important in their encounter submission process, and 2) conduct their own investigations in a more efficient manner.
2.	**Determine Provider Mapping Data Submission Requirements:** HSAG recommends that OHA work with the CCOs to determine the data submission requirements pertaining to provider mapping.
3.	**Assess CCO Data Validation Capacity:** OHA should develop an annual process to assess the CCOs' data validation capacity and capabilities among encounters submitted to OHA, as well as to ensure the CCOs' accountability for claims and encounter data validation.
4.	**Conduct Medical Record Review Validation:** While several CCOs demonstrated that chart review was one of the validations conducted to ensure accuracy and completeness, some CCOs did not indicate such activities were being conducted. As such, HSAG recommends that OHA consider requiring all CCOs to conduct a standardized validation of encounter data using medical record reviews.
5.	**Establish Validation Guidelines:** OHA should establish validation guidelines including medical records for use by the CCOs in conducting their internal validation. The guidelines may assist with improving the quality of encounter data submitted by the CCOs to OHA and may include, but not be limited to, record sampling, reporting requirements, and the file format to guide the CCOs in conducting their internal validation.
6.	**Annual Validation:** OHA should conduct evaluations of CCO annual validation activities, providing feedback to CCOs and corrective actions when appropriate.

#	2020 EQR Recommendations
7.	**Medical Record Review:** HSAG recommends that OHA conduct a medical record review of all CCOs by selecting a random sample of cases based on specific encounter types or service categories. These cases may coincide with the cases the CCOs use to conduct chart/medical record reviews, which would reduce the CCOs' burden in procuring chart/medical records for OHA's review.
8.	**CCOs Submit All Encounter Data:** HSAG recommends that OHA require CCOs to collect, validate, and submit all encounter data on behalf of their delegates, holding the CCOs accountable for delegate encounter completeness, accuracy, and timeliness.
EQR MHP Recommendations	
1.	**OHP FFS Collaboration with CCOs on Operational Changes that Could Impact MHP:** Given that the CCOs share responsibility with OHP FFS for the provision of benefits to Medicaid members under the CCO E and CCO G benefit packages, OHP FFS should develop a mechanism to track and communicate changes to OHP FFS processes that could impact MHP across the two benefit packages. Operational areas for which OHP FFS should track and communicate changes to the CCOs include adjustments to UM processes for Inpatient, Outpatient, and prescription drug benefits, as well as adjustments to OON/OOS benefit management.
2.	**Annual Attestations:** To ensure the CCOs are regularly monitored for continued compliance with MHP regulations, OHA should require the CCOs to submit an annual attestation certifying whether policies have changed in a way that could impact MHP. In addition, the CCOs should be required to list any adjustments made over the previous year in support of providing enhanced quality services for MH/SUD benefits. This would additionally allow OHA to obtain information from the CCOs on operational activities in support of MH/SUD benefit delivery that could be shared as best practices or implemented by the OHP FFS program.
3.	**Material Change Criteria:** States are required to 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. HSAG recommends that OHA develop material change criteria that establishes triggering events for which an MHP Analysis should occur. This could include changes to CCO or OHP FFS delegation agreements involving the management of UM for MH/SUD or M/S benefits, substantive 2021 CCO Health Care Services Contract changes impacting UM, and changes to provider admission policies. Material change triggers could be assessed via annual attestations as recommended above.
4.	**2021 MHP Medical Records Review:** HSAG's 2020 analysis of Inpatient, Outpatient, and prescription drug UM data revealed various PA policies and procedures as well as various levels of denial categorization and reporting details. To further understand UM decision details and their impact on parity, HSAG recommends a review of CCO and OHP FFS PA records encompassing both MH/SUD and M/S denials. The MHP records review should include the following: • A sampling of MH/SUD and M/S records from each CCO that include denials. • A review of the sampled records focusing on adherence to each CCO's UM policies and denial description detail. • Record review tools to be completed by HSAG reviewers for each CCO and OHP FFS. • An aggregate report documenting observations and results by CCO and for OHP FFS.
5.	**2022 MH/SUD Provider Validation Records Review:** Provider credentialing is generally required for licensed providers, whereas validation of qualifications is required for unlicensed MH/SUD

#	2020 EQR Recommendations
	providers, of which there are many (e.g., qualified MH professionals, THWs, SUD counselors, etc.). The 2020 MHP Analysis focused on credentialing data and did not fully assess the validation of unlicensed MH/SUD provider qualifications. Since many of the CCOs delegate the validation of MH provider qualifications for the provision of MH/SUD services to Medicaid members, a randomized sample of MH/SUD provider validation documentation from both the CCOs and their delegates should be reviewed to ensure all components are validated and documented. The MH/SUD provider validation documentation review should include the following: • A sampling of unlicensed MH/SUD provider validation records for each CCO. • A review of the sampled MH/SUD provider validation records focusing on adherence to relevant federal and State requirements and each CCO's provider validation policies and procedures. • Record review tools to be completed by HSAG reviewers for each CCO and OHP FFS. • An aggregate report documenting observations and results by CCO and for OHP FFS.
6.	**2023 MHP Claims Denial Records Analysis:** HSAG recommends OHA consider conducting an MH/SUD claims denial records analysis. Claims-level detail was not included in the 2020 MHP Analysis but could help determine, in operation, whether parities exist in claims processing operations across the CCOs and within OHP FFS. HSAG will engage OHA in further discussions on this type of analysis.

2020 Quality Strategy Recommendations

Although OHA's quality strategy appeared to encompass all federally required elements with regular progress monitoring, HSAG identified a lack of clarity in how each project supported the federally required quality strategy elements listed in 42 CFR §438.340(b) and a few other discrepancies. HSAG provides the following recommendations for OHA's consideration when updating the quality strategy in 2021. OHA should:

- Develop a crosswalk to clearly identify how each project supports federal quality strategy requirements in 42 CFR §438.340(b), listing aligned goals and objectives.
- Ensure that all EQR performance assessment recommendations are considered to target the goals and objectives of the quality strategy.
- Ensure its update to the quality strategy in 2021 includes reporting on the effectiveness of the quality strategy collectively across all correlating projects.
- Develop a State definition of a "significant change" for the purposes of 42 CFR §438.340(c)(3)(ii) relating to the provision of quality strategy revisions to CMS when significant changes are made to the quality strategy, or whenever significant changes occur within the State's Medicaid program.

Advanced Health (AH)

AH EQR Overview		
AH is contracted with OHA as a CCO to provide physical, dental, and behavioral health services to 23,461 Medicaid members residing primarily in Coos and Curry counties. With administrative offices in Coos Bay, AH began as an independent physician association (IPA), forming in 2011 when the IPA and community partners banded together with a goal of delivering fully integrated and coordinated health care services as a CCO. The geographic distribution of AH's provider network presents challenges for those with barriers to care. AH contracted with every physician, nurse practitioner, and physician assistant in its service area and expanded its behavioral health network to include all local providers.		
Compliance With Regulatory and Contractual Standards		
Compliance Standard	**Score**	
Standard III—Coordination and Continuity of Care	14.5/15 (97%)	
Standard IV—Coverage and Authorization of Services	16.5/17 (97%)	
Standard VII—Member Rights and Protections	8.0/9 (89%)	
Standard X—Grievance and Appeal Systems	19.0/22 (86%)	
Standard XV—Member Information	9.5/10 (95%)	
Overall Compliance as of December 2020	67.5/73 (92%)	
Performance Improvement Projects (PIPs)		
Statewide PIP		
Interventions: *Not assessed. The CCO developed the PIP design in CY 2020. The CCO had not yet progressed to carrying out, evaluating, and reporting interventions for the PIP.*		
CCO-Specific PIP/Focus Study		
• **Oral Health Care for Patients with Diabetes** • **Reducing Preventable Emergency Department (ED) Utilization** • **Prenatal / Postnatal Care Incentive**		
Delivery System Network Evaluation/Network Adequacy		
DSN Evaluation Category	**Outcome**	
DSN Provider Narrative	26.0/26 (100%)	
Time and Distance	14.0/14 (100%)	
DSN Provider Capacity—Percent Accepting New Patients	100%	
Mental Health Parity		
NQTL Category	**Comparability**	**Stringency**
Category I—UM Limits Applied to Inpatient Services	Compliant	Non-Compliant

AH EQR Overview		
Category II—UM Limits Applied to Outpatient Services	Compliant	Non-Compliant
Category III—Prior Authorization for Prescription Drug Limits	Compliant	Compliant
Category IV—Provider Admission—Closed Network	Compliant	Compliant
Category V—Provider Admission—Network Credentialing	Compliant	Compliant
Category VI—Out-of-Network/Out-of-State Limits	Compliant	Compliant

Quality, Timeliness, and Access Assessment Related to 2020 EQR Activities	
Domain	**Strengths and Areas for Improvement**
Quality	**Strengths:** • The CCO demonstrated excellent implementation of health risk screenings, integrated treatment plans, and tracking time frames with a sophisticated software platform. • The CCO's PIP measures and interventions were well-defined and objective with a methodologically sound data collection process to produce valid and reliable results. • The CCO's policies included standardized processes that applied to both MH/SUD and M/S benefits, applying UM equitably across all benefit types and packages. **Areas for Improvement:** • The CCO had missing information for members on grievance and appeal processes.
Timeliness	**Strengths:** • The CCO demonstrated timely processing of and a sophisticated tracking system for service authorizations. **Areas for Improvement:** • The CCO was unable to demonstrate that the geographic distribution of members to the required provider service categories was within OHA-defined time and distance standards.
Access	**Strengths:** • The CCO demonstrated multiple established network monitoring and oversight mechanisms. • The CCO increased provider availability to technology and improved access to telehealth services. • The CCO did not close its network to any providers and equitably applied criteria for provider admission. • The CCO's policies included standardized processes that applied to both MH/SUD and M/S benefits, applying UM equitably across all benefit types and packages. **Areas for Improvement:** • The CCO's inability to demonstrate geographic distribution of members to the required provider service categories impacted compliance with percentage of member access standards. • The CCO had more stringent MH/SUD UM limits applied to inpatient and outpatient service time frame allowances and testing standards than OHP FFS stringency standards and should adjust to match OHP FFS.

AllCare CCO, Inc. (AllCare)

AllCare EQR Overview		
AllCare, based in Grants Pass, is contracted with OHA as a CCO to provide physical, behavioral, and oral health care services to 51,981 Medicaid members residing primarily in Curry, Jackson, and Josephine counties. Formed in 1994 by local physicians, AllCare began as a small IPA. While the IPA remains the cornerstone of the organization, AllCare has rebranded itself to represent the inclusion of an array of health plans and services. AllCare is owned by 100 shareholders including practicing and retired providers, clinics, and a Federally Qualified Health Center (FQHC).		
Compliance With Regulatory and Contractual Standards		
Compliance Standard	**Score**	
Standard III—Coordination and Continuity of Care	13.5/15 (90%)	
Standard IV—Coverage and Authorization of Services	17.0/17 (100%)	
Standard VII—Member Rights and Protections	7.0/9 (78%)	
Standard X—Grievance and Appeal Systems	21.0/22 (95%)	
Standard XV—Member Information	10.0/10 (100%)	
Overall Compliance as of December 2020	68.5/73 (94%)	
Performance Improvement Projects (PIPs)		
Statewide PIP		
Interventions: *Not assessed. The CCO developed the PIP design in CY 2020. The CCO had not yet progressed to carrying out, evaluating, and reporting interventions for the PIP.*		
CCO-Specific PIP/Focus Study		
• **Improve Type II Diabetes Poor Control** • **Pediatric Asthma Management** • **Health Equity—Increase Access to Primary Care Among African American Members**		
Delivery System Network Evaluation/Network Adequacy		
DSN Evaluation Category	**Outcome**	
DSN Provider Narrative	21.0/26 (81%)	
Time and Distance	14.0/14 (100%)	
DSN Provider Capacity—Percent Accepting New Patients	22.4%	
Mental Health Parity		
NQTL Category	**Comparability**	**Stringency**
Category I—UM Limits Applied to Inpatient Services	Compliant	Non-Compliant
Category II—UM Limits Applied to Outpatient Services	Compliant	Non-Compliant
Category III—Prior Authorization for Prescription Drug Limits	Compliant	Compliant
Category IV—Provider Admission—Closed Network	Compliant	Compliant

AllCare EQR Overview		
Category V—Provider Admission—Network Credentialing	Compliant	Non-Compliant
Category VI—Out-of-Network/Out-of-State Limits	Compliant	Compliant
Quality, Timeliness, and Access		

Domain	Strengths and Areas for Improvement
Quality	**Strengths:** • The CCO conducted screenings on all members within 30 days in lieu of the required 90-day time frame. • The CCO's treatment plans were comprehensive with interdisciplinary goals, evidence of member participation, distinct roles for team members, and appropriate communications. • The CCO's PIP measures and interventions were well-defined and objective with a methodologically sound data collection process to produce valid and reliable results. **Areas for Improvement:** • The CCO did not directly maintain treatment plans for its members, particularly for members with SPMI whose ICC services were delegated, resulting in a lack of integrated care coordination at the CCO level.
Timeliness	**Strengths:** • The CCO demonstrated timely processing of and a sophisticated tracking system for service authorizations. **Areas for Improvement:** • The CCO showed delays in identifying higher priority members due to a lengthy risk assessment on all members. • The CCO was unable to demonstrate that the geographic distribution of members to the required provider service categories was within OHA-defined time and distance standards.
Access	**Strengths:** • The CCO demonstrated exemplary efforts to provide proactive support to members displaced by wildfires and the pandemic. • The CCO showed a strong commitment to health equity and cultural accessibility, including robust trainings, institution of a health equity measure for its value-based payment model, and establishing itself as an accredited interpreter training and testing locus. • The CCO demonstrated broad member access to various types of THWs directly from the CCO, contracted provider groups, and community stakeholders. • The CCO's policies included standardized processes that applied to both MH/SUD and M/S benefits, applying UM equitably across all benefit types and packages. **Areas for Improvement:** • The CCO's MH subcontractor provided some member communications that did not meet either readability or informational requirements, indicating a need for additional oversight by the CCO.

