

Oregon Health Authority

2024 External Quality Review Technical Report

April 2025



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Abbreviations and Acronyms Used in This Report

42 CFR	Title 42 of the Code of Federal Regulations
AL/ADLs	Aggregate Lifetime and Annual Dollar Limits
ALIM	Allergy & Immunology
BH	Behavioral Health
BI	Business Intelligence
BIPOC	Black, Indigenous, and People of Color
BY	Baseline Year
CASS	Coding Accuracy Support System
CCO	Coordinated Care Organization
CHIP	Children's Health Insurance Program
CLAS	Culturally and Linguistically Appropriate Services
CMHC	Community Mental Health Center
CMHP	Community Mental Health Provider
CMR	Compliance Monitoring Review
CMS	Centers for Medicare & Medicaid Services
COBA	Coordination of Benefits Agreement
COVID-19	Coronavirus Disease 2019
CRD	Cardiology
CY	Calendar Year
DERM	Dermatology
DMAP	Division of Medical Assistance Programs
DME	Durable Medical Equipment
DNR	Do Not Report
DOS	Date of Service
DRG	Diagnosis-Related Group
DSN	Delivery System Network
EC	Emergency Care
ED	Emergency Department
EDV	Encounter Data Validation
END	Endocrinology
EQR	External Quality Review

EQRO.....	External Quality Review Organization
FFS.....	Fee-for-Service
FR.....	Financial Requirement
GST.....	Gastroenterology
HALO.....	Health Assistance, Linkage, and Outreach
HB 3046.....	Oregon House Bill 3046
HCPCS.....	Healthcare Common Procedure Coding System
HEDIS [®] , ¹	Healthcare Effectiveness Data and Information Set
HEM.....	Hematology
HOSP.....	Hospital
HRA.....	Health Risk Assessment
HSAG.....	Health Services Advisory Group, Inc.
ICD-10.....	International Classification of Diseases, 10th Revision
ICN.....	Internal Control Number
ID.....	Identification
IET.....	Initiation and Engagement in Treatment
IP.....	Inpatient
ISCA.....	Information Systems Capabilities Assessment
ISCAT.....	Information Systems Capabilities Assessment Tool
LTSS.....	Long-Term Services and Supports
M-ONC.....	Medical Oncology
MCE.....	Managed Care Entity
MCO.....	Managed Care Organization
MH.....	Mental Health
MHP.....	Mental Health Parity
MHPAEA.....	Mental Health Parity and Addiction Equity Act of 2008
MM.....	Member Months
MMIS.....	Medicaid Management Information System
MOTS.....	Measures and Outcomes Tracking System
MRR.....	Medical Record Review
M/S.....	Medical/Surgical
MTD.....	Methadone Clinic
MY.....	Measurement Year
NA.....	Not Applicable

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

NAV	Network Adequacy Validation, also referred to as Validation of Network Adequacy
NCQA	National Committee for Quality Assurance
NDC	National Drug Code
NEMT	Non-Emergent Medical Transportation
NEPH	Nephrology
NEUR.....	Neurology
NOABD	Notice of Adverse Benefit Determination
NPI	National Provider Identifier
NQTL	Non-Quantitative Treatment Limitation
NVS.....	Network Validation Survey
OARs.....	Oregon Administrative Rules
OB/GYN	Obstetrics/Gynecology
OHA.....	Oregon Health Authority
OHP.....	Oregon Health Plan
OP	Outpatient
OPH.....	Ophthalmology
OPT	Optometry
OT	Occupational Therapy
OTO	Otolaryngology
PA	Prior Authorization
PAHP	Prepaid Ambulatory Health Plan
PBM	Pharmacy Benefit Manager
PCCM	Primary Care Case Management
PCD.....	Primary Care Dentist
PCP	Primary Care Provider
PDT	Pacific Daylight Time
PHE.....	Public Health Emergency
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Project
PMV	Performance Measure Validation
POD.....	Podiatry
PSV	Primary Source Verification
PSYC.....	Psychiatry
PT	Physical Therapy
PUL.....	Pulmonology
Q.....	Quarter

QA.....	Quality Assurance
QAPI	Quality Assessment and Performance Improvement
QHCI.....	Qualified Health Care Interpreter
QHOC	Quality and Health Outcomes Committee
QI	Quality Improvement
QM	Quality Management
QTL.....	Quantitative Treatment Limitation
R.....	Reportable
R-ONC	Radiation Oncology
REALD	Race, Ethnicity, Language, and Disability
RHEU.....	Rheumatology
Rx.....	Pharmacy
RY	Remeasurement Year
SDOH.....	Social Determinants of Health
SHCN.....	Special Health Care Needs
SLP.....	Speech Language Pathology
SNF	Skilled Nursing Facility
SOGI	Sexual Orientation and Gender Identity
SUD.....	Substance Use Disorder
THW	Traditional Health Worker
UM.....	Utilization Management
URO	Urology
WDG.....	Willamette Dental Group

1. Executive Summary

Report Purpose and Overview

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

Under Oregon's 2022–2027 Section 1115(a) Medicaid demonstration waiver approved by the Centers for Medicare & Medicaid Services (CMS) on September 28, 2022, OHA contracts with 16 coordinated care organizations (CCOs) to deliver managed care physical, behavioral, and oral health benefits to members enrolled in the State Medicaid program ("members"), referred to as the Oregon Health Plan (OHP). The CCOs are accountable for providing integrated physical, behavioral, and oral health care benefits to members enrolled in the State's Medicaid managed care program. Each CCO is responsible for ensuring that services are delivered in a manner that complies with legal, contractual, and regulatory obligations to provide effective care.

Table 1-1 displays the 16 CCOs contracted with OHA and included in all external quality review (EQR) activities during calendar year (CY) 2024. No CCOs were exempt from the 2023–2024 reporting cycle.

Table 1-1—List of CCOs

CCO Plan Name ¹ⁱ	CCO Short Name ²
Advanced Health	AH
AllCare CCO, Inc.	AllCare
Cascade Health Alliance, LLC	CHA
Columbia Pacific CCO, LLC	CPCCO
Eastern Oregon CCO, LLC	EOCCO
Health Share of Oregon	HSO
InterCommunity Health Network	IHN
Jackson Care Connect	JCC
PacificSource Community Solutions—Central Oregon	PCS-CO
PacificSource Community Solutions—Columbia Gorge	PCS-CG
PacificSource Community Solutions—Lane	PCS-LN
PacificSource Community Solutions—Marion Polk	PCS-MP

CCO Plan Name ¹	CCO Short Name ²
Trillium Community Health Plan, Inc.–Southwest	TCHP-SW
Trillium Community Health Plan, Inc.–Tri-County	TCHP-TC
Umpqua Health Alliance, LLC	UHA
Yamhill Community Care Organization	YCCO

¹Trillium Community Health Plan, Inc., implemented changes affecting the terms used to reference its service regions, including Southwest (formerly South) and Tri-County (formerly North).

²Short names were revised for the CY 2024 EQR impacting HSO (formerly Health Share), PCS-LN (formerly PCS-Lane), TCHP-SW (formerly TCHP-South), and TCHP-TC (formerly TCHP-North).