AllCare EQR Overview	
	• The CCO's inability to demonstrate geographic distribution of members to the required provider service categories impacted compliance with percentage of member access standards. • The CCO had more stringent MH/SUD UM limits applied to inpatient and outpatient service testing standards than OHP FFS stringency standards and should adjust to match OHP FFS. • The CCO had an overall high rate of closed provider credentialing applications, primarily due to expiration of application or missing application information.

Cascade Health Alliance, LLC (CHA)

CHA EQR Overview
CHA is contracted with OHA as a CCO to provide physical, behavioral, and oral health care services to 21,496 Medicaid members residing primarily in Klamath county, with some members in Clackamas, Jackson, and Lane counties. With its office based in Klamath Falls, Oregon, CHA is locally owned by health care organizations and providers. CHA innovatively launched the Access Mobile Campaign to provide mobile phones for its members to access information about the pandemic and local resources. A risk stratification process for members likely to experience a poor outcome from COVID-19 prioritized outreach efforts showed a rapid response to early pandemic information.

Compliance With Regulatory and Contractual Standards

Compliance Standard	Score
Standard III—Coordination and Continuity of Care	12.0/15 (80%)
Standard IV—Coverage and Authorization of Services	16.0/17 (94%)
Standard VII—Member Rights and Protections	8.0/9 (89%)
Standard X—Grievance and Appeal Systems	19.5/22 (89%)
Standard XV—Member Information	8.5/10 (85%)
Overall Compliance as of December 2020	64.0/73 (88%)

Performance Improvement Projects (PIPs)

Statewide PIP

Interventions: *Not assessed. The CCO developed the PIP design in CY 2020. The CCO had not yet progressed to carrying out, evaluating, and reporting interventions for the PIP.*

CCO-Specific PIP/Focus Study

- **Reducing Emergency Department (ED) Utilization Among High-Frequency Users**
- **Oral Health Care Access Across All Ages**
- **Health Complexity**

Delivery System Network Evaluation/Network Adequacy

DSN Evaluation Category	Outcome
DSN Provider Narrative	15.5/26 (60%)
Time and Distance	14.0/14 (100%)
DSN Provider Capacity—Percent Accepting New Patients	35.6%

Mental Health Parity

NQTL Category	Comparability	Stringency
Category I—UM Limits Applied to Inpatient Services	Compliant	Non-Compliant
Category II—UM Limits Applied to Outpatient Services	Compliant	Non-Compliant
Category III—Prior Authorization for Prescription Drug Limits	Compliant	Compliant

CHA EQR Overview		
Category IV—Provider Admission—Closed Network	Compliant	Compliant
Category V—Provider Admission—Network Credentialing	Compliant	Compliant
Category VI—Out-of-Network/Out-of-State Limits	Compliant	Compliant

Quality, Timeliness, and Access	
Domain	**Strengths and Areas for Improvement**
Quality	**Strengths:** • The CCO displayed a highly integrated and comprehensive approach to care coordination with frequently updated treatment plans. • The CCO's PIP measures and interventions were well-defined and objective with a methodologically sound data collection process to produce valid and reliable results. • The CCO conducted quarterly analysis of grievance and appeal data. **Areas for Improvement:** • The CCO did not have a solid foundation of documented processes for care coordination. • The CCO frequently failed to meet readability requirements for member communications.
Timeliness	**Strengths:** • The CCO maintained accurate service authorization policies and demonstrated timely authorization decisions and member notifications. • The CCO had comprehensive processes and mechanisms to monitor member wait times and ensure appropriate access to urgent, emergency, crisis, and triage services 24 hours a day, seven days a week. • The CCO demonstrated timely resolution of grievances and appeals. **Areas for Improvement:** • The CCO was unable to demonstrate that the geographic distribution of members to the required provider service categories was within OHA-defined time and distance standards.
Access	**Strengths:** • The CCO demonstrated excellent COVID-19 outreach efforts and engagement of pregnant members. • The CCO implemented new community partnerships that increased the number of available THWs. • The CCO's policies included standardized processes that applied to both MH/SUD and M/S benefits, applying UM equitably across all benefit types and packages. **Areas for Improvement:** • The CCO was inconsistent in achieving compliance with health risk screening for prioritized members in favor of COVID-19 high-risk members. • The CCO should incorporate policies, desktop procedures, data dashboards, analytics, and other supporting documentation to further demonstrate that it maintains networks with adequate provider capacity.

CHA EQR Overview	
	• The CCO's inability to demonstrate geographic distribution of members to the required provider service categories impacted compliance with percentage of member access standards. • The CCO should develop a mechanism and standard, including frequency of review, for reviewing Inpatient/Outpatient MH/SUD cases as a method to promote consistency of medical necessity determinations.

Columbia Pacific CCO, LLC (CPCCO)

CPCCO EQR Overview
CPCCO is contracted with OHA as a CCO subsidiary of CareOregon to provide physical, behavioral, and oral health care services to 29,521 Medicaid members residing primarily in Columbia, Clatsop, and Tillamook counties. CPCCO developed a collaborative five-year Regional Health Improvement Plan (RHIP), which was also adopted by the public health authorities in all three counties moving from 100 percent FFS payments for physical health services to community gain/risk models with participation by hospitals, primary care clinics, and Community Mental Health Programs (CMHPs) in two of the three counties.

Compliance With Regulatory and Contractual Standards

Compliance Standard	Score
Standard III—Coordination and Continuity of Care	13.0/15 (87%)
Standard IV—Coverage and Authorization of Services	14.0/17 (82%)
Standard VII—Member Rights and Protections	5.5/9 (61%)
Standard X—Grievance and Appeal Systems	20.0/22 (91%)
Standard XV—Member Information	8.0/10 (80%)
Overall Compliance as of December 2020	60.5/73 (83%)

Performance Improvement Projects (PIPs)

Statewide PIP

Interventions: *Not assessed. The CCO developed the PIP design in CY 2020. The CCO had not yet progressed to carrying out, evaluating, and reporting interventions for the PIP.*

CCO-Specific PIP/Focus Study

- **Tobacco Cessation**
- **Reducing Emergency Department (ED) Utilization Among High-Frequency Users**
- **Oral Health Care Access Across All Ages**

Delivery System Network Evaluation/Network Adequacy

DSN Evaluation Category	Outcome
DSN Provider Narrative	26.0/26 (100%)
Time and Distance	14.0/14 (100%)
DSN Provider Capacity—Percent Accepting New Patients	18.9%

Mental Health Parity

NQTL Category	Comparability	Stringency
Category I—UM Limits Applied to Inpatient Services	Compliant	Compliant
Category II—UM Limits Applied to Outpatient Services	Compliant	Compliant
Category III—Prior Authorization for Prescription Drug Limits	Compliant	Non-Compliant
Category IV—Provider Admission—Closed Network	Compliant	Non-Compliant

CPCCO EQR Overview		
Category V—Provider Admission—Network Credentialing	Compliant	Compliant
Category VI—Out-of-Network/Out-of-State Limits	Compliant	Compliant
Quality, Timeliness, and Access		

Domain	Strengths and Areas for Improvement
Quality	**Strengths:** • The CCO displayed innovative strategies in response to pandemic-prompted needs such as expanded function of NEMT to provide food delivery and DME for members in need. • Multidisciplinary care team members provided integrated care coordination and developed comprehensive treatment plans. • The CCO demonstrated notable oversight of subcontractor grievance and appeal systems. • The CCO's PIP measures and interventions were well-defined and objective with a methodologically sound data collection process to produce valid and reliable results. **Areas for Improvement:** • Many of the CCO's policies were provided in draft format, were in the process of approval, or were shown to have been approved after the designated review period. • The CCO failed to assume overall accountability for members enrolled in care coordination with an MH subcontractor. • The CCO should ensure that all provider categories and associated service categories are incorporated in its DSN Provider Capacity Report, demonstrating that all covered services are available and accessible to members. • The CCO should ensure that the required DSN Provider Capacity Report data records are populated with valid values in valid formats.
Timeliness	**Strengths:** • The CCO had efficient service authorization processes that demonstrated the creation of preemptive and standing authorizations to enable seamless care delivery. **Areas for Improvement:** • The CCO lacked relevant details on the authorization process in policies and provider materials.
Access	**Strengths:** • The CCO utilized geocoding software for mapping, analysis, and identifying non-contracted providers within the service area that could be contracted to expand the network delivery system. • The CCO closely monitored utilization of physical, behavioral, and oral health care services at both the member and provider levels. • The CCO created DCO DSN Provider Capacity Reports by county, which were shared with the DCOs for their plan-specific monitoring. • Geographic distribution of individual practitioners and facility/business/service providers compared to its membership was sufficient to cover the CCO's service area based on the pre-defined OHA time and distance thresholds.

CPCCO EQR Overview	
	• The CCO's policies included standardized processes that applied to both MH/SUD and M/S benefits, applying UM equitably across all benefit types and packages. **Areas for Improvement:** • The CCO had high denial rates for prescription drug PA requests that should be evaluated to determine whether areas for improvement exist in the CCO's UM process or formulary. • The CCO must develop a mechanism to document and track network closures for MH/SUD and M/S providers to determine whether parity concerns exist in operation.

Eastern Oregon CCO, LLC (EOCCO)

EOCCO EQR Overview
EOCCO is contracted with OHA to provide physical, behavioral, and oral health care services to 58,426 Medicaid members residing in 12 of Oregon's eastern counties. With its administrative offices located in Portland, Oregon, its shared ownership structure has allowed the CCO to set aside reserves for 98 percent reinvestment into its communities and network providers. With pervasive access and transportation barriers resulting from its rural and frontier landscapes, the CCO contracts with out-of-state providers and takes advantage of telehealth options to supplement the care of its members. EOCCO has fostered the growth of PCPCHs beginning with a reported 3 percent member enrollment in 2012 with only one PCPCH and increasing to 95 percent member enrollment with multiple PCPCHs by 2020.

Compliance With Regulatory and Contractual Standards	
Compliance Standard	**Score**
Standard III—Coordination and Continuity of Care	12.5/15 (83%)
Standard IV—Coverage and Authorization of Services	15.5/17 (91%)
Standard VII—Member Rights and Protections	7.5/9 (83%)
Standard X—Grievance and Appeal Systems	18.0/22 (82%)
Standard XV—Member Information	8.0/10 (80%)
Overall Compliance as of December 2020	61.5/73 (84%)

Performance Improvement Projects (PIPs)

Statewide PIP

Interventions: *Not assessed. The CCO developed the PIP design in CY 2020. The CCO had not yet progressed to carrying out, evaluating, and reporting interventions for the PIP.*

CCO-Specific PIP/Focus Study

- **Improve Type II Diabetes Poor Control**
- **Childhood Immunization Status**
- **Reducing Emergency Department (ED) Utilization Among Members With Mental Illness**

Delivery System Network Evaluation/Network Adequacy	
DSN Evaluation Category	**Outcome**
DSN Provider Narrative	24.0/26 (92%)
Time and Distance	13.5/14 (96%)
DSN Provider Capacity—Percent Accepting New Patients	76.9%

Mental Health Parity		
NQTL Category	**Comparability**	**Stringency**
Category I—UM Limits Applied to Inpatient Services	Compliant	Compliant
Category II—UM Limits Applied to Outpatient Services	Compliant	Compliant
Category III—Prior Authorization for Prescription Drug Limits	Compliant	Compliant

EOCCO EQR Overview		
Category IV—Provider Admission—Closed Network	Compliant	Compliant
Category V—Provider Admission—Network Credentialing	Compliant	Compliant
Category VI—Out-of-Network/Out-of-State Limits	Compliant	Compliant

Quality, Timeliness, and Access	
Domain	**Strengths and Areas for Improvement**
Quality	**Strengths:** • The CCO prioritized alignment of data sharing, pulling clinical data into a single repository to improve coordination and continuity of care. • The CCO invested in reducing health disparities by providing video interpretation and training staff members to become qualified/certified health care interpreters. • The CCO's PIP measures and interventions were well-defined and objective with a methodologically sound data collection process to produce valid and reliable results. • The CCO utilized multiple forms of technology to deliver team-based care and engage providers and community stakeholders. **Areas for Improvement:** • The CCO did not have a solid foundation of documented processes for care coordination. • The CCO failed to provide adequate evidence of oversight for its crisis management system, subcontractor grievance and appeal systems, and advance directive training implementation. • The CCO should ensure that the required DSN Provider Capacity Report data records are populated with valid values in valid formats.
Timeliness	**Strengths:** • The CCO's authorization process demonstrated a solid policy foundation that fostered a culture of fluency and compliance for service authorizations. **Areas for Improvement:** • The CCO was unable to demonstrate that the geographic distribution of members to the required provider service categories was within OHA-defined time and distance standards.
Access	**Strengths:** • The CCO provided robust member education materials as evidence of a "member empowerment" approach to service accessibility. • The CCO was involved in multiple collaborative initiatives and established memorandums of understanding (MOUs) with community partners and stakeholders, showing collaboration and integration with its broader community. • The CCO was awarded a grant from Health Resources and Services (HRSA) to acquire telecommunication equipment to increase access and quality of tele-behavioral care. • The CCO's policies included standardized processes that applied to both MH/SUD and M/S benefits, applying UM equitably across all benefit types and packages.

EOCCO EQR Overview	
	Areas for Improvement: • The CCO did not demonstrate that its members had access to available alternative therapies allowed by OHP. • The CCO's inability to demonstrate geographic distribution of members to the required provider service categories impacted compliance with percentage of member access standards. • The CCO showed a much higher denial rate for MH/SUD PA requests than M/S requests and should review its UM of Outpatient MH/SUD PA requests for parity.

Health Share of Oregon (Health Share)

Health Share EQR Overview
Located in Portland, Health Share is contracted with OHA as a CCO to provide physical, behavioral, and oral health care services to 367,799 Medicaid members residing primarily in the Clackamas, Multnomah, and Washington Tri-County area. Serving the largest member population of any CCO in the State demands vast resources; Health Share subcontracts with four Integrated Delivery Systems and one Integrated Community Network, which assume full financial risk for providing and managing physical and behavioral health services for Health Share's members. Health Share's subcontractors are required to regularly submit reports on their delegated functions. The CCO also performs annual oversight audits and ongoing monitoring to ensure all contractual and regulatory obligations are met. Health Share hosts a number of workgroups and committees, such as its Compliance and Care Integration Workgroups, which include the participation of its subcontractors as well as community organizations and CMHPs.

Compliance With Regulatory and Contractual Standards

Compliance Standard	Score
Standard III—Coordination and Continuity of Care	13.5/15 (90%)
Standard IV—Coverage and Authorization of Services	14.5/17 (85%)
Standard VII—Member Rights and Protections	7.0/9 (78%)
Standard X—Grievance and Appeal Systems	19.0/22 (86%)
Standard XV—Member Information	8.5/10 (85%)
Overall Compliance as of December 2020	62.5/73 (86%)

Performance Improvement Projects (PIPs)

Statewide PIP

Interventions: *Not assessed. The CCO developed the PIP design in CY 2020. The CCO had not yet progressed to carrying out, evaluating, and reporting interventions for the PIP.*

CCO-Specific PIP/Focus Study

- **Expanding Access to Medication-Assisted Treatment (MAT) for Opioid Use Disorder**
- **Increasing Access to THW Services**
- **Improving Foster Care Relational Health, Academic, Psychological, Intellectual, Developmental (RAPID) Assessment Process**

Delivery System Network Evaluation/Network Adequacy

DSN Evaluation Category	Outcome
DSN Provider Narrative	25.0/26 (96%)
Time and Distance	14.0/14 (100%)
DSN Provider Capacity—Percent Accepting New Patients	100%

Mental Health Parity

NQTL Category	Comparability	Stringency

Health Share EQR Overview		
Category I—UM Limits Applied to Inpatient Services	Compliant	Compliant
Category II—UM Limits Applied to Outpatient Services	Compliant	Compliant
Category III—Prior Authorization for Prescription Drug Limits	Compliant	Compliant
Category IV—Provider Admission—Closed Network	Compliant	Compliant
Category V—Provider Admission—Network Credentialing	Compliant	Compliant
Category VI—Out-of-Network/Out-of-State Limits	Compliant	Compliant

Quality, Timeliness, and Access	
Domain	**Strengths and Areas for Improvement**
Quality	**Strengths:** • The CCO successfully established partnerships with multiple community agencies and fostered those relationships with its subcontractors, often bringing those agencies to workgroups with the subcontractors to engage them in care coordination activities. • The CCO had a comprehensive annual audit tool for care coordination record review fortifying its oversight of subcontractors. • The CCO's PIP measures and interventions were well-defined and objective with a methodologically sound data collection process to produce valid and reliable results. • The CCO conducted detailed analysis of its grievance system by type of plan, unique delegated subcontractors, provider type, service type, and the corresponding category of grievance. • The CCO showed earnest efforts at ensuring culturally competent care and offered a wealth of training opportunities for providers, staff, and partners. **Areas for Improvement:** • Although CMR audit tools were comprehensive for oversight of subcontractors, Health Share's own policies lacked important foundational elements and details. • The CCO did not consistently conduct sufficient QA or oversight of its subcontractors' grievance and appeal systems.
Timeliness	**Strengths:** • The CCO used health information technology and multiple sources of member data to predict and stratify member risk pools. **Areas for Improvement:** • The CCO's UM handbook and services authorization policy omitted procedures for processing PA requests and did not identify accurate PA tracking and time frame requirements. • The CCO's grievance and appeal cases and member communications were not consistently timely. • The CCO was unable to demonstrate that the geographic distribution of members to the required provider service categories was within OHA-defined time and distance standards.

Health Share EQR Overview	
Access	**Strengths:** • The CCO demonstrated a rapid response to prioritizing outreach to members at high risk for COVID-19 along with proactive efforts to promote MH resources. • The CCO disseminated weekly and biweekly lists of access and availability for MH resources in response to COVID-19. • The CCO demonstrated a high degree of skill at building community partnerships and bringing entities together to coordinate care. • The CCO's policies included standardized processes that applied to both MH/SUD and M/S benefits, applying UM equitably across all benefit types and packages. **Areas for Improvement:** • The CCO's inability to demonstrate geographic distribution of members to the required provider service categories impacted compliance with percentage of member access standards. • While no MH/SUD parity concerns were identified, the operational variation across the CCO's many delegate policies was difficult to discern and created parity and quality concerns related to consistency in the management of OHP benefits and the availability of information for both members and providers.

InterCommunity Health Network (IHN)

IHN EQR Overview
IHN is contracted with OHA to provide physical, behavioral, and oral health care services to 65,099 Medicaid members residing primarily in Benton, Lincoln, and Linn counties. Based in Corvallis, Oregon, the CCO was formed in 2012 by a local private-public partnership that consisted of county governments and community health partners. The CCO collaborates with community partners to reduce inappropriate ED utilization and develop a regional housing strategy. IHN prides itself on its member-centered philosophy of care.

Compliance With Regulatory and Contractual Standards

Compliance Standard	Score
Standard III—Coordination and Continuity of Care	11.0/15 (73%)
Standard IV—Coverage and Authorization of Services	16.0/17 (94%)
Standard VII—Member Rights and Protections	8.0/9 (89%)
Standard X—Grievance and Appeal Systems	18.5/22 (84%)
Standard XV—Member Information	8.5/10 (85%)
Overall Compliance as of December 2020	62.0/73 (85%)

Performance Improvement Projects (PIPs)

Statewide PIP

Interventions: *Not assessed. The CCO developed the PIP design in CY 2020. The CCO had not yet progressed to carrying out, evaluating, and reporting interventions for the PIP.*

CCO-Specific PIP/Focus Study

- **Improve Type II Diabetes Poor Control**
- **Adolescent Well-Child Visits**
- **Maternity Case Management**

Delivery System Network Evaluation/Network Adequacy

DSN Evaluation Category	Outcome
DSN Provider Narrative	21.5/26 (83%)
Time and Distance	10.0/14 (71%)
DSN Provider Capacity—Percent Accepting New Patients	96%

Mental Health Parity

NQTL Category	Comparability	Stringency
Category I—UM Limits Applied to Inpatient Services	Compliant	Compliant
Category II—UM Limits Applied to Outpatient Services	Compliant	Compliant
Category III—Prior Authorization for Prescription Drug Limits	Compliant	Compliant
Category IV—Provider Admission—Closed Network	Compliant	Compliant
Category V—Provider Admission—Network Credentialing	Compliant	Compliant

IHN EQR Overview		
Category VI—Out-of-Network/Out-of-State Limits	Compliant	Compliant
Quality, Timeliness, and Access		

Domain	Strengths and Areas for Improvement
Quality	**Strengths:** • Member materials were generally compliant with readability requirements, particularly the member handbook. • The CCO's PIP measures and interventions were well-defined and objective with a methodologically sound data collection process to produce valid and reliable results. **Areas for Improvement:** • The CCO had inadequate oversight of MH and oral health subcontractors. Although a care coordination subcontractor was frequently monitored, IHN failed to recognize some areas of noncompliance. • The CCO failed to assume overall accountability for members enrolled in care coordination with an MH subcontractor. • The CCO should address, describe, and incorporate necessary analysis, examples, applicable scenarios, and/or supporting documentation, as illustrated in the *2020 Annual CCO DSN Provider Narrative Report Instructions*. • The CCO should ensure that all provider categories and associated service categories are incorporated in its DSN Provider Capacity Report, demonstrating that all covered services are available and accessible to members. • The CCO should ensure that the required DSN Provider Capacity Report data records are populated with valid values in valid formats.
Timeliness	**Strengths:** • A risk stratification process allowed the CCO to effectively prioritize outreach to high-risk members with complex needs. • The CCO had a timely and compliant service authorization process with a tendency to make clinical decisions in favor of members. **Areas for Improvement:** • The CCO's grievance and appeal member notifications were not consistently timely. • The CCO was unable to demonstrate that the geographic distribution of members to the required provider service categories was within OHA-defined time and distance standards.
Access	**Strengths:** • The CCO established metric-based contracts with six community-based organizations that employ THWs. • The CCO conducted an assessment of internal and external resources available to members that promote cultural and linguistic competency within its organization and provider network. • The CCO funded the Homelessness Response Team, a pilot program to address ED utilization rates with THWs, community-based organizations, and local EDs.

IHN EQR Overview	
	• The CCO's policies included standardized processes that applied to both MH/SUD and M/S benefits, applying UM equitably across all benefit types and packages. **Areas for Improvement:** • The CCO's inability to demonstrate geographic distribution of members to the required provider service categories impacted compliance with percentage of member access standards.

Jackson Care Connect (JCC)

JCC EQR Overview
With its headquarters in Portland, JCC is contracted with OHA as a CCO subsidiary of CareOregon to provide physical, behavioral, and oral health care services to 54,098 Medicaid members residing primarily in Jackson County. JCC saw a 60 percent increase in its membership between December 31, 2019, and October 2020. While part of this increase was due to the impacts of COVID-19 and wildfires in September 2020, most of the membership increase was driven by the CCO 2.0 process. JCC has prioritized access to both affordable and emergency housing, building a network of and utilization for behavioral health and addiction services, and providing early intervention and family support resources.