Scope of External Quality Review

As set forth in 42 CFR §438.358, HSAG conducted all EQR-related activities in compliance with the *CMS External Quality Review (EQR) Protocols, February 2023* (CMS EQR Protocols).² For the CY 2024 assessment, HSAG used findings from the mandatory and optional EQR activities displayed in Table 1-2 to derive conclusions and make recommendations about the quality, timeliness, and accessibility of health care services provided by the CCOs. Detailed information about each activity methodology is provided in Section 3 of this report.

Table 1-2—EQR Activities

Activity	Description
Compliance Monitoring Review (CMR)	This activity determines the extent to which the CCO is in compliance with federal standards and associated state-specific requirements, when applicable.
Validation of Performance Improvement Projects (PIPs)	This activity verifies whether a PIP conducted by a CCO used sound methodology in its design, implementation, analysis, and reporting.
Performance Measure Validation (PMV)	This activity assesses whether performance measures calculated by the State are accurate based on measure specifications and reporting requirements.
Validation of Network Adequacy (NAV)	This activity determines the extent to which a CCO's delivery system network has adequate provider networks in service areas to deliver timely care and an appropriate breadth of health care services to its managed care members and validates the CCO's methodology used to calculate network adequacy indicators to ensure accuracy, completeness, and consistency of reported results. Appointment availability is also assessed through access and availability surveys conducted by revealed telephone survey methods.

² Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols, February 2023*. Available at: <https://www.medicare.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: Feb 27, 2025.

Activity	Description
Encounter Data Validation (EDV)	This activity evaluates the CCO's processes for collecting, maintaining, and submitting accurate and complete encounter data.
Mental Health Parity (MHP) Evaluation	This activity determines whether coverage and access to mental health (MH)/substance use disorder (SUD) benefits were provided in parity with medical/surgical (M/S) benefits.

Aggregating and Analyzing Statewide Data

HSAG follows a four-step process to aggregate and analyze data collected from all EQR activities and draw conclusions about the quality, timeliness, and accessibility of health care services furnished by each CCO, as well as the program overall. To produce Oregon's 2024 annual EQR technical report, HSAG performed the following steps to analyze the data obtained and draw statewide conclusions about the quality, timeliness, and accessibility of health care services provided by the CCOs:

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

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

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

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

Quality, Timeliness, and Access

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

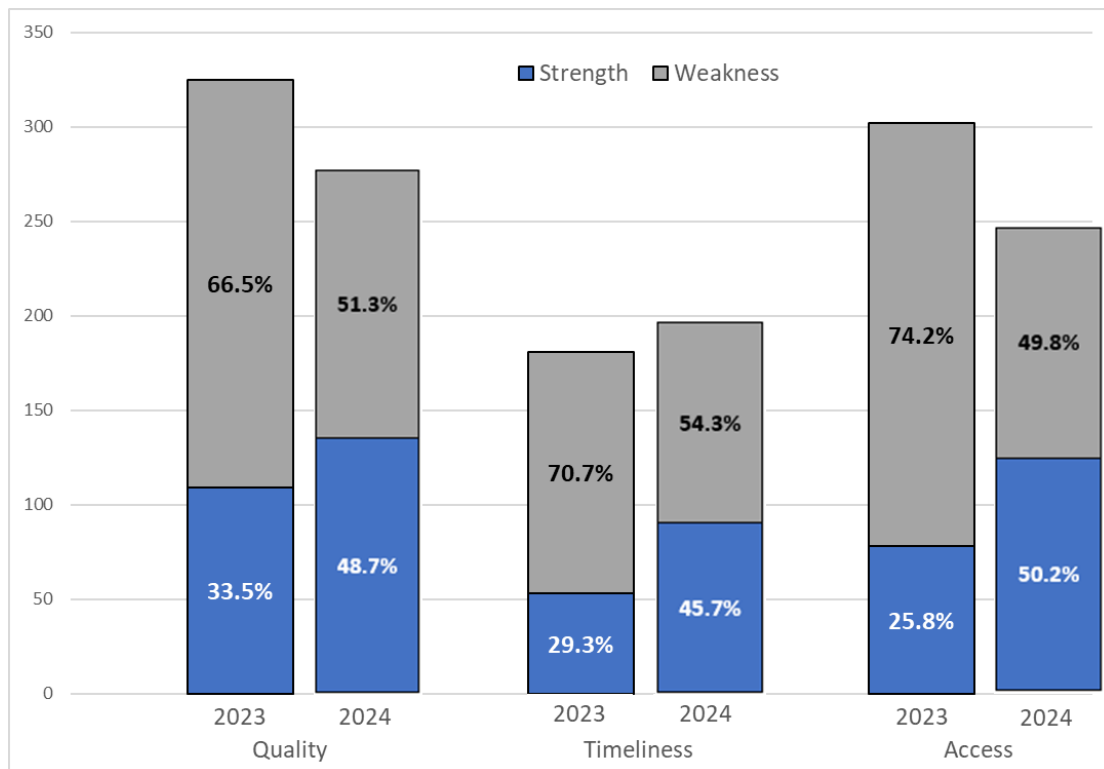
		
Quality as it pertains to EQR, means the degree to which an MCE (described in §438.310[c][2]) increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics, the provision of services that are consistent with current professional, evidence-based knowledge, and interventions for performance improvement.¹	Timeliness as it pertains to EQR, is described by the NCQA to meet the following criteria: “The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation.”² It further discusses the intent of this standard to minimize any disruption in the provision of healthcare. HSAG extends this definition to include other managed care provisions that impact services to members and that require a timely response from the MCE (e.g., processing expedited member appeals and providing timely follow-up care).	Access as it pertains to EQR, means the timely use of services to achieve optimal outcomes, as evidenced by MCEs successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (network adequacy standards) and §438.206 (availability of services). Under §438.206, availability of services means that each state must ensure that all services covered under the state plan are available and accessible to enrollees of MCEs in a timely manner.¹
¹ Department of Health and Human Services, Centers for Medicare & Medicaid Services. Federal Register Vol. 81 No. 18/Friday, May 6, 2016, Rules and Regulations, p. 27882. 42 CFR §438.320 Definitions; Medicaid Program; External Quality Review, Final Rule.		
² National Committee for Quality Assurance. <i>2013 Standards and Guidelines for MBHOs and MCOs</i>.		

Oregon Managed Care Program Conclusions and Recommendations

HSAG used its analyses and evaluations of EQR activity findings from CY 2024 to assess the CCOs’ performance in providing quality, timely, and accessible health care services to Oregon Medicaid members as required in 42 CFR §438.364. For each CCO reviewed, HSAG provides a summary of its overall key findings, conclusions, recommendations, based on the CCO’s performance, which can be found in Section 4 and Section 5 of this report. These findings include an assessment of the overall strengths and weaknesses based on the CCOs’ performance as well as the degree to which the CCOs addressed the recommendations and/or findings issued during CY 2023 and unresolved findings from CY 2020, CY 2021, and CY 2022. The overall findings and conclusions for all plans were also compared and analyzed to develop overarching conclusions and recommendations for the Oregon managed care program.