Compliance With Regulatory and Contractual Standards	
Compliance Standard	**Score**
Standard III—Coordination and Continuity of Care	13.0/15 (87%)
Standard IV—Coverage and Authorization of Services	14.0/17 (82%)
Standard VII—Member Rights and Protections	5.5/9 (61%)
Standard X—Grievance and Appeal Systems	20.0/22 (91%)
Standard XV—Member Information	8.0/10 (80%)
Overall Compliance as of December 2020	60.5/73 (83%)

Performance Improvement Projects (PIPs)
Statewide PIP
Interventions: *Not assessed. The CCO developed the PIP design in CY 2020. The CCO had not yet progressed to carrying out, evaluating, and reporting interventions for the PIP.*
CCO-Specific PIP/Focus Study
• **Improve Type II Diabetes Poor Control** • **Increase Access to MAT in Primary Care** • **SDOH Screening and Follow-Up**

Delivery System Network Evaluation/Network Adequacy	
DSN Evaluation Category	**Outcome**
DSN Provider Narrative	26.0/26 (100%)
Time and Distance	14.0/14 (100%)
DSN Provider Capacity—Percent Accepting New Patients	19.7%

Mental Health Parity		
NQTL Category	**Comparability**	**Stringency**
Category I—UM Limits Applied to Inpatient Services	Compliant	Compliant
Category II—UM Limits Applied to Outpatient Services	Compliant	Compliant
Category III—Prior Authorization for Prescription Drug Limits	Compliant	Non-Compliant

JCC EQR Overview		
Category IV—Provider Admission—Closed Network	Compliant	Non-Compliant
Category V—Provider Admission—Network Credentialing	Compliant	Compliant
Category VI—Out-of-Network/Out-of-State Limits	Compliant	Compliant

Quality, Timeliness, and Access	
Domain	**Strengths and Areas for Improvement**
Quality	**Strengths:** • The CCO responded quickly, competently, and massively to the COVID-19 pandemic and September 2020 wildfires in its service area, including emergency pandemic relief funding to over 15 community-based organizations, reallocation of staff to Jackson County Public Health to assist in case investigation and connecting COVID-positive members with PCPs, wildfire outreach logistics, contact tracing, support for telehealth visits, and temporarily lifting all requirements for use of NEMT to members within wildfire-affected areas. • Multidisciplinary care team members provided integrated care coordination and developed comprehensive treatment plans. • The CCO demonstrated notable oversight of subcontractor grievance and appeal systems. • The CCO's PIP measures and interventions were well-defined and objective with a methodologically sound data collection process to produce valid and reliable results. **Areas for Improvement:** • Many of the CCO's policies were provided in draft format, were in the process of approval, or were shown to have been approved after the designated review period. • The CCO failed to assume overall accountability for members enrolled in care coordination with an MH subcontractor. • The CCO should ensure that the DSN Provider Capacity Report includes required data fields populated with valid values, in valid formats, as outlined in the *2020 Quarterly CCO DSN Provider Capacity Report Instructions*, demonstrating that all covered services are available and accessible to members.
Timeliness	**Strengths:** • The CCO had efficient service authorization processes that demonstrated the creation of preemptive and standing authorizations to enable seamless care delivery. **Areas for Improvement:** • The CCO lacked relevant details on the authorization process in policies and provider materials.
Access	**Strengths:** • The CCO utilized geocoding software for mapping, analysis, and identifying non-contracted providers within the service area that could be contracted to expand the network delivery system. • The CCO created and maintained a public website for its providers to obtain telehealth support and resources.

JCC EQR Overview	
	• The CCO implemented a multi-pronged approach to improve and increase well-child visits and childhood/adolescent vaccination metric performance, which included expanding capacity. • The CCO was involved in multiple collaborative initiatives and established MOUs with community partners and stakeholders, showing collaboration and integration with its broader community. • The CCO's policies included standardized processes that applied to both MH/SUD and M/S benefits, applying UM equitably across all benefit types and packages. **Areas for Improvement:** • Although not an MHP concern, the CCO's high denial rate for prescription drug PA requests should be evaluated to determine if parity issues exist. • The CCO was unable to provide information on how many providers were impacted by the CCO's decision to close all or part of its network to new providers in the last contract year as denied requests were not formally tracked. • The CCO's inability to demonstrate geographic distribution of members to the required provider service categories impacted compliance with percentage of member access standards.

PacificSource Community Solutions—Central Oregon (PSCS-CO)

PSCS-CO EQR Overview
Based in Bend, PSCS-CO is contracted with OHA to provide physical, behavioral, and oral health care services to 59,281 Medicaid members residing in Crook, Deschutes, and Jefferson counties. PSCS has operated as a health plan in some capacity since 1933, beginning with 21 physicians and 600 members. With a vast expansion of services launching in the 1970s, PSCS is now a regional enterprise, managing several lines of business including plans for Medicaid and Medicare Advantage, as well as commercial plans that extend across Idaho, Washington, and Montana. Today, PSCS is the parent company to four CCOs in Oregon with two CCOs from the inception of Oregon's health care transformation: Central Oregon (CO) and Columbia Gorge (CG), and two additional CCOs introduced with the advent of CCO 2.0: Lane and Marion Polk (MP). PSCS has invested $20 million since the beginning of the CCO model implementation, supporting value-based payment arrangements, fully integrated care, and other community benefit initiatives as directed by the CAC.

Compliance With Regulatory and Contractual Standards

Compliance Standard	Score
Standard III—Coordination and Continuity of Care	15.0/15 (100%)
Standard IV—Coverage and Authorization of Services	16.5/17 (97%)
Standard VII—Member Rights and Protections	8.0/9 (89%)
Standard X—Grievance and Appeal Systems	18.5/22 (84%)
Standard XV—Member Information	9.5/10 (95%)
Overall Compliance as of December 2020	67.5/73 (92%)

Performance Improvement Projects (PIPs)

Statewide PIP

Interventions: *Not assessed. The CCO developed the PIP design in CY 2020. The CCO had not yet progressed to carrying out, evaluating, and reporting interventions for the PIP.*

CCO-Specific PIP/Focus Study

- **Adolescent Human Papillomavirus (HPV) Immunization Rates**
- **Oral Health Care During Pregnancy**
- **SDOH Screening and Follow-Up**

Delivery System Network Evaluation/Network Adequacy

DSN Evaluation Category	Outcome
DSN Provider Narrative	25.0/26 (97%)
Time and Distance	14.0/14 (100%)
DSN Provider Capacity—Percent Accepting New Patients	69.6%

Mental Health Parity

NQTL Category	Comparability	Stringency
Category I—UM Limits Applied to Inpatient Services	Compliant	Non-Compliant
Category II—UM Limits Applied to Outpatient Services	Compliant	Non-Compliant

PSCS-CO EQR Overview		
Category III—Prior Authorization for Prescription Drug Limits	Compliant	Compliant
Category IV—Provider Admission—Closed Network	Compliant	Compliant
Category V—Provider Admission—Network Credentialing	Compliant	Compliant
Category VI—Out-of-Network/Out-of-State Limits	Compliant	Compliant

Quality, Timeliness, and Access	
Domain	**Strengths and Areas for Improvement**
Quality	**Strengths:** • The CCO demonstrated outstanding care coordination engagement efforts, member-centric treatment plans, and active member and family involvement in goal setting. • The CCO's PIP measures and interventions were well-defined and objective with a methodologically sound data collection process to produce valid and reliable results. • The CCO described multiple mechanisms used to incorporate member feedback from CAHPS surveys, health surveys, grievances and complaints, and its CAC into its network adequacy decision making. • The CCO used interdisciplinary care teams to coordinate services across the continuum of care. **Areas for Improvement:** • The CCO's member notifications showed room for improved readability and fullness of information. • The CCO should provide community-specific resources for health and wellness. • The CCO should address, describe, and incorporate necessary analysis, examples, applicable scenarios, and/or supporting documentation, as illustrated in the *2020 Annual CCO DSN Provider Narrative Report Instructions.*
Timeliness	**Strengths:** • Service authorizations were timely and overall lenient, favoring members; restrictions were removed to ease processing during COVID-19 challenges and CCO expansion. **Areas for Improvement:** • The CCO should ensure that all provider categories and associated service categories are incorporated in its DSN Provider Capacity Report, demonstrating that all covered services are available and accessible to members.
Access	**Strengths:** • The CCO had a robust member education program, notably providing a year's worth of free text messages to engage pregnant members. • The CCO used geocoding software for detailed qualitative and quantitative time and distance analysis, and a comparison of the geographic distribution of members to providers. • The CCO's policies included standardized processes that applied to both MH/SUD and M/S benefits, applying UM equitably across all benefit types and packages. **Areas for Improvement:**

PSCS-CO EQR Overview	
	• The CCO should ensure and demonstrate that the geographic distribution of members to the required provider service categories is within the OHA-defined time, distance, and percentage of member access standards. • The CCO had more stringent MH/SUD UM limits applied to inpatient and outpatient service time frame allowances than OHP FFS stringency standards and should adjust to match OHP FFS.

PacificSource Community Solutions—Columbia Gorge (PSCS-CG)

PSCS-CG EQR Overview
Based in Bend, PSCS-CG is contracted with OHA to provide physical, behavioral, and oral health care services to 13,967 Medicaid members residing in Hood River and Wasco counties. PSCS has operated as a health plan in some capacity since 1933, beginning with 21 physicians and 600 members. With a vast expansion of services launching in the 1970s, PSCS is now a regional enterprise, managing several lines of business including plans for Medicaid and Medicare Advantage, as well as commercial plans that extend across Idaho, Washington, and Montana. Today, PSCS is the parent company to four CCOs in Oregon with two CCOs from the inception of Oregon's health care transformation: Central Oregon (CO) and Columbia Gorge (CG), and two additional CCOs introduced with the advent of CCO 2.0: Lane and Marion Polk (MP). PSCS has invested $20 million since the beginning of the CCO model implementation, supporting value-based payment arrangements, fully integrated care, and other community benefit initiatives as directed by the CAC.

Compliance With Regulatory and Contractual Standards

Compliance Standard	Score
Standard III—Coordination and Continuity of Care	15.0/15 (100%)
Standard IV—Coverage and Authorization of Services	16.5/17 (97%)
Standard VII—Member Rights and Protections	8.0/9 (89%)
Standard X—Grievance and Appeal Systems	18.5/22 (84%)
Standard XV—Member Information	9.5/10 (95%)
Overall Compliance as of December 2020	67.5/73 (92%)

Performance Improvement Projects (PIPs)

Statewide PIP

Interventions: *Not assessed. The CCO developed the PIP design in CY 2020. The CCO had not yet progressed to carrying out, evaluating, and reporting interventions for the PIP.*

CCO-Specific PIP/Focus Study

- **Adolescent HPV Immunization Rates**
- **Oral Health Care During Pregnancy**
- **SDOH Screening and Follow-Up**

Delivery System Network Evaluation/Network Adequacy

DSN Evaluation Category	Outcome
DSN Provider Narrative	25.0/26 (97%)
Time and Distance	14.0/14 (100%)
DSN Provider Capacity—Percent Accepting New Patients	91.4%

Mental Health Parity

NQTL Category	Comparability	Stringency
Category I—UM Limits Applied to Inpatient Services	Compliant	Non-Compliant
Category II—UM Limits Applied to Outpatient Services	Compliant	Non-Compliant

PSCS-CG EQR Overview		
Category III—Prior Authorization for Prescription Drug Limits	Compliant	Compliant
Category IV—Provider Admission—Closed Network	Compliant	Compliant
Category V—Provider Admission—Network Credentialing	Compliant	Compliant
Category VI—Out-of-Network/Out-of-State Limits	Compliant	Compliant

Quality, Timeliness, and Access	
Domain	**Strengths and Areas for Improvement**
Quality	**Strengths:** • The CCO demonstrated outstanding care coordination engagement efforts, member-centric treatment plans, and active member and family involvement in goal setting. • The CCO's PIP measures and interventions were well-defined and objective with a methodologically sound data collection process to produce valid and reliable results. • The CCO described multiple mechanisms used to incorporate member feedback from CAHPS surveys, health surveys, grievances and complaints, and its CAC into its network adequacy decision making. • The CCO used interdisciplinary care teams to coordinate services across the continuum of care. **Areas for Improvement:** • The CCO's member notifications showed room for improved readability and fullness of information. • The CCO should provide community-specific resources for health and wellness. • The CCO should address, describe, and incorporate necessary analysis, examples, applicable scenarios, and/or supporting documentation, as illustrated in the *2020 Annual CCO DSN Provider Narrative Report Instructions.*
Timeliness	**Strengths:** • Service authorizations were timely and overall lenient, favoring members; restrictions were removed to ease processing during COVID-19 challenges and CCO expansion. **Areas for Improvement:** • The CCO should ensure that all provider categories and associated service categories are incorporated in its DSN Provider Capacity Report, demonstrating that all covered services are available and accessible to members.
Access	**Strengths:** • The CCO had a robust member education program, notably providing a year's worth of free text messages to engage pregnant members. • The CCO used geocoding software for detailed qualitative and quantitative time and distance analysis, and a comparison of the geographic distribution of members to providers. • The CCO described and demonstrated the continuum of care for ensuring adequate access to MH disorders and SUD services and treatment.

PSCS-CG EQR Overview	
	• Based on underutilization monitoring, the CCO implemented a collaborative effort with both physical and oral health care providers to eliminate barriers and increase oral health care services for diabetic members. • The CCO's policies included standardized processes that applied to both MH/SUD and M/S benefits, applying UM equitably across all benefit types and packages. **Areas for Improvement:** • The CCO should ensure and demonstrate that the geographic distribution of members to the required provider service categories is within the OHA-defined time, distance, and percentage of member access standards. • The CCO had more stringent MH/SUD UM limits applied to inpatient and outpatient service time frame allowances than OHP FFS stringency standards and should adjust to match OHP FFS.

PacificSource Community Solutions—Lane (PSCS-Lane)

PSCS-Lane EQR Overview
Based in Bend, PSCS-Lane is contracted with OHA to provide physical, behavioral, and oral health care services to 69,283 Medicaid members residing primarily in Lane County. PSCS has operated as a health plan in some capacity since 1933, beginning with 21 physicians and 600 members. With a vast expansion of services launching in the 1970s, PSCS is now a regional enterprise, managing several lines of business including plans for Medicaid and Medicare Advantage, as well as commercial plans that extend across Idaho, Washington, and Montana. Today, PSCS is the parent company to four CCOs in Oregon with two CCOs from the inception of Oregon's health care transformation: Central Oregon (CO) and Columbia Gorge (CG), and two additional CCOs introduced with the advent of CCO 2.0: Lane and Marion Polk (MP). PSCS has invested $20 million since the beginning of the CCO model implementation, supporting value-based payment arrangements, fully integrated care, and other community benefit initiatives as directed by the CAC.

Compliance With Regulatory and Contractual Standards	
Compliance Standard	**Score**
Standard III—Coordination and Continuity of Care	15.0/15 (100%)
Standard IV—Coverage and Authorization of Services	16.5/17 (97%)
Standard VII—Member Rights and Protections	8.0/9 (89%)
Standard X—Grievance and Appeal Systems	18.5/22 (84%)
Standard XV—Member Information	9.5/10 (95%)
Overall Compliance as of December 2020	67.5/73 (92%)

Performance Improvement Projects (PIPs)

Statewide PIP

Interventions: *Not assessed. The CCO developed the PIP design in CY 2020. The CCO had not yet progressed to carrying out, evaluating, and reporting interventions for the PIP. Additionally, the CCO did not submit a statewide PIP for validation in 2020. The CCO became operational in January 2020 and a January 2020 statewide PIP submission for validation was not required.*

CCO-Specific PIP/Focus Study

- **Adolescent HPV Immunization Rates**
- **Oral Health Care During Pregnancy**
- **SDOH Screening and Follow-Up**

Delivery System Network Evaluation/Network Adequacy	
DSN Evaluation Category	**Outcome**
DSN Provider Narrative	25.0/26 (97%)
Time and Distance	14.0/14 (100%)
DSN Provider Capacity—Percent Accepting New Patients	65.4%

Mental Health Parity		
NQTL Category	**Comparability**	**Stringency**

PSCS-Lane EQR Overview		
Category I—UM Limits Applied to Inpatient Services	Compliant	Non-Compliant
Category II—UM Limits Applied to Outpatient Services	Compliant	Non-Compliant
Category III—Prior Authorization for Prescription Drug Limits	Compliant	Compliant
Category IV—Provider Admission—Closed Network	Compliant	Compliant
Category V—Provider Admission—Network Credentialing	Compliant	Compliant
Category VI—Out-of-Network/Out-of-State Limits	Compliant	Compliant

Quality, Timeliness, and Access	
Domain	**Strengths and Areas for Improvement**
Quality	**Strengths:** • The CCO demonstrated outstanding care coordination engagement efforts, member-centric treatment plans, and active member and family involvement in goal setting. • The CCO invested in and made sophisticated use of an integrated medical management platform for both UM and care management, including accessing contracted providers' EHRs to retrieve member data and measure clinical quality indicators (e.g., screenings and preventive measures). **Areas for Improvement:** • The CCO's member notifications showed room for improved readability and fullness of information. • The CCO should provide community-specific resources for health and wellness. • The CCO should address, describe, and incorporate necessary analysis, examples, applicable scenarios, and/or supporting documentation, as illustrated in the *2020 Annual CCO DSN Provider Narrative Report Instructions.*
Timeliness	**Strengths:** • Service authorizations were timely and overall lenient, favoring members; restrictions were removed to ease processing during COVID-19 challenges and CCO expansion. **Areas for Improvement:** • The CCO should ensure that all provider categories and associated service categories are incorporated in its DSN Provider Capacity Report, demonstrating that all covered services are available and accessible to members.
Access	**Strengths:** • The CCO had a robust member education program, notably providing a year's worth of free text messages to engage pregnant members. • The CCO used geocoding software for detailed qualitative and quantitative time and distance analysis, and a comparison of the geographic distribution of members to providers. • Delegated providers were required to submit weekly and/or monthly reporting deliverables and provider data for regular geocoding and mapping to ensure adequate access and availability.

PSCS-Lane EQR Overview	
	• The CCO's policies included standardized processes that applied to both MH/SUD and M/S benefits, applying UM equitably across all benefit types and packages. **Areas for Improvement:** • The CCO should ensure and demonstrate that the geographic distribution of members to the required provider service categories is within the OHA-defined time, distance, and percentage of member access standards. • The CCO had more stringent MH/SUD UM limits applied to inpatient and outpatient service time frame allowances than OHP FFS stringency standards and should adjust to match OHP FFS.

PacificSource Community Solutions—Marion Polk (PSCS-MP)

PSCS-MP EQR Overview
Based in Bend, PSCS-MP is contracted with OHA to provide physical, behavioral, and oral health care services to 114,527 Medicaid members residing in Marion and Polk counties. PSCS has operated as a health plan in some capacity since 1933, beginning with 21 physicians and 600 members. With a vast expansion of services launching in the 1970s, PSCS is now a regional enterprise, managing several lines of business including plans for Medicaid and Medicare Advantage, as well as commercial plans that extend across Idaho, Washington, and Montana. Today, PSCS is the parent company to four CCOs in Oregon with two CCOs from the inception of Oregon's health care transformation: Central Oregon (CO) and Columbia Gorge (CG), and two additional CCOs introduced with the advent of CCO 2.0: Lane and Marion Polk (MP). PSCS has invested $20 million since the beginning of the CCO model implementation, supporting value-based payment arrangements, fully integrated care, and other community benefit initiatives as directed by the CAC.

Compliance With Regulatory and Contractual Standards

Compliance Standard	Score
Standard III—Coordination and Continuity of Care	15.0/15 (100%)
Standard IV—Coverage and Authorization of Services	16.5/17 (97%)
Standard VII—Member Rights and Protections	8.0/9 (89%)
Standard X—Grievance and Appeal Systems	18.5/22 (84%)
Standard XV—Member Information	9.5/10 (95%)
Overall Compliance as of December 2020	67.5/73 (92%)

Performance Improvement Projects (PIPs)

Statewide PIP

Interventions: *Not assessed. The CCO developed the PIP design in CY 2020. The CCO had not yet progressed to carrying out, evaluating, and reporting interventions for the PIP. Additionally, the CCO did not submit a statewide PIP for validation in 2020. The CCO became operational in January 2020 and a January 2020 statewide PIP submission for validation was not required.*

CCO-Specific PIP/Focus Study

- **Adolescent HPV Immunization Rates**
- **Oral Health Care During Pregnancy**
- **SDOH Screening and Follow-Up**

Delivery System Network Evaluation/Network Adequacy

DSN Evaluation Category	Outcome
DSN Provider Narrative	25.0/26 (97%)
Time and Distance	14.0/14 (100%)
DSN Provider Capacity—Percent Accepting New Patients	69.1%

PSCS-MP EQR Overview		
Mental Health Parity		
NQTL Category	**Comparability**	**Stringency**
Category I—UM Limits Applied to Inpatient Services	Compliant	Compliant
Category II—UM Limits Applied to Outpatient Services	Compliant	Non-Compliant
Category III—Prior Authorization for Prescription Drug Limits	Compliant	Compliant
Category IV—Provider Admission—Closed Network	Compliant	Compliant
Category V—Provider Admission—Network Credentialing	Compliant	Compliant
Category VI—Out-of-Network/Out-of-State Limits	Compliant	Compliant

Quality, Timeliness, and Access	
Domain	**Strengths and Areas for Improvement**
Quality	**Strengths:** • The CCO demonstrated outstanding care coordination engagement efforts, member-centric treatment plans, and active member and family involvement in goal setting. • The CCO used regional care teams consisting of UM and care management interdisciplinary teams with clinical expertise in BH and population health. **Areas for Improvement:** • The CCO's member notifications showed room for improved readability and fullness of information. • The CCO should provide community-specific resources for health and wellness. • The CCO should address, describe, and incorporate necessary analysis, examples, applicable scenarios, and/or supporting documentation, as illustrated in the *2020 Annual CCO DSN Provider Narrative Report Instructions.*
Timeliness	**Strengths:** • Service authorizations were timely and overall lenient, favoring members; restrictions were removed to ease processing during COVID-19 challenges and CCO expansion. **Areas for Improvement:** • The CCO should ensure that all provider categories and associated service categories are incorporated in its DSN Provider Capacity Report, demonstrating that all covered services are available and accessible to members.
Access	**Strengths:** • The CCO had a robust member education program, notably providing a year's worth of free text messages to engage pregnant members. • The CCO used geocoding software for detailed qualitative and quantitative time and distance analysis, and a comparison of the geographic distribution of members to providers. • The CCO's policies included standardized processes that applied to both MH/SUD and M/S benefits, applying UM equitably across all benefit types and packages.

PSCS-MP EQR Overview	
	Areas for Improvement: • The CCO should ensure and demonstrate that the geographic distribution of members to the required provider service categories is within the OHA-defined time, distance, and percentage of member access standards. • The CCO had more stringent MH/SUD UM limits applied to inpatient and outpatient service time frame allowances than OHP FFS stringency standards and should adjust to match OHP FFS.

Trillium Community Health Plan, Inc. (TCHP)

TCHP EQR Overview
Headquartered in Eugene, TCHP is contracted with OHA as a CCO to provide physical, behavioral, and oral health care services to 41,185 Medicaid members residing primarily in Lane, Linn, and Douglas counties. In 2015, TCHP was acquired by Centene Corporation, a national MCO, and the CCO merged with HealthNet in 2017. Some administrative and operational functions such as claims management, actuarial services, finance, IT, and human resources are managed at the corporate level, while final adjudication of grievances and appeals, QI activities, delegation oversight, and provider network management are locally managed. TCHP makes SDOH a priority in its approach to serving members. In 2014, Lane Equity Coalition, co-chaired by TCHP and PSCS, was formed to advance community engagement, promote health equity, and reduce barriers that prevent equal access to resources. TCHP focuses on food insecurity as a top SDOH priority, establishing partnerships with the local food bank to provide fresh produce, a stable food supply for youth, and perks that allow members to stretch Supplemental Nutrition Assistance Program dollars further.

Compliance With Regulatory and Contractual Standards

Compliance Standard	Score
Standard III—Coordination and Continuity of Care	11.5/15 (77%)
Standard IV—Coverage and Authorization of Services	16.0/17 (94%)
Standard VII—Member Rights and Protections	7.5/9 (83%)
Standard X—Grievance and Appeal Systems	18.5/22 (84%)
Standard XV—Member Information	9.0/10 (90%)
Overall Compliance as of December 2020	62.5/73 (86%)

Performance Improvement Projects (PIPs)

Statewide PIP

Interventions: *Not assessed. The CCO developed the PIP design in CY 2020. The CCO had not yet progressed to carrying out, evaluating, and reporting interventions for the PIP.*

CCO-Specific PIP/Focus Study

- **Pharmacological Management of Chronic Obstructive Pulmonary Disease (COPD)**
- **Colorectal Cancer Screening**
- **Childhood Immunization Status**

Delivery System Network Evaluation/Network Adequacy

DSN Evaluation Category	Outcome
DSN Provider Narrative	23.0/26 (84%)
Time and Distance	14.0/14 (100%)
DSN Provider Capacity—Percent Accepting New Patients	100%

Mental Health Parity

NQTL Category	Comparability	Stringency
Category I—UM Limits Applied to Inpatient Services	Compliant	Compliant

TCHP EQR Overview		
Category II—UM Limits Applied to Outpatient Services	Compliant	Non-Compliant
Category III—Prior Authorization for Prescription Drug Limits	Compliant	Compliant
Category IV—Provider Admission—Closed Network	Compliant	Compliant
Category V—Provider Admission—Network Credentialing	Compliant	Compliant
Category VI—Out-of-Network/Out-of-State Limits	Compliant	Compliant

Quality, Timeliness, and Access	
Domain	**Strengths and Areas for Improvement**
Quality	**Strengths:** • The CCO showed exemplary efforts at member outreach and engagement, accepting any level of willingness to participate in its member-centric care coordination program. • The CCO reviewed grievance and appeal decisions diligently, with proactive attempts to consider health literacy in its member communications. • The CCO's PIP measures and interventions were well-defined and objective with a methodologically sound data collection process to produce valid and reliable results. • The CCO used an integrated health management tool to house a single comprehensive member record that supported both care coordination and UM activities and functions. **Areas for Improvement:** • The CCO did not demonstrate adequate oversight of its crisis management subcontractor regarding initial service plans. • Policies were sometimes missing details and the structural basis for processes was disorganized in select areas. • The CCO should address, describe, and incorporate necessary analysis, examples, applicable scenarios, and/or supporting documentation, as illustrated in the *2020 Annual CCO DSN Provider Narrative Report Instructions.*
Timeliness	**Strengths:** • The CCO used geocoding software to perform quarterly analysis to monitor the network and conduct time and distance calculations and aggregated mapping. **Areas for Improvement:** • The CCO did not consistently meet time frames for member notifications regarding expedited appeal requests. • The CCO should ensure that all provider categories and associated service categories are incorporated in its DSN Provider Capacity Report, demonstrating that all covered services are available and accessible to members.
Access	**Strengths:** • The CCO partnered with local organizations to dispatch behavioral health and medical professionals in lieu of law enforcement where appropriate for crisis response. • The CCO had a robust member education program.