Figure 1-1 illustrates the number of strengths exhibited across all CCOs relative to the number of weaknesses identified across the three domains. The greater the proportion of weaknesses, the greater the opportunities for improvement relative to the CCOs’ strengths. Results are provided for both CY 2023 and CY 2024 activities to demonstrate changes in CCO performance.

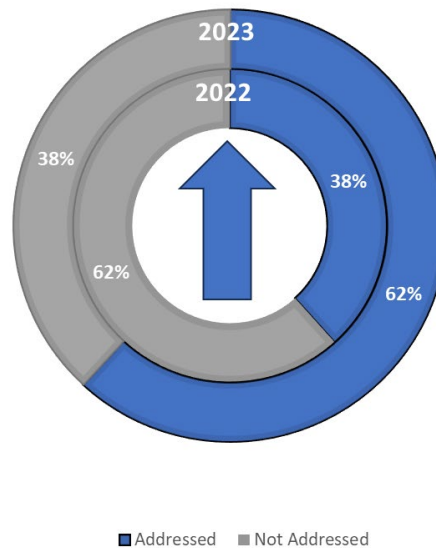
Figure 1-1—CCO Overall Number of Findings (Strengths and Weaknesses) by Domain



Overall, the results show a substantial increase in the number of strengths identified for the CCOs relative to the number of weaknesses across all three domains. While the number of weaknesses remained higher in two of the three domains (i.e., Quality [51.3 percent] and Timeliness [54.3 percent]), the CCOs exhibited a slightly higher number of strengths within the access domain (50.2 percent). Between CY 2023 and CY 2024, the relative percentage of weaknesses dropped from an average 40.9 percentage point difference to 3.6 percentage points. Although this finding demonstrates improvement, the findings continue to highlight considerable room for improvement across the CCOs.

Figure 1-2 illustrates the degree to which the CCOs sufficiently addressed the recommendations for quality improvement (QI) made by HSAG during the CY 2022 and CY 2023 EQR.

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



Overall, HSAG’s assessment of the CCOs’ responses and/or improvement plan outcomes revealed the CCOs were able to sufficiently address 62 percent of the recommendations for QI made during the CY 2023 EQR. Although the results indicate substantial opportunities for improvement exist for all CCOs, the results show 24 percentage point increase between CY 2022 and CY 2023. Each CCO had an opportunity to describe the activities and/or interventions implemented to address specific recommendations that were not evaluated by HSAG through the CY 2024 EQR activities. Four CCOs (PCS-CO, PCS-CG, PCS-LN, and PCS-MP) did not provide responses, and CHA and HSO’s responses did not address all of the recommendations. The CCOs not addressing identified findings and opportunities for improvements are at risk of remaining out of compliance with their contracts.

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

³ Oregon Health Plan. 2017–2022 Accountability Plan. Part II: Quality Strategy. Available at: https://www.oregon.gov/oha/HPA/DSI/QIDocs/2017-2022-Oregon-Health-Plan_Oregon-Accountability-Plan.pdf. Accessed on: Feb 27, 2025.

Table 1-3—Oregon Managed Care Program Substantive Findings

Program Strengths	Domain(s) ⁴
OHA's Quality Assurance unit expanded its CCO data analytics team, established a data analytics infrastructure and processes, improved deliverable reporting, and established additional monitoring tools to support improvements in quality of care for CCO enrolled Medicaid members.	
OHA developed a noncompliance escalation process for CCOs that will be used to address outstanding findings and other compliance-related issues which may result in improvement plans, corrective action plans, and/or other sanctions, depending on noncompliance length of time and severity. OHA has also onboarded additional data analysts with a focus on network adequacy and the quality of provider data reported to OHA by the CCOs.	
OHA has launched several initiatives to address the goals currently defined in the Oregon Medicaid Quality Strategy, including race, ethnicity, language, and disability (REALD) and sexual orientation and gender identity (SOGI) data initiatives to address member needs; payment initiatives targeted on expanding the use of direct payments for culturally and linguistically appropriate services (CLAS) and behavioral health/substance use disorder (BH/SUD) providers; care coordination initiatives; refining contract deliverables; strengthening grievance and appeal system reporting; and risk stratification initiatives.	
The CY 2024 CMR activity identified numerous best practices among the CCOs related to health equity initiatives with respect to availability of services and member-focused practices when adopting and reviewing practice guidelines.	  
The CCO's measurement year (MY) 2023 performance on the <i>Child and Adolescent Well-Care Visits</i> measure, the <i>Engagement of SUD Treatment—Ages 13 to 17 Years</i> and <i>Ages 18 Years and Older</i> measure indicators, the <i>Members Receiving Preventive Dental or Oral Health Services—Ages 1 to 5 Years</i> and <i>Ages 6 to 14 Years</i> measure indicators, and the <i>Oral Evaluation for Adults With Diabetes</i> measure increased statewide from MY 2022 to MY 2023.	  
All CCOs received a <i>High Confidence</i> rating for their overall adherence to acceptable methodology for all phases of the <i>Mental Health Service Access Monitoring</i> PIP as well as the <i>Initiation, Engagement, and Treatment of Alcohol and Other Drug Use Disorders</i> PIP, also referred to as the <i>Substance Use Disorder</i> PIP. All CCOs also conducted methodologically sound improvement strategies for both statewide PIPs.	  
All CCOs showed full implementation of OHA's new 2024 time and distance standards, which represented an operational improvement in CCO compliance with monitoring standards over previous years. In addition, all CCOs achieved a <i>High Confidence</i> validation rating, demonstrating the acceptable use of data collection	  

⁴  = Quality,  = Timeliness,  = Access

Program Strengths	Domain(s) ⁴
procedures, methods, and the calculation and interpretation of network adequacy time and distance results.	
Based on the findings outlined in the 2024 MHP Evaluation, and in collaboration with the community partner groups, the administration of MH/SUD and M/S benefits was largely found to be in parity for the CCOs.	
Program Weaknesses	Domain(s)
The Oregon managed care program demonstrated numerous opportunities for improvement during the CMR activity, resulting in required improvement plans to ensure corrective actions are implemented to achieve compliance with federal and State regulations. Additionally, none of the CCOs successfully resolved all of their CY 2023 CMR improvement plan findings, resulting in some CMR findings remaining noncompliant since the CY 2020 CMR audit.	
The Oregon managed care program was comprised of CCOs that relied heavily on multilayered, delegated arrangements to conduct core managed care functions outlined in the CCO Contract. Due to the lack of sufficient oversight, numerous opportunities for improvement were identified across multiple EQR activities.	
While the CCOs were able to demonstrate acceptable use of data collection procedures, network adequacy methods, and calculation of time and distance metrics, the CCOs participating in Oregon's managed care program continued to experience challenges describing and demonstrating effective systems to assess and monitor the adequacy of their provider networks, including the collection and use of provider, member, and network adequacy data to drive network adequacy monitoring and decision-making. In addition, the methodologies used to define distance for network adequacy indicator calculations (i.e., straight line versus driving distance) varied across CCOs.	
Although most CCOs demonstrated a high level of compliance with Oregon network adequacy standards across adult, pediatric, and facility providers, time and distance results varied by adult and pediatric populations and provider tiers. In addition, there were CCOs that did not have at least one provider within its network for each type of medical service that is covered under the health plan.	
The CCOs participating in the Oregon managed care program continued to implement a variety of approaches to monitoring appointment availability and using the data collected with widely varying degrees of relevance, rigor, and utility. As a result, data are not comparable across plans and, in some cases, are of limited value to support monitoring of network adequacy by individual CCOs and the overall Oregon managed care program. In addition, findings from the CY 2024 revealed telephone surveys demonstrated continued provider directory inaccuracies, limited appointment availability for primary care and outpatient (OP) SUD providers, and appointment wait times beyond the OHA appointment compliance standards.	
With one exception, all CCOs failed to achieve statistically significant improvement in overall indicator results from baseline to remeasurement year (RY) 1 for the <i>Substance Use Disorder</i> PIP.	