TCHP EQR Overview	
	• The CCO conducted a detailed annual analysis of member characteristics and demographics such as race, ethnicity, gender, age, and non-English language spoken. • The CCO demonstrated its commitment to providing culturally and linguistically appropriate services through participation in a community health coalition that engaged diverse demographic groups to ensure that gathered knowledge is applied and that the network includes culturally and linguistically appropriate services. • The CCO's policies included standardized processes that applied to both MH/SUD and M/S benefits, applying UM equitably across all benefit types and packages. **Areas for Improvement:** • The CCO should ensure and demonstrate that the geographic distribution of members to the required provider service categories is within the OHA-defined time, distance, and percentage of member access standards. • The CCO had more stringent MH/SUD UM limits applied to inpatient and outpatient service time frame allowances than OHP FFS stringency standards and should adjust to match OHP FFS.

Umpqua Health Alliance, LLC (UHA)

UHA EQR Overview
With administrative offices in Roseburg, UHA is contracted with OHA to provide physical, behavioral, and oral health care services to 31,235 Medicaid members residing primarily in Douglas County. UHA is governed by a local board of directors and guided by a CAC composed of diverse stakeholders that closely mirror the composition of the community, including representation from the Cow Creek Band of Umpqua Tribe of Indians. TCHP funds address SDOH, prioritizing such needs as behavioral health and addiction services, food security, housing, and access to care.

Compliance With Regulatory and Contractual Standards

Compliance Standard	Score
Standard III—Coordination and Continuity of Care	14.0/15 (93%)
Standard IV—Coverage and Authorization of Services	17.0/17 (100%)
Standard VII—Member Rights and Protections	8.5/9 (94%)
Standard X—Grievance and Appeal Systems	19.5/22 (89%)
Standard XV—Member Information	10.0/10 (100%)
Overall Compliance as of December 2020	69.0/73 (95%)

Performance Improvement Projects (PIPs)

Statewide PIP

Interventions: *Not assessed. The CCO developed the PIP design in CY 2020. The CCO had not yet progressed to carrying out, evaluating, and reporting interventions for the PIP.*

CCO-Specific PIP/Focus Study

- **Reduce Re-Hospitalization**
- **Reduce ED Utilization Among Members With Mental Illness**
- **Maternity Case Management**
- **Behavioral Support Services and Care Coordination for Children 0–5 Years With High Social Complexity**

Delivery System Network Evaluation/Network Adequacy

DSN Evaluation Category	Outcome
DSN Provider Narrative	18.5/26 (71%)
Time and Distance	7.0/14 (50%)
DSN Provider Capacity—Percent Accepting New Patients	80.5%

Mental Health Parity

NQTL Category	Comparability	Stringency
Category I—UM Limits Applied to Inpatient Services	Compliant	Compliant
Category II—UM Limits Applied to Outpatient Services	Compliant	Compliant
Category III—Prior Authorization for Prescription Drug Limits	Compliant	Compliant
Category IV—Provider Admission—Closed Network	Compliant	Compliant

UHA EQR Overview		
Category V—Provider Admission—Network Credentialing	Compliant	Compliant
Category VI—Out-of-Network/Out-of-State Limits	Compliant	Compliant
Quality, Timeliness, and Access		

Domain	Strengths and Areas for Improvement
Quality	**Strengths:** • The CCO showed diligent delivery and tracking of training and education, particularly advance directive training for employees, members, providers, and the community at large. • The CCO's PIP measures and interventions were well-defined and objective with a methodologically sound data collection process to produce valid and reliable results. • The CCO used its EHR system to guide and facilitate proper discharge planning decision making. • The CCO demonstrated timely health risk assessments, fully integrated and comprehensive treatment plans, and notable member involvement and provider communication. **Areas for Improvement:** • The CCO lacked a formal reassessment process for members experiencing a triggering event and demonstrated a cumbersome tracking process for care coordination activities. • Some grievance and appeal information in policies and member materials were incomplete or inaccurate. • The CCO should ensure that its DSN Provider Narrative Report and DSN Provider Capacity Report submissions include all necessary information in valid formats and include supporting documentation as applicable using guidance from the *2020 Annual CCO DSN Provider Narrative Report Instructions* and *2020 Quarterly CCO DSN Provider Capacity Report Instructions*.
Timeliness	**Strengths:** • The CCO achieved a perfect score in the review of coverage and authorization, demonstrating accurate policies and adherence to timeliness standards for authorization requests. **Areas for Improvement:** • The CCO should ensure that all provider categories and associated service categories are incorporated in its DSN Provider Capacity Report, demonstrating that all covered services are available and accessible to members.
Access	**Strengths:** • The CCO practiced proactive efforts to reduce the cost of care by working with community partners and ensuring access to essential resources (e.g., developing a sobering center to reduce inappropriate ED utilization and jailing of members with SUDs). • The CCO's policies included standardized processes that applied to both MH/SUD and M/S benefits, applying UM equitably across all benefit types and packages. **Areas for Improvement:** None identified.

Yamhill Community Care Organization (YCCO)

YCCO EQR Overview
With administrative offices in McMinnville, YCCO is contracted with OHA as a CCO to provide physical, behavioral, and oral health care services to 29,890 Medicaid members residing primarily in Yamhill County. YCCO has made some significant changes since its last review including selecting a new subcontractor for physical health and a singular oral health subcontractor, as well as the transition of behavioral health services in house. YCCO recognizes the impact of early learning on the trajectory of population health. As such, YCCO has worked to become the first CCO designated as an Early Learning Hub. Its close partnership with educators allows the CCO to target SDOH, early childhood developmental needs, and parenting education gaps.

Compliance With Regulatory and Contractual Standards	
Compliance Standard	**Score**
Standard III—Coordination and Continuity of Care	10.5/15 (70%)
Standard IV—Coverage and Authorization of Services	15.5/17 (91%)
Standard VII—Member Rights and Protections	8.5//9 (94%)
Standard X—Grievance and Appeal Systems	19.5/22 (89%)
Standard XV—Member Information	9.0/10 (90%)
Overall Compliance as of December 2020	63.0/73 (86%)

Performance Improvement Projects (PIPs)

Statewide PIP

Interventions: *Not assessed. The CCO developed the PIP design in CY 2020. The CCO had not yet progressed to carrying out, evaluating, and reporting interventions for the PIP.*

CCO-Specific PIP/Focus Study

- **Hepatitis C Screening and Treatment**
- **Reducing Preventable ED Utilization**
- **Reducing Housing Instability**

Delivery System Network Evaluation/Network Adequacy	
DSN Evaluation Category	**Outcome**
DSN Provider Narrative	17.5/26 (67%)
Time and Distance	13.5/14 (96%)
DSN Provider Capacity—Percent Accepting New Patients	0.0%

Mental Health Parity		
NQTL Category	**Comparability**	**Stringency**
Category I—UM Limits Applied to Inpatient Services	Compliant	Compliant
Category II—UM Limits Applied to Outpatient Services	Compliant	Compliant
Category III—Prior Authorization for Prescription Drug Limits	Compliant	Compliant
Category IV—Provider Admission—Closed Network	Compliant	Compliant

YCCO EQR Overview		
Category V—Provider Admission—Network Credentialing	Compliant	Compliant
Category VI—Out-of-Network/Out-of-State Limits	Compliant	Compliant
Quality, Timeliness, and Access		

Domain	Strengths and Areas for Improvement
Quality	**Strengths:** • The CCO demonstrated operational oversight with an onsite audit tool, showing a mechanism for monitoring the policies and procedures of its delegates. • The CCO had a robust member education program with a wealth of information on COVID-19 prevention and its impact on MH, helpful non-medical resources that targeted SDOH, and leveraging of social media to provide succinct yet effective advance directive information for members and the community at large. • The CCO's PIP measures and interventions were well-defined and objective with a methodologically sound data collection process to produce valid and reliable results. **Areas for Improvement:** • The CCO showed inadequate oversight and lack of initiative in QI regarding care coordination. • The CCO should ensure that its DSN Provider Narrative Report and DSN Provider Capacity Report submissions include all necessary information in valid formats and include supporting documentation as applicable using guidance from the *2020 Annual CCO DSN Provider Narrative Report Instructions* and *2020 Quarterly CCO DSN Provider Capacity Report Instructions*.
Timeliness	**Strengths:** • The CCO demonstrated excellent turnaround time and prompt notification regarding service authorizations, grievances, and appeals. **Areas for Improvement:** • Record reviews showed delays in care coordination outreach to prioritized members due to missing data from transition of subcontractors. • The CCO should ensure and demonstrate that the geographic distribution of members to the required provider service categories is within the OHA-defined time, distance, and percentage of member access standards.
Access	**Strengths:** • The CCO had detailed policies and procedures that demonstrated oversight and monitoring activities to ensure member access and availability. • The CCO had strong community partnerships to operate the CCO's Community Health Worker Hub and peer support programs. • The CCO conducted two recruitment and contracting campaigns to increase network capacity and address metrics related to childhood immunizations and assessments for children in the custody of Oregon DHS.

YCCO EQR Overview	
	• The CCO's policies included standardized processes that applied to both MH/SUD and M/S benefits, applying UM equitably across all benefit types and packages. **Areas for Improvement:** • The CCO's provider directory did not contain all required provider information. • The CCO should ensure that all provider categories and associated service categories are incorporated in its DSN Provider Capacity Report, demonstrating that all covered services are available and accessible to members.

Advantage Dental Services, LLC (ADS)

ADS EQR Overview	
Founded in 1994 by a group of dentists, ADS is one of the largest DCOs in Oregon. ADS began partnering with the CCOs in 2013 and, in 2016, joined DentaQuest Care Management Group, a national dental benefits administrator that the DCO has been able to leverage for operational and network needs. In 2017, Access Dental Plan, LLC merged with ADS, allowing it to expand its network capacity. Based in Redmond, ADS serves approximately 21,124 members through its direct contract with OHA and also provides oral health care services for 13 of the State's CCOs. ADS is a full service DCO that does not delegate any benefits or administration functions. Its network is a hybrid vertical delivery model consisting of its own dental practices as well as contracted providers and community care hygienists.	
Compliance With Regulatory and Contractual Standards	
Compliance Standard	**Score**
Standard III—Coordination and Continuity of Care	7.5/9 (83%)
Standard IV—Coverage and Authorization of Services	11.0/12 (92%)
Standard VII—Member Rights and Protections	6.5/7 (93%)
Standard X—Grievance and Appeal Systems	19.5/22 (89%)
Standard XV—Member Information	15.0/18 (83%)
Overall Compliance as of July 2020	59.5/68 (88%)
Compliance Follow-Up	
Cumulative 2019–2020 Compliance Findings Resolved as of January 2021	8/13 (62%)
Performance Improvement Projects (PIPs)	
DCO-Specific PIP	
Topic: Increasing Dental Care Utilization During Pregnancy **Interventions:** *Not assessed. The DCO developed the PIP design in CY 2020. The DCO had not yet progressed to carrying out, evaluating, and reporting interventions for the PIP.*	
Delivery System Network Evaluation/Network Adequacy	
DSN Evaluation Category	**Outcome**
DSN Provider Narrative	9.0/14 (64%)
Time and Distance	5.0/5 (100%)
DSN Provider Capacity—Percent Accepting New Patients	15.6%
Quality, Timeliness, and Access	
Domain	**Strengths and Areas for Improvement**

ADS EQR Overview	
Quality	**Strengths:** • The DCO demonstrated notable improvements in the readability of member-facing materials over the 2019 CMR. • The DCO had a robust system for coordination and integration of care, including Health Information Exchange connectivity resources. • The DCO's PIP measures and interventions were well-defined and objective with a methodologically sound data collection process to produce valid and reliable results. • The DCO had strong technological capabilities and multiple membership outreach activities. **Areas for Improvement:** • The DCO had difficulty in identifying prioritized populations for care coordination. • Policies related to out-of-network emergency care were not always consistent. • Member-facing materials did not always contain all necessary information. • The DCO should ensure that its DSN Provider Narrative Report and DSN Provider Capacity Report submissions include all necessary information in valid formats and include supporting documentation as applicable using guidance from the *2020 Annual DCO DSN Provider Narrative Report Instructions* and *2020 Quarterly DCO DSN Provider Capacity Report Instructions*.
Timeliness	**Strengths:** • The DCO performed well on the coverage and authorization standard, demonstrating consistent compliance with required authorization time frames. **Areas for Improvement:** • The DCO requires the member to call his or her PCD before seeking emergency dental care in contradiction with State and federal regulations, which prohibits PA for members seeking emergency services. • The DCO was unable to demonstrate that the geographic distribution of members to the required provider service categories was within OHA-defined time and distance standards.
Access	**Strengths:** • The DCO demonstrated diligent and timely outreach to ensure its members receive essential benefit and provider information. • The DCO significantly invested in and leveraged its telehealth capabilities to provide expanded access for members. The DCO exhibited a robust online provider directory, electronic monitoring and assignment system, utilization analysis process, member choice model, and care coordination apparatus. **Areas for Improvement:** • The DCO did not provide tobacco cessation information in member information. • The DCO's inability to demonstrate geographic distribution of members to the required provider service categories impacted compliance with percentage of member access standards.

Capitol Dental Care, Inc. (CDC)

CDC EQR Overview	
CDC is contracted with OHA as a DCO to provide oral health care services to 15,322 OHP members through its direct contract with OHA. Based in Salem, Oregon, CDC was founded in 1991 to serve Oregon's Medicaid population with efforts concentrated on underserved children. CDC was one of the first DCOs to serve low-income Oregonians beginning in 1994 and soon thereafter became a leading financial sponsor for the Exceptional Needs Dental Services program, ensuring high-quality treatment for those with barriers to care. In 2012, CDC, along with its smaller Portland metropolitan counterpart, MDCO, were the first DCOs to contract with the CCOs to provide oral health care to members. CDC and MDCO share the same staff members, policies and procedures, member and provider materials, and some overlap in governance. Today, the two DCOs own and operate 52 locations throughout Oregon and have 236 partner locations that provide service to areas where over 90 percent of OHP's population lives.	
Compliance With Regulatory and Contractual Standards	
Compliance Standard	**Score**
Standard III—Coordination and Continuity of Care	2.0/9 (22%)
Standard IV—Coverage and Authorization of Services	11.0/12 (92%)
Standard VII—Member Rights and Protections	5.5/7 (79%)
Standard X—Grievance and Appeal Systems	18/22 (82%)
Standard XV—Member Information	12.0/18 (67%)
Overall Compliance as of July 2020	48.5/68 (71%)
Compliance Follow-Up	
Cumulative 2019–2020 Compliance Findings Resolved as of January 2021	9/15 (60%)
Performance Improvement Projects (PIPs)	
DCO-Specific PIP	
Topic: Implementation of a Customer Relationship Management (CRM) System for Improved Member Engagement **Interventions:** *Not assessed. The DCO developed the PIP design in CY 2020. The DCO had not yet progressed to carrying out, evaluating, and reporting interventions for the PIP.*	
Delivery System Network Evaluation/Network Adequacy	
DSN Evaluation Category	**Outcome**
DSN Provider Narrative	11.0/14 (79%)
Time and Distance	5.0/5 (100%)
DSN Provider Capacity—Percent Accepting New Patients	98.8%

CDC EQR Overview	
Quality, Timeliness, and Access	
Domain	**Strengths and Areas for Improvement**
Quality	**Strengths:** • The DCO's PIP measures and interventions were well-defined and objective with a methodologically sound data collection process to produce valid and reliable results. • The DCO's experienced Member Services Team provided frequent and consistent education and outreach to members. **Areas for Improvement:** • The DCO's care coordination procedures lacked some fundamentals, including assignment of all members to a PCD and identification of prioritized populations for care coordination. • The DCO should ensure that its DSN Provider Narrative Report and DSN Provider Capacity Report submissions include all necessary information in valid formats and include supporting documentation as applicable using guidance from the *2020 Annual DCO DSN Provider Narrative Report Instructions* and *2020 Quarterly DCO DSN Provider Capacity Report Instructions*.
Timeliness	**Strengths:** • The DCO consistently met time frames for service authorizations. **Areas for Improvement:** • The DCO was unable to demonstrate that the geographic distribution of members to the required provider service categories was within OHA-defined time and distance standards.
Access	**Strengths:** • The DCO's co-location at nine pediatric, primary care, OB/GYN, and behavioral health clinics demonstrated strong support for integrated health and coordination of care. • The DCO demonstrated an innovative and successful pilot program, which embedded an EPDH in a hospital to reduce ED utilization for dental services and prevent hospital-acquired infections. • The DCO expanded and leveraged its teledentistry capabilities to provide access to care during the COVID-19 pandemic. **Areas for Improvement:** • The DCO failed to provide welcome packets to new members except by request. • The DCO's inability to demonstrate geographic distribution of members to the required provider service categories impacted compliance with percentage of member access standards.

Family Dental Care, Inc. (FDCi)

FDCi EQR Overview	
FDCi is contracted with OHA as a DCO to provide direct oral health care services to members residing in the Portland Tri-County region. Based in Beaverton, FDCi serves approximately 3,408 members residing in Clackamas, Multnomah, and Washington counties. FDCi is a small dental health plan with seven employees, and its executive leadership is actively involved in day-to-day operations. With 63 participating providers, FDCi's network is a hybrid of both staff-affiliated clinics and community panel providers. Of the 23 network locations, seven of the dental clinics are owned by the DCO.	
Compliance With Regulatory and Contractual Standards	
Compliance Standard	**Score**
Standard III—Coordination and Continuity of Care	4.0/9 (44%)
Standard IV—Coverage and Authorization of Services	12.0/12 (100%)
Standard VII—Member Rights and Protections	5.5/7 (79%)
Standard X—Grievance and Appeal Systems	16.0/22 (73%)
Standard XV—Member Information	13.5/18 (75%)
Overall Compliance as of July 2020	51.0/68 (75%)
Compliance Follow-Up	
Cumulative 2019–2020 Compliance Findings Resolved as of January 2021	10/12 (83%)
Performance Improvement Projects (PIPs)	
DCO-Specific PIP	
Topic: Reduction of No-Shows to Improve Access **Interventions:** *Not assessed. The DCO developed the PIP design in CY 2020. The DCO had not yet progressed to carrying out, evaluating, and reporting interventions for the PIP.*	
Delivery System Network Evaluation/Network Adequacy	
DSN Evaluation Category	**Outcome**
DSN Provider Narrative	10.0/14 (71%)
Time and Distance	0.0/5 (0%)
DSN Provider Capacity—Percent Accepting New Patients	100%
Quality, Timeliness, and Access	
Domain	**Strengths and Areas for Improvement**
Quality	**Strengths:** • The DCO had solid infrastructure for care coordination requirements including policies, risk assessment templates, and treatment plan templates. • The DCO showed proficiency in monitoring network providers for compliance with its grievance and appeal processes.

FDCi EQR Overview	
	Areas for Improvement: • The DCO had insufficient evidence of implementation of care coordination requirements. • The DCO had difficulty identifying prioritized populations for care coordination. • Member communications did not consistently meet readability requirements. • The DCO should define a PIP study indicator and develop a data collection process that can be used consistently for the baseline measurement period and all subsequent remeasurement periods to produce valid and reliable results. Annual measurement results must be comparable over time to allow for evaluation of improvement. • The DCO should ensure that its DSN Provider Narrative Report and DSN Provider Capacity Report submissions include all necessary information in valid formats and include supporting documentation as applicable using guidance from the *2020 Annual DCO DSN Provider Narrative Report Instructions* and *2020 Quarterly DCO DSN Provider Capacity Report Instructions*.
Timeliness	**Strengths:** • The DCO performed in compliance with comprehensive coverage and authorization policies and provided evidence of member notifications meeting required time frames. • The DCO demonstrated how its UM processes support individuals with ongoing or chronic conditions or who require LTCSS. **Areas for Improvement:** • The DCO was unable to demonstrate that the geographic distribution of members to the required provider service categories was within OHA-defined time and distance standards.
Access	**Strengths:** • The DCO had proactive processes to conduct assessment during member intake and "soft" PCD assignment. • The DCO provided strong examples to demonstrate its commitment to culturally and linguistically appropriate services, as well as efforts to quickly address any service gaps. **Areas for Improvement:** • The DCO's inability to demonstrate geographic distribution of members to the required provider service categories impacted compliance with percentage of member access standards.

Managed Dental Care of Oregon, Inc. (MDCO)

MDCO EQR Overview	
MDCO is contracted with OHA as a DCO to provide direct oral health care services to approximately 3,361 members in the Portland metropolitan area. Based in Salem, MDCO was founded in 1991 to serve Oregon's Medicaid population with efforts concentrated on underserved children. The DCO was acquired by InterDent in 1997. MDCO is a leading financial sponsor for the Exceptional Needs Dental Services program, ensuring high-quality treatment for those with barriers to care. In 2012, MDCO, along with its larger statewide counterpart, CDC, were the first DCOs to contract with the CCOs to provide oral health care to CCO members. MDCO and CDC share the same staff members, policies and procedures, member and provider materials, and some overlap in governance. Today, the two DCOs own and operate 52 locations throughout Oregon and have 236 partner locations that provide service to areas where over 90 percent of OHP's population lives.	
Compliance With Regulatory and Contractual Standards	
Compliance Standard	**Score**
Standard III—Coordination and Continuity of Care	2.0/9 (22%)
Standard IV—Coverage and Authorization of Services	8.5/12 (71%)
Standard VII—Member Rights and Protections	4.0/7 (57%)
Standard X—Grievance and Appeal Systems	17.0/22 (77%)
Standard XV—Member Information	9.0/18 (50%)
Overall Compliance as of July 2020	40.5/68 (60%)
Compliance Follow-Up	
Cumulative 2019–2020 Compliance Findings Resolved as of January 2021	8/15 (53%)
Performance Improvement Projects (PIPs)	
DCO-Specific PIP	
Topic: Implementation of a Customer Relationship Management (CRM) System for Improved Member Engagement **Interventions:** *Not assessed. The DCO developed the PIP design in CY 2020. The DCO had not yet progressed to carrying out, evaluating, and reporting interventions for the PIP.*	
Delivery System Network Evaluation/Network Adequacy	
DSN Evaluation Category	**Outcome**
DSN Provider Narrative	11.0/14 (79%)
Time and Distance	5.0/5 (100%)
DSN Provider Capacity—Percent Accepting New Patients	96.8%

MDCO EQR Overview	
Quality, Timeliness, and Access	
Domain	**Strengths and Areas for Improvement**
Quality	**Strengths:** • The DCO's PIP measures and interventions were well-defined and objective with a methodologically sound data collection process to produce valid and reliable results. • The DCO's experienced Member Services Team provided frequent and consistent education and outreach to members. **Areas for Improvement:** • The DCO's care coordination procedures lacked some fundamentals, including assignment of all members to a PCD and identification of prioritized populations for care coordination. • The DCO should ensure that its DSN Provider Narrative Report and DSN Provider Capacity Report submissions include all necessary information in valid formats and include supporting documentation as applicable using guidance from the *2020 Annual DCO DSN Provider Narrative Report Instructions* and *2020 Quarterly DCO DSN Provider Capacity Report Instructions*. • MDCO did not have its own branding on many critical policies, forms, and templates, instead relying on Capitol Dental-branded documentation, which did not constitute sufficient evidence of implementation.
Timeliness	**Strengths:** • The DCO consistently met time frames for service authorizations. **Areas for Improvement:** • The CCO should ensure and demonstrate that the geographic distribution of members to the required provider service categories is within the OHA-defined time, distance, and percentage of member access standards.
Access	**Strengths:** • The DCO's co-location at nine pediatric, primary care, OB/GYN, and behavioral health clinics demonstrated strong support for integrated health and coordination of care. • The DCO demonstrated an innovative and successful pilot program, which embedded an EPDH in a hospital to reduce ED utilization for dental services and prevent hospital-acquired infections. • The DCO expanded and leveraged its teledentistry capabilities to provide access to care during the COVID-19 pandemic. **Areas for Improvement:** • The DCO failed to provide welcome packets to new members except by request; additionally, with no member handbook electronically available, members were not receiving the member handbook in any meaningful way. • The DCO's inability to demonstrate geographic distribution of members to the required provider service categories impacted compliance with percentage of member access standards.

ODS Community Dental (ODS)

ODS EQR Overview	
ODS is contracted with OHA as a DCO to provide direct oral health care services to approximately 13,469 members. Based in Portland, ODS began operations in Oregon in 1955 and was one of three founders of Delta Dental, the largest dental plan system in the United States. In 1994, ODS launched its Medicaid plan. In order to optimize access, ODS accepts providers into its network that are willing to serve any volume of Medicaid members, allowing the DCO to maintain a robust network of 1,050 contracted providers. The DCO has several community programs such as its own dental clinics and the Tooth Taxi program, which allows for mobile dental care with a focus on both Medicaid and non-Medicaid school-age children.	
Compliance With Regulatory and Contractual Standards	
Compliance Standard	**Score**
Standard III—Coordination and Continuity of Care	4.5/9 (50%)
Standard IV—Coverage and Authorization of Services	12.0/12 (100%)
Standard VII—Member Rights and Protections	6.0/7 (86%)
Standard X—Grievance and Appeal Systems	15.5/22 (70%)
Standard XV—Member Information	10.0/18 (56%)
Overall Compliance as of July 2020	48.0/68 (71%)
Compliance Follow-Up	
Cumulative 2019–2020 Compliance Findings Resolved as of January 2021	1/5 (20%)
Performance Improvement Projects (PIPs)	
DCO-Specific PIP	
Topic: Targeted Outreach for Members Not Engaged in Regular Dental Care **Interventions:** *Not assessed. The DCO developed the PIP design in CY 2020. The DCO had not yet progressed to carrying out, evaluating, and reporting interventions for the PIP.*	
Delivery System Network Evaluation/Network Adequacy	
DSN Evaluation Category	**Outcome**
DSN Provider Narrative	13.0/14 (93%)
Time and Distance	5.0/5 (100%)
DSN Provider Capacity—Percent Accepting New Patients	59.2%
Quality, Timeliness, and Access	
Domain	**Strengths and Areas for Improvement**
Quality	**Strengths:** • The DCO's policies, procedures, and community initiatives showed strong commitment to improving population health for its whole community, not just Medicaid members. • The DCO's PIP measures and interventions were well-defined and objective with a methodologically sound data collection process to produce valid and reliable results.