Program Recommendations	
Recommendation	Associated Quality Strategy Goals to Target for Improvement
Continue to identify additional clinical and operational goals that align with OHA's long-term objectives for improving the quality of equitable care among Medicaid members.	This recommendation does not apply to current quality strategy goals. It is an overarching recommendation for OHA to consider adding goals and objectives to its quality strategy that can be directly targeted to better support improvement in the quality, timeliness, and access to health care services furnished to Medicaid members.
Identify non-CCO incentive-based quality measures that are tied to OHA's quality strategy objectives and set specific targets or benchmarks to assess performance and progress on the established goals.	Goal 1: Improve the BH system and address barriers to access to and integration of care. Goal 2: Increase value and pay for performance. Goal 3: Focus on social determinants of health (SDOH) and health equity. Goal 4: Maintain sustainable cost growth and ensure financial transparency.
Establish guidelines for the CCOs implementing acceptable methodologies for measuring appointment wait times, as well as develop performance thresholds for determining provider network compliance with appointment availability standards.	Goal 1: Improve the BH system and address barriers to access to and integration of care. Goal 2: Increase value and pay for performance.
Develop comprehensive technical specifications to ensure consistent and accurate calculation of time and distance metrics to ensure consistency across all CCOs. The technical specifications should address data cleaning, population definitions, calculation parameters, and reporting guidelines.	Goal 1: Improve the BH system and address barriers to access to and integration of care. Goal 2: Increase value and pay for performance. Goal 3: Focus on SDOH and health equity. Goal 4: Maintain sustainable cost growth and ensure financial transparency.
Require all CCOs to have at least one provider within its contracted network for each type of medical service that is covered under the health plan, ensuring that members can access necessary care, regardless of the specialty within the CCO's provider network.	Goal 1: Improve the BH system and address barriers to access to and integration of care. Goal 2: Increase value and pay for performance. Goal 3: Focus on SDOH and health equity.

Managed Care in Oregon

OHP is the source of health coverage for approximately 1.4 million Oregonians for physical, behavioral, and dental services, with most care provided through the CCOs.⁵ Members who receive services through the State’s fee-for-service (FFS) program are excluded from this report; only members receiving services from the CCOs fall under the purview of this annual EQR technical report.

CCOs are networks of health care providers who work together in their local communities to serve members who receive health care coverage under OHP. The CCOs’ coordinated care model is focused on prevention and managing chronic conditions to reduce costs and support better health. In 2024, there were 16 CCOs providing physical, behavioral, and oral health care services to OHP members in Oregon. All CCO contracts with Medicaid expansion began January 1, 2020, with the exception of TCHP-TC, which was awarded a contract in September 2020.

Table 2-1 displays the CCOs and their enrollment totals as of January 2025.⁶ The numbers in the table were provided by OHA’s Health Analytics Division and were considered preliminary at the time of this report.

Table 2-1—OHP Enrollment by CCO

CCO	Total Members
AH	28,666
AllCare	66,671
CHA	27,660
CPCCO	38,741
EOCCO	81,833
HSO	466,300
IHN	87,395
JCC	68,345
PCS-CO	79,647
PCS-CG	19,210
PCS-LN	95,356
PCS-MP	160,575

⁵ Oregon Health Authority. Medicaid Enrollment Report for Oregon for: Jan 2025, All Age Groups, Updated January 2025. Available at: <https://www.oregon.gov/oha/HPA/ANALYTICS/Pages/Medicaid-enrollment.aspx#Dashboard>. Accessed on: Feb 20, 2025.

⁶ Ibid.

CCO	Total Members
TCHP-SW	36,339
TCHP-TC	71,337
UHA	40,576
YCCO	38,700
Total Enrolled in a CCO	1,407,351

Oregon's Medicaid Quality Strategy

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

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

Table 2-2—OHA Quality Strategy Goals and Objectives

Triple Aim Dimension	OHA Goals	Objectives and Strategies to Achieve Goals
Improving the member experience of care	1. Improve the BH system and address barriers to access to and integration of care	- Integrate behavioral, physical, and oral health to allow members to receive the right care at the right time and in the right place - Focus on BH (MH and SUD) services - Assure needs of children with serious BH needs are addressed as a priority
	2. Increase value and pay for performance	- Reward providers' delivery of patient-centered and high-quality care - Reward health plan and system performance - Ensure consideration of health disparities - Align payment reforms with other State and federal efforts
Improving the health of Oregonians	3. Focus on SDOH and health equity	- Build stronger relationships between the CCOs and other sectors - Align outcomes between health care and other social systems to improve health equity

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

OHA evaluates progress in meeting its quality strategy goals through:

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

Annual Quality Strategy Evaluation

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

- Oregon Health Policy Board—develops strategic direction of health system transformation.
- OHA Quality Council—monitors clinical quality performance, health system transformation, and QI.
- Medicaid Advisory Committee—advises OHA on the policies, procedures, and operation of OHP.
- Medicaid Division CCO Quality Assurance—monitors the CCOs for contract compliance, EQR, and quality assurance (QA) elements (complaints, fraud, waste, abuse).
- Quality Management Committee—provides overall structure for OHP quality governance to monitor and improve quality initiatives.
- Health delivery system (partnership committees with delivery system and OHA).
 - Quality and Health Outcomes Committee (QHOC)—monitors clinical quality performance with improvement strategy development and implementation.
 - Health Evidence Review Committee—reviews and develops evidence-based practices for all CCOs (including FFS).

- CCO Operations Collaborative and Contracts and Compliance Workgroup—monitors compliance with CCO Contract requirements and provides guidance on the operational implementation of requirements.

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

HSAG made recommendations in the CY 2023 EQR technical report for OHA based on the conclusions drawn from activities conducted. Table 2-3 is a summary of the follow-up actions that OHA completed in response to HSAG’s recommendations during CY 2023. The information included within the “OHA Action” column of this table was provided by OHA.