ODS EQR Overview	
	Areas for Improvement: • There was little policy basis for or evidence of implementing many components of a care coordination program. • The DCO had difficulty identifying prioritized populations for care coordination and had only four members with an established care coordination record, which did not reasonably align with the size of its member population. • Member grievance and appeal communications did not always contain complete information.
Timeliness	**Strengths:** • The DCO demonstrated consistent compliance with PA time frames. **Areas for Improvement:** • The DCO did not consistently meet time frames for grievance and appeal processes.
Access	**Strengths:** • An expansive provider network offered members many choices and good access to care. • The DCO retained an in-house Latino specialist for culturally responsive services. • The DCO leveraged robust in-house electronic and IT resources for effective DSN analysis and population management. **Areas for Improvement:** • While the DCO described its provision of interpretive services and the hiring of an in-house Latino specialist for culturally responsive services, no analysis of its membership was provided as rationale for the position. • The DCO did not demonstrate that member characteristics were considered when making provider assignments. • The DCO should ensure and demonstrate that the geographic distribution of members to the required provider service categories (i.e., EPDHs) is within the OHA-defined time, distance, and percentage of member access standards.

Appendix C. 2019 EQR Recommendations Follow-Up

HSAG, as the EQRO for OHA, conducted the EQR activities for the Oregon MCEs during CY 2019, identifying overarching recommendations for OHA in the 2019 External Quality Review Technical Report. Table C-1 is an account of the 2019 EQR recommendations and a summary of actions taken by OHA in CY 2020 based on those recommendations. Recommendations for individual MCEs are contained in standalone reports for each EQR activity and are provided regularly to both OHA and the MCEs.

Table C-1—2019 EQR Recommendation Follow-Up

#	2019 EQR Recommendations	Action Taken During 2020
EQR Process Recommendations		
1.	Ensure appropriate timing of activities so that activities involving the same CCO staff members do not unnecessarily overlap.	OHA in coordination with HSAG worked to ensure an offset deliverable schedule for both the 2020 and 2021 workplans.
2.	Coordinate OHA and HSAG communications with MCEs regarding EQR activities, ensuring the right MCE staff members are involved in such communications.	OHA in coordination with HSAG made progress on a communications plan, which delineated the appropriate parties to send and receive communications about specific topics.
3.	Clarify regulatory references to eliminate ambiguity in areas where a high degree of interpretation is required.	OHA and HSAG identified areas of high need for regulatory interpretation and provided TA to MCEs on those subjects.
4.	Continue QI efforts to ensure streamlined and value-added EQR activities.	OHA and HSAG continued QI efforts in 2020 per the OHA/HSAG QI Protocol document.
EQR CMR Recommendations		
1.	**Documentation:** Across the MCEs, clear documentation on processes and delegation activities was not demonstrated. For many MCEs, policies were in place that provided evidence of activities being conducted, but the procedural detail, time frames, and roles and responsible parties were lacking. In some cases, the applicability of policies was also unclear due to policies not including the MCE's name or being accompanied by clear delegation agreements when they are directed from a delegate. Documentation (e.g., policies and procedures, contracts, etc.) should be developed and maintained to clearly and effectively define MCE operational and delegated activities, ensuring compliance with regulations and contractual provisions related to Medicaid members.	OHA and HSAG worked to ensure the 2020 CMR process provided consistent messaging on the need for clear and effective operational and delegate documentation. HSAG provided TA wherever appropriate, both through the formal CMR process (including onsite reviews) and through standalone TA efforts.

#	2019 EQR Recommendations	Action Taken During 2020
2.	**Interpretation:** EQR activities over the last year identified inconsistencies with how MCEs are interpreting specific regulatory and contractual requirements. HSAG recommends that OHA ensure contractual and other guidance documentation include consistent interpretations of regulatory requirements. OHA can also assess which regulatory areas experience the most inconsistent interpretations (e.g., care coordination) and target opportunities for TA across the MCEs.	OHA worked to ensure that all points of contact between OHA and the MCEs provided consistent interpretations of regulatory requirements. OHA in coordination with HSAG provided one-on-one TA and feedback to the MCEs on the highest-need areas of regulatory interpretation (e.g., care coordination).
3.	**Follow-Up on Findings:** HSAG recommends that follow-up on findings from EQR activities be addressed soon after the findings are reported, rather than during the next year's EQR activities. This would ensure the same MCE staff members and reviewers are available to recall the issues and context of the findings in order to appropriately address them and would also help ensure that compliance issues are mitigated immediately.	OHA and HSAG implemented a system for CMR follow-up that includes quarterly follow-up on findings.
4.	**Care Coordination and Treatment Plans:** CCOs continue to struggle with care coordination and appropriately developing and maintaining treatment plans. Delegation also continues to make care coordination challenging, especially when there are no formalized systems or processes in which to capture and maintain treatment plans. Specifically, the systems most MCEs are continuing to use allow the tracking of care coordination in the form of notes, but do not clearly contain treatment plan information, specific diagnostic/referral criteria, treatment goals, or a crosswalk of care activities with claims. OHA should continue to work with the MCEs to provide guidance on care coordination, treatment planning, and effective care coordination system functionality, especially when these functions are delegated to other entities. It is additionally necessary for the MCEs to be able to properly identify and track individuals with SHCN to proactively ensure they are receiving the services they need.	OHA in coordination with HSAG provided one-on-one TA and feedback to MCEs on care coordination in the areas of treatment planning, effective care coordination system functionality, delegate oversight, and proper identification and tracking of individuals with SHCN.
5.	**Contracting with Out-of-Network Providers:** DCO compliance reviews identified the need to ensure that the DCOs properly contract with out-	OHA and HSAG worked to ensure that the DCOs implemented formal agreements when providing out-of-network care such that contracted providers

#	2019 EQR Recommendations	Action Taken During 2020
	of-network providers to provide oral health care services to members. Many of the DCOs lacked formal contracts or agreements with out-of-network providers, which could result in liabilities related to service costs and member care. OHA should ensure the DCOs utilize formal agreements when providing out-of-network care that require such providers to adhere to any pertinent DCO policies and secure pricing for services.	adhered to any pertinent DCO policies and services pricing.
6.	**Readability:** While this area continues to be a challenge across all MCEs, there is a clear acknowledgement that readability is a priority to achieve a significant impact on health literacy for their members. Part of the challenge is related to the inconsistency of readability tools. OHA should identify a consistently accurate readability tool for the MCEs to use when assessing member materials.	OHA identified a consistent standard and tool for assessing member material readability. OHA and HSAG clearly and consistently communicated the standard (sixth-grade reading level) and tool (Microsoft Word Flesch-Kincaid) to use when assessing member material readability.
7.	**Delegation Accountability:** OHA should continue working with the MCEs on identifying clear expectations for oversight activities. The concept of care coordination brings together a broad array of organizations that partner together in order to integrate care across physical, behavioral, and oral health care for Medicaid members. While this integration can enhance quality of care for members, the complexity of managing those partnerships may lead to a decrease in quality due to a lack of clarity in expectations and oversight. Many of the Oregon MCEs have contractual relationships with delivery partners that are clear, but the monitoring of delegated activities is being done inconsistently, in a way that does not define what is being reviewed regularly, and not at all in some cases. The MCEs are ultimately accountable for all activities subcontracted or delegated to other organizations or providers.	OHA and HSAG used the CMR process to provide clear direction and TA to the MCEs on the expectations for delegate monitoring and oversight for the compliance standards under review in 2020. Currently, OHA is working internally to assess whether requirements for the delegation of managed care functions should be further addressed or expanded.
EQR PIP Recommendations		
1.	**Quarterly Progress Report Redesign:** HSAG recommends that OHA consider a redesign of the quarterly PIP Progress Report Template to better align with CMS' EQR protocols, support clearer	OHA approved and implemented a redesigned quarterly PIP Progress Review Tool designed by HSAG to better align with CMS' EQR protocols and streamline feedback on PIP activities for OHA and the CCOs. OHA has also made efforts to facilitate more effective TA by providing the

#	2019 EQR Recommendations	Action Taken During 2020
	documentation of PIP activities by the CCOs, and facilitate more effective TA.	CCOs more frequent information and forums to discuss PIP activities. OHA continues to work with HSAG on improving the quarterly PIP Progress Report process to increase CCO accountability and facilitate TA.
2.	**Feedback to CCOs on Quarterly Progress Reports:** HSAG recommends that OHA consider sharing HSAG's written feedback on the quarterly statewide PIP progress reports directly with the CCOs to facilitate communication and TA opportunities.	OHA reviewed HSAG's written feedback on quarterly statewide PIP progress reports and provided TA directly to the MCEs in response to HSAG's feedback. In December 2020, OHA conducted comprehensive PIP progress check-ins with all CCOs in response to HSAG's feedback on the PIP progress reports.
3.	**Ensuring Improvement Strategies Directly Impact Defined Outcome Measures:** HSAG recommends that OHA work with the CCOs to ensure the improvement strategies developed for the new statewide PIP on acute opioid prescribing address barriers identified through root cause analysis and can be expected to directly impact the outcome measures defined for the PIP.	OHA abandoned the statewide PIP on acute opioid prescribing in favor of a new statewide PIP. This new PIP is currently being developed and will be validated in 2021. While the new statewide PIP will focus on a separate topic for improvement, OHA continues to provide guidance to the CCOs on opioid prescribing and opioid medication management through the Opioid Prescribing Guidelines Taskforce.[C-1]
4.	**Promoting Efficient CCO Engagement in Statewide PIP Activities:** HSAG recommends that OHA examine processes that may promote a balance of CCO engagement with efficient progress in PIP activities. OHA may want to consider staffing, planning, and scheduling needs that may support the timely progression of PIP activities.	OHA has worked with HSAG to provide additional TA sessions for the MCEs on the PIP activities and expectations. In addition, OHA's QA department has been actively involved in PIP activities to ensure better engagement and communications regarding PIP activities. OHA is also considering hiring additional staff members to support ongoing PIP activities at the State level.
EQR PMV Recommendations		
1.	All five performance measure indicators in the scope of HSAG's PMV activities for CY 2019 were compliant with the measure specifications and the rates can be reported. HSAG did not identify any issues or concerns with the accuracy or validity of OHA's calculation of the performance measure rates. However, given OHA's reliance on CCO-submitted encounters for calculating performance measures, HSAG	OHA in coordination with HSAG implemented a formal EDV EQR activity in 2020.

[C-1] Oregon Health Authority. Opioid Prescribing Guidelines Task Force. Available at: https://www.oregon.gov/oha/PH/PREVENTIONWELLNESS/SUBSTANCEUSE/OPIOIDS/Pages/task-force.aspx. Accessed on: Mar 16, 2021.

#	2019 EQR Recommendations	Action Taken During 2020
	recommends OHA implement a more formal process for evaluating the completeness and accuracy of encounter data used in calculating incentive measures.	
EQR DSN Recommendations		
1.	**Standardizing DSN Reporting:** HSAG recommends further standardization of OHA DSN reporting templates to ensure alignment with contractual provisions, minimize inconsistent interpretations of the elements, and reduce ambiguity around appropriate types of supplemental documentation. This should include moving away from assessing providers using the categories of service list and instead using the Standardized Healthcare Provider Taxonomy Code Set and clearly defining specific provider types (e.g., PCPs).	OHA contracted with HSAG to conduct a data structure questionnaire to better understand MCE processes involving provider data collection, classification, storage, validation, and maintenance, including use of provider taxonomy codes. The survey will be conducted in 2021, and the results will be used to develop a provider taxonomy crosswalk and methodology for the analysis of provider capacity data using the Standardized Healthcare Provider Taxonomy Code Set for specific provider types (e.g., PCPs, specialists, and facilities).
2.	**Addressing Provider Capacity:** HSAG recommends OHA adjust the self-reported mechanism currently used to evaluate capacity to ensure a value-added approach to understanding access to care. This could include a provider directory comparative analysis with provider capacity data reported to OHA and secret shopper calls to assess capacity directly with provider offices.	HSAG began a provider directory validation activity using MCE provider capacity data and online directories to ensure members have appropriate access to provider information. Results of the provider directory validation will be reported in 2021. Additionally, OHA contracted with HSAG to conduct a one-time secret shopper telephone survey among PCPs for the CCOs and general and pediatric dentists for the DCOs to assess appointment availability/timeliness in 2021. Secret shopper survey results will be reported in 2022.
3.	**TA to CCOs:** Due to inconsistencies in CCO reporting of DSN data elements, OHA should provide additional DSN reporting guidance in the form of TA on compliance expectations and proper reporting.	HSAG conducted a TA session with the MCEs in July 2020 to provide information and guidance on the DSN protocol and instructions including specifications for provider capacity data submissions. HSAG additionally provided TA to the DCOs and CCOs requesting additional guidance.