Table 2-3—HSAG Recommendations With OHA Actions

HSAG CY 2023 Recommendation	OHA Action
Identify additional clinical and operational goals that align with OHA’s long-term objectives for improving the quality of equitable care among Medicaid members.	In 2024, OHA’s operational goal was to improve its ability to monitor CCO quality of care. To achieve this goal, OHA’s CCO Quality Assurance unit expanded its CCO data analytics team, established a data analytics infrastructure and processes, improved deliverable reporting, and established an initial set of monitoring tools. OHA will continue to build upon these efforts to establish additional monitoring tools to support improvements in quality of care for CCO-enrolled Medicaid members. Additionally, OHA improved care coordination regulatory requirements to address member challenges in accessing care coordination. OHA modified the requirements to ensure care coordination is available and provided to all members identified as medium to high risk; defined expectations for ongoing monitoring of needs through a care profile; and identified the requirements of a care plan. OHA is currently developing its monitoring strategy for CY 2025 to ensure compliance with the requirements.
Identify non-CCO incentive-based quality measures that are tied to OHA’s quality strategy objectives and set specific targets or benchmarks to assess performance and progress on the established goals.	OHA is working on updating its Oregon Medicaid Quality Strategy. Quality measure development will follow the development of the quality strategy objectives. Data driven dashboards to assess performance will be used to guide progress to established goals.
Require all CCOs to use the state-developed model member handbook and member notice templates to ensure compliance with 42 CFR §438.10(c)(4)(ii).	OHA added the requirement in the CCO Contract as well as the Oregon Administrative Rules (OARs) that for CY 2026, the CCOs must use OHA’s model member handbook. Most CCOs have adopted the existing model member handbook for 2025.

HSAG CY 2023 Recommendation	OHA Action
	OHA has not explicitly required the CCOs to use the model notice templates provided by the State. However, OHA has issued member notice templates for use by the CCOs and evaluated notices of adverse benefit determination (NOABDs) quarterly using criteria based on State and federal requirements. OHA implemented a process to ensure that the CCOs respond to and correct findings identified in their NOABDs. Based on the severity and frequency of the finding(s), the CCOs are also required to conduct a root cause analysis to determine the cause(s) of noncompliance and implement a plan to correct their internal processes and submit evidence thereof. Additionally, the CCOs are required to establish ongoing monitoring/auditing to ensure sustained compliance. OHA has communicated to the CCOs that any NOABD template findings existing after December 31, 2025, will be referred to the noncompliance escalation process.
Strengthen and clarify requirements and expectations of the CCOs with regard to oversight and compliance of their subcontractors.	In CY 2024, OHA revised 2025 CCO Contract language and reporting tools, effective January 1, 2025, to strengthen and clarify requirements related to CCO oversight and compliance of subcontractors, including downstream entities. OHA updated subcontractor-related CCO Contract deliverables to ensure alignment with contract changes, provide clarity regarding the content of annual Subcontractor Performance Reports, and ensure subcontractors are regularly reporting and monitoring any/all downstream entities performing CCO Contract-specific functions. OHA also enhanced CCO reporting tools to capture subcontractor data related to grievances, prior authorizations (PAs), denials, and appeals to allow for in-depth data analyses and monitoring of trends. The Quality Assurance unit has also increased resources to provide enhanced auditing and recommendations for improvement.
Ensure CCO-specific PIP performance indicator data are provided at the earliest opportunity so that the CCOs can use community-level data to guide root cause analyses, identify high-priority barriers to improvement, and develop innovative and appropriate interventions. OHA should ensure that indicator data updates are clearly communicated to the CCOs to	OHA provides each CCO with CCO-specific PIP performance indicator data as soon as possible given the three-month claims rollout/reconciliation period that is also followed by the Quality Metrics program. Statewide CCO summary files and member-level detail files are made available to the CCOs through monthly posting to the secure Microsoft SharePoint sites specific to each respective CCO,

HSAG CY 2023 Recommendation	OHA Action
facilitate effective, data-driven assessment of progress toward achieving improvement.	generally on the last Wednesday of every month. Staff from the Quality Metrics team announce the posting of the PIP files as part of a monthly alert correspondence with the CCOs. In some unique cases, the posting date for these files must be delayed due to research and testing associated with National Committee for Quality Assurance (NCQA) coding certification or other specification updates. In these situations, OHA communicates the delay to the CCOs. For the <i>Substance Use Disorder</i> PIP measure, any changes to PIP performance indicators are communicated in a documentation tab on the Quarterly Performance Metrics dashboard. Additionally, major changes have been discussed during technical assistance sessions through QHOC, when requested. For CY 2025, OHA has added additional technical assistance at the beginning of the year and will include OHA analysts in the annual PIP training for the CCOs hosted by HSAG.
Establish guidelines for the CCOs implementing acceptable methodologies for measuring appointment wait times, as well as develop performance thresholds for determining provider network compliance with appointment availability standards.	OHA will prioritize establishing acceptable methodologies for measuring appointment wait times as well as associated performance thresholds in CY 2025. Beginning in 2025, OHA will begin the planning phase to implement new appointment wait time standards established by CMS in the Medicaid and Children’s Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality rule.
Develop compliance thresholds for CMR standards and Delivery System Network (DSN) provider data quality and reporting to monitor and hold the CCOs accountable for findings that remain unresolved for multiple review years.	OHA developed a noncompliance escalation process for the CCOs that will be used to address outstanding findings and other compliance-related issues which may result in improvement plans, corrective action plans, and/or other sanctions, depending on noncompliance length of time and severity. OHA has also onboarded additional data analysts with a focus on network adequacy and the quality of provider data reported to OHA by the CCOs.

In CY 2024, OHA continued to work collaboratively with CMS on its alignment of the quality strategy with the 2022–2027 Medicaid 1115 Demonstration Waiver. OHA launched several initiatives to achieve the goals that are currently defined in the Oregon Medicaid Quality Strategy, including:

- Data Initiatives:
 - Provided the CCOs with REALD and SOGI data to inform and address member needs.
 - OHA began disaggregating data by REALD and SOGI to assess disparities between populations.

- Payment Initiatives:
 - Expanded use of directed payments for CLAS and BH/SUD providers.
- Care Coordination Initiatives:
 - Updated care coordination requirements mandating the development of operational, technological, and care management infrastructure to ensure access to care coordination services for all members.
- CCO Contract Improvements:
 - Convened workgroups with the CCOs to refine contract deliverables, including incorporating new data elements and strengthening grievance and appeal system reporting.
- Risk Stratification Initiative:
 - Conducted virtual demonstrations and technical assistance sessions to assist the CCOs with implementation of risk stratification models.
 - Focused on identifying care management plans for individual members, with special attention on special health care needs (SHCN), long-term services and supports (LTSS), and BH populations.

OHA also began collaborating with internal and external partners to revise and update the Oregon Medicaid Quality Strategy goals and objectives. Areas identified include, but are not limited to:

- Improving quality and access to care through equity-centered and data-driven interventions.
- Incorporating screening and support to address health-related social needs through quality measurement, coordination with community partners, opportunities for payment, and collection of social needs data in standardized formats.
- Improving integration and care coordination to ensure underserved and high-risk complex members have the appropriate interventions to support their individual needs.
- Demonstrating meaningful improvement in access to culturally and linguistically appropriate services and supports that are understandable, respectful, and responsive to preferred languages, health literacy, and other diverse communication needs.
- Enhancing oversight of CCO subcontractors and downstream entities to improve quality of care.
- Developing a plan for CCO operational infrastructure that supports implementation of contractual and regulatory requirements.

OHA has remained committed to progressing the Oregon Medicaid Quality Strategy through collaboration and initiatives, and with an emphasis on improving the quality, timeliness, and accessibility of health care services for all Medicaid beneficiaries. OHA will continue to monitor progress and its approach to meet the changing needs of Oregon's Medicaid members.

3. Methodology

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

Compliance Monitoring Review

Background

CMRs assess CCO compliance with the federal compliance review standards outlined in 42 CFR §438.358(b)(1)(iii) and related State contract requirements. CY 2023 began the new three-year review cycle for the CCOs, and HSAG will complete the comprehensive review of compliance with all federal requirements stipulated in 42 CFR §438.358(b)(1)(iii) in CY 2025. HSAG's CY 2024 CMR of provider-focused standards included the following:

- Standard I—Assurance of Adequate Capacity and Availability of Services
- Standard V—Provider Selection
- Standard VI—Subcontractual Relationships and Delegation
- Standard XI—Practice Guidelines

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

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

Standard ¹	Federal Requirements Included	Year of Review		
		2023	2024	2025
Standard I—Assurance of Adequate Capacity and Availability of Services ²	42 CFR §438.206 42 CFR §438.207		✓	
Standard III—Coordination and Continuity of Care	42 CFR §438.208	✓		
Standard IV—Coverage and Authorization of Services	42 CFR §438.210	✓		
Standard V—Provider Selection	42 CFR §438.12 42 CFR §438.214		✓	
Standard VI—Subcontractual Relationships and Delegation	42 CFR §438.230		✓	
Standard VII—Member Rights and Protections	42 CFR §438.100– 42 CFR §438.102	✓		
Standard VIII—Confidentiality	42 CFR §438.224			✓

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

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

² Standard I—Availability of Services and Standard II—Assurances of Adequate Capacity and Services were combined, and all elements required by 42 CFR §438.206 and §438.207 were assessed under the combined Standard I—Assurance of Adequate Capacity and Availability of Services during the CY 2024 CMR activity.

Objectives

The objectives of the CMR activity were to:

- Evaluate each CCO’s compliance with federal Medicaid managed care regulations, OARs, and contract requirements with the standard areas reviewed.
- Conduct a follow-up reevaluation of any CCO that required implementation of corrective actions in order to attain full compliance to previously reviewed standards.
- Identify strengths and opportunities for improvement related to quality, timeliness, and accessibility of care and services furnished by each CCO, as well as any required actions necessary to comply with State and federal regulatory requirements within the specific areas reviewed.
- Provide additional recommendations to improve the quality of the CCO’s care provided and services offered related to the areas reviewed, where appropriate.

Technical Methods of Data Collection

To assess for the CCOs' compliance with regulations, HSAG conducted the five activities described in the CMS EQR *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 3).⁷ Table 3-2 describes the five protocol activities and the specific tasks that HSAG performed to complete each activity.

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

Protocol Activities	Steps Associated with Protocol Activities
Activity 1:	Establish Compliance Thresholds
	- Conducted before the review to assess compliance with federal managed care regulations and OHA requirements: - HSAG and OHA participated in meetings to determine the timing and scope of the reviews, as well as any applicable scoring strategies. - HSAG developed and submitted the CMR Protocol, compliance review tools, and technical assistance webinar slides. - OHA reviewed and approved the CMR compliance review tools.
Activity 2:	Perform Preliminary Review
	- HSAG distributed the CMR Protocol, compliance review tools, and applicable guidance to the CCOs. - HSAG hosted a preliminary review technical assistance session with the CCOs. - HSAG scheduled the in-person and virtual site visits, distributed the site visit meeting agendas, and conducted preliminary phone calls with the CCOs scheduled for in-person site visits to facilitate preparation of HSAG's site visits. - HSAG received and reviewed all documentation submitted for the CY 2023 review period (i.e., January 1, 2023, through December 31, 2023) prior to the virtual and in-person site visits to increase its knowledge and understanding of each CCO's operations, identify areas needing clarification, and begin compiling information before the in-person and virtual site visits.
Activity 3:	Conduct Site Visit Review
	- HSAG conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG's in-person and virtual site visit review activities. - HSAG reviewed additional documents requested and made available by the CCOs during the interview sessions. - HSAG reviewed applicable data systems used in the CCOs' operations.

⁷ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023. Available at: <https://www.medicare.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf>. Accessed on: Feb 27, 2025.

Protocol Activities	Steps Associated with Protocol Activities
	– HSAG conducted interviews with the CCOs’ key administrative and program staff members. – HSAG conducted a closing conference during which HSAG reviewers summarized their preliminary findings and next steps.
Activity 4:	Compile and Analyze Findings
	• HSAG used the CMR report template to compile the findings and incorporate information from the CMR activities. • HSAG analyzed the findings and calculated final scores based on pre-established scoring strategies. • HSAG determined opportunities for improvement, recommendations, and required actions based on the review findings.
Activity 5:	Report Results to OHA
	• HSAG populated and submitted the draft reports to OHA and the CCOs for review and comment. • HSAG incorporated the feedback, as applicable, and finalized the reports. • HSAG included a pre-populated improvement plan template along with the final report for all requirements determined to be out of compliance with managed care regulations (i.e., received a score of <i>Partially Met</i> or <i>Not Met</i>). • HSAG distributed the final reports to the CCOs and OHA.

Description of Data Obtained

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

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

How Data Were Aggregated and Analyzed

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

Met indicates full compliance, defined as:

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

Partially Met indicates partial compliance, defined as:

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

Not Met indicates noncompliance, defined as:

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

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

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

How Conclusions Were Drawn

Using the following standardized methodology, HSAG assigned a confidence rating based upon the overall percentage-of-compliance score across all standards to assess the degree to which each CCO's operational structure and implementation of documented processes achieved compliance with the standards reviewed. The compliance threshold for all regulatory and contractual requirements is 100 percent. HSAG used the ratings of *High Confidence*, *Moderate Confidence*, *Low Confidence*, and *No Confidence*, as defined in Table 3-3, to indicate the level of confidence exhibited by the CCOs' performance.

Table 3-3—Data Quality Confidence Ratings

Confidence Rating	Description
<i>High Confidence</i>	Definition: The CCO's operational structure, including its policies and procedures as well as implementation of its documented processes, demonstrated substantial compliance with State, federal, and contract regulations and provisions. Performance across each standard exhibited mostly <i>Met</i> ratings and high overall compliance scores (i.e., ≥ 95 percent). Criteria: Overall compliance score is greater than or equal to 95 percent.
<i>Moderate Confidence</i>	Definition: The CCO's operational structure, including its policies and procedures as well as implementation of its documented processes, demonstrated moderate compliance with State, federal, and contract regulations and provisions. Performance across each standard exhibited a mix of <i>Met</i>, <i>Partially Met</i>, and <i>Not Met</i> ratings resulting in moderate compliance scores (i.e., $85 \text{ percent} \leq \text{compliance score} \leq 95 \text{ percent}$), indicating opportunities for improvement across one or more standards. Criteria: Overall compliance score is greater than or equal to 85 percent and less than 95 percent.
<i>Low Confidence</i>	Definition: The CCO's operational structure, including its policies and procedures as well as implementation of its documented processes, demonstrated low compliance with State, federal, and contract regulations and provisions. Performance across each standard exhibited a mix of <i>Met</i>, <i>Partially Met</i>, and <i>Not Met</i> ratings resulting in low to moderate compliance scores (i.e., $75 \text{ percent} \leq \text{compliance score} \leq 85 \text{ percent}$), indicating opportunities for improvement across multiple standards. Criteria: Overall compliance score is greater than or equal to 75 percent and less than 85 percent.
<i>No Confidence</i>	Definition: The CCO's operational structure, including its policies and procedures as well as implementation of its documented processes, demonstrated general noncompliance with State, federal, and contract regulations and provisions. Performance across each standard exhibited a large proportion of <i>Partially Met</i> and <i>Not Met</i> ratings resulting in low compliance scores (i.e., $< 75 \text{ percent}$), indicating substantial opportunities for improvement across most standards. Criteria: Overall compliance score is less than 75 percent.

To draw conclusions about the quality, timeliness, and accessibility of health care services provided by the CCOs, HSAG assigned each of the components reviewed for assessment of compliance with regulations to one or more of those domains of care. Each standard may involve the assessment of more

than one domain of care due to the combination of individual requirements within each standard. HSAG then analyzed, to draw conclusions and make recommendations, the individual requirements within each standard that assessed the quality, timeliness, or accessibility of health care services provided by the CCOs. Table 3-4 depicts the assignment of the standards reviewed in CY 2024 to the domains of care.

Table 3-4—Assignment of Compliance Standards to the Quality, Timeliness, and Access Domains

Compliance Review Standard	Quality	Timeliness	Access
Standard I—Assurance of Adequate Capacity and Availability of Services	✓	✓	✓
Standard V—Provider Selection	✓	✓	
Standard VI—Subcontractual Relationships and Delegation	✓		
Standard XI—Practice Guidelines	✓	✓	

Validation of Performance Improvement Projects

Background

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

Objectives

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

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

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

Technical Methods of Data Collection

HSAG, as the State's EQRO, validated the PIPs through an independent review process. In its evaluation and validation of the PIPs conducted by the CCOs in CY 2024, using performance indicator results from MY 2023 (i.e., January 1, 2023, through December 31, 2023), HSAG used the CMS *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 1).⁸

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

1. HSAG evaluated the technical structure of the PIP to ensure the CCO designs, conducts, and reports the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., PIP Aim statement, population, sampling

⁸ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: Feb 27, 2025.

techniques, performance indicator, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.

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

Description of Data Obtained

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

HSAG’s PIP submission form allowed the CCOs to document the data collection methods used to obtain performance indicator results for monitoring improvement achieved through each PIP. Table 3-5 summarizes the performance indicator description and data sources used for each PIP topic.

Table 3-5—CCO PIP Topics, Performance Indicators, and Data Sources

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

How Data Were Aggregated and Analyzed

Using the PIP Validation Tool and standardized scoring, HSAG evaluated each required step on one or more elements that form a valid PIP. The HSAG PIP review team scored each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designated evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must be *Met*.

How Conclusions Were Drawn

In alignment with CMS EQR Protocol 1, HSAG assigned two PIP validation ratings, summarizing overall PIP performance. One validation rating reflects HSAG's confidence that the CCO adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. This validation rating is based on the scores for applicable evaluation elements in steps 1 through 8 of the PIP Validation Tool. The second validation rating is only assigned for PIPs that have progressed to the Outcomes stage (Step 9) and reflects HSAG's confidence that the PIP's performance indicator results demonstrate evidence of significant improvement. The second validation rating is based on scores from Step 9 in the PIP Validation Tool. For each applicable validation rating, HSAG reported the percentage of applicable evaluation elements that received a *Met* validation score and the corresponding confidence rating: *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*. The confidence rating definitions for each validation rating are as follows:

1. Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Steps 1 Through 8)

- *High Confidence*: High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.
- *Moderate Confidence*: Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
- *Low Confidence*: Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.
- *No Confidence*: No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.

2. Overall Confidence That the PIP Achieved Significant Improvement (Step 9)

- *High Confidence*: All performance indicators demonstrated *statistically significant* improvement over the baseline.
- *Moderate Confidence*: One of the three scenarios below occurred:
 - All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline.
 - All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
 - Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
- *Low Confidence*: The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator **or** some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated *statistically significant* improvement over the baseline.

- **No Confidence:** The remeasurement methodology was not the same as the baseline methodology for all performance indicators **or** none of the performance indicators demonstrated improvement over the baseline.

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

To draw conclusions about the quality, timeliness, and accessibility of health care services provided by the CCOs, HSAG assigned each of the components reviewed for PIP validation to one or more of these three domains. While the focus of an CCO’s PIP may have been to improve performance related to health care quality, timeliness, or accessibility, PIP validation activities were designed to evaluate the validity and quality of the CCO’s process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. In addition, all PIP topics were also assigned to other domains as appropriate. This assignment to domains is shown in Table 3-6.

Table 3-6—Assignment of PIPs to the Quality, Timeliness, and Access Domains

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

Performance Measure Validation

Background

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

Objectives

The primary objectives of the PMV activities were to:

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

Technical Methods of Data Collection

OHA selected and calculated the performance measures by using a number of data sources, including claims/encounter data and enrollment/eligibility data. During the CY 2024 PMV activity, HSAG evaluated the accuracy and validity of OHA's calculation of four MY 2023 (i.e., January 1, 2023, through December 31, 2023) performance measures for the CCOs in accordance with the CMS EQR *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 2).⁹ HSAG collected information using several methods including interviews, system demonstrations, review of data output files, primary source verification (PSV), observation of data processing, and review of data reports.

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

⁹ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: <https://www.medicaid.gov/sites/default/files/2023-03/2023-eqr-protocols.pdf>. Accessed on: Feb 27, 2025.

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

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

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

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

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

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

Description of Data Obtained

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

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

How Data Were Aggregated and Analyzed

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

How Conclusions Were Drawn

HSAG analyzed OHA's ISCAT responses; source code (i.e., programming language) for performance measures; and supporting documentation including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. Based on this analysis and the virtual audit review of data integration, data control, and performance measure documentation, HSAG determined results for each performance measure and assigned each an indicator designation of "Reportable (R)" or "Do Not Report (DNR)" as defined in Table 3-7. In the context of validation of performance measures, bias is based on the extent to which the data sources used to calculate the denominator and numerator were complete and accurate, and degree to which the calculation of the performance measure adhered to the specifications for all components of the reporting requirements. HSAG based each validation finding on the magnitude of errors detected for the measure's evaluation elements, not by the number of elements determined to be noncompliant. Consequently, it was possible that an error for a single element resulted in a designation of "DNR" because the impact of the error

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

Table 3-7—Validation Results for Performance Indicators

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

To draw conclusions about the quality, timeliness, and accessibility of health care services provided by the Medicaid CCOs, HSAG assigned each of the measures reviewed for PMV to one or more of three domains of care. This assignment to domains of care is depicted in Table 3-8.

Table 3-8—Assignment of Performance Measures to the Quality, Timeliness, and Access Domains

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

Validation of Network Adequacy

Network Adequacy Validation

Background

Federal regulations under 42 CFR §438.358(b)(iv) require validation of CCO network adequacy to ensure provider networks are sufficient to provide timely and accessible care to Medicaid and CHIP beneficiaries across the continuum of services. During CY 2024, OHA contracted with HSAG to conduct a NAV study. HSAG's approach to conducting NAV activities included validating the systems and processes, data sources, methods, and results using the most recent calculated time and distance results prepared by the CCOs as of October 1, 2024. HSAG conducting the NAV validation in accordance with the CMS EQR *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 4).¹⁰

HSAG worked with OHA to identify applicable quantitative network adequacy standards by provider type to be validated. Information such as descriptions of network adequacy data and documentation submitted by the CCOs to the State, information flow from the CCOs to the State, NAV reports from the prior year, and additional supporting information relevant to network adequacy monitoring and validation were obtained from the State and incorporated into all phases of validation activities.

Objectives

The primary objectives of the NAV activity were to:

- Determine whether each CCO's information systems are able to collect and report accurate data related to each network adequacy indicator.
- Evaluate each CCO's ability to (1) collect reliable and valid network adequacy monitoring data, (2) use sound methods to assess the adequacy of its managed care networks, and (3) produce accurate results to support CCO and State network adequacy monitoring efforts.

Technical Methods of Data Collection

HSAG collected information using several methods including interviews, system demonstrations, review of source data output files, PSV, observation of data processing, and review of final network adequacy indicator-level reports. HSAG's process included the following steps:

¹⁰ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: Feb 27, 2025.

Pre-Onsite Review Activities: Based on network adequacy standards identified by OHA, HSAG:

- Developed and forwarded an ISCAT that was used to collect the necessary background information on OHA's information systems, policies, processes, and data needed for the virtual NAV activities.
- Conducted technical assistance sessions with the CCOs to review the ISCAT, data submission requirements, and upcoming virtual onsite visits.
- Scheduled virtual onsite review dates.
- Reviewed completed ISCAT and associated documentation submitted by the CCOs.

Virtual Onsite Review Activities: HSAG conducted a virtual onsite visit with the CCOs to collect additional information and validate the CCOs' ability to collect and report valid and reliable network adequacy data. The virtual onsite visit included:

- An opening conference that included an introduction of the validation team and key CCO staff members involved in the NAV activities, the review purpose, the required documentation, basic meeting logistics, and organization overview.
- Evaluation of underlying systems and processes.
 - HSAG evaluated the CCO's information systems, focusing on the CCO's processes for maintaining and updating provider data; integrity of the systems used to collect, store, and process data; CCO oversight of external information systems, processes, and data; and knowledge of the staff members involved in collecting, storing, and analyzing data.
 - HSAG conducted interviews with key CCO staff members familiar with the processing, monitoring, reporting, and calculation of network adequacy indicators. Key staff members included executive leadership, enrollment specialists, provider relations, business analysts, data analytics staff, claims processors, and other front-line staff members familiar with network adequacy monitoring and reporting activities.
- Evaluation of data collection, integration, methods, and control procedures.
 - HSAG observed methods and logic used to calculate each network adequacy indicator.
 - HSAG evaluated the integration and validation process across all source data and how the analytics files were produced to inform network adequacy monitoring and calculation at the indicator level.
 - HSAG also addressed control and security procedures during this session.
- Validation of network adequacy source data PSV and results.
 - HSAG performed additional validation using PSV to further validate the accuracy and integrity of the source data files used to inform network adequacy monitoring and reporting at the indicator level.
 - HSAG assessed the methods, logic, and processes used to confirm accuracy of the data and detect errors.
 - HSAG selected key data elements within each source data output file to confirm that the primary source system maintained by the CCO or obtained through external entities matched.

- HSAG reviewed indicator-level results and determined whether the results were valid, accurate, and reliable, and whether the CCO's interpretation of the data was accurate.
- The closing conference included a summation of preliminary findings based on the review of the underlying systems and processes, data collection, integration, and methods used. In addition, findings from the virtual review and documentation requirements for any post-virtual review activities were shared with the CCO.

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

- Communicated preliminary NAV findings to each CCO, including overall findings, preliminary validation ratings, areas of potential concern, and recommendations for improvement.
- Worked collaboratively with each CCO to provide the opportunity to correct any preliminary report omissions and/or errors.
- Submitted the aggregate report to the State summarizing the NAV findings.

Description of Data Obtained

The following are examples of the documentation and data obtained to conduct the NAV activities:

- **ISCAT:** Provided information on the CCO's information systems, processes for maintaining and updating provider data; integrity of the systems used to collect, store, and process data; CCO oversight of external information systems, processes, and data; and knowledge of the staff members involved in collecting, storing, and analyzing data.
- **Network Adequacy Logic:** Included documented code, logic, or manual workflows for calculation of each network adequacy indicator in the scope of the review. Each CCO that did not use computer programming language to calculate the performance indicators were required to submit documentation describing the steps the CCO took for indicator calculation.
- **Network Adequacy Data and Methods:** Included network data files or directories, member enrollment data files, claims and encounter data files (if applicable), member experience survey results, and/or provider and member handbooks.
- **Supporting Documentation:** Included any additional information to complete the validation process, including policies and procedures, file layouts, data dictionaries, system flow diagrams, system log files, and data collection process descriptions.
- **Results of Network Adequacy Calculations:** Included the most recent network adequacy reports.
- **Virtual Interviews and Demonstrations:** Provided additional information through interviews with key CCO staff involved in the calculation and reporting of network adequacy indicators and system demonstrations.

How Data Were Aggregated and Analyzed

Network Adequacy Standards and Indicators

Based on the state-defined network adequacy standards, OHA determined the network adequacy indicators to be validated by HSAG included the CCOs' calculation of the percentage of members within acceptable travel time and distance standards for the reporting period between January 1, 2024, and October 1, 2024. Table 3-9 lists OHA's time and distance standards and the indicators calculated by the CCOs and validated by HSAG.

Table 3-9—CCO Network Adequacy Standards and Indicators Validated

Urbanicity Classification	Definition	Provider Tier	Time Standard	Distance Standard	Indicator
Large Urban	Conjoined urban areas with a total population of at least 1 million people or with a population density greater than 1,000 people per square mile.	Tier 1	10 Minutes	5 Miles	Percentage of Members With Access
		Tier 2	20 Minutes	10 Miles	
		Tier 3	30 Minutes	15 Miles	
Urban	An area with greater than 40,000 people within a 10-mile radius of a city center.	Tier 1	25 Minutes	15 Miles	Percentage of Members With Access
		Tier 2	30 Minutes	20 Miles	
		Tier 3	45 Minutes	30 Miles	
Rural	An area greater than 10 miles from the center of an urban area.	Tier 1	30 Minutes	20 Miles	Percentage of Members With Access
		Tier 2	75 Minutes	60 Miles	
		Tier 3	110 Minutes	90 Miles	
Extreme Access	County with a population density of 10 or fewer people per square mile.	Tier 1	40 Minutes	30 Miles	Percentage of Members With Access
		Tier 2	95 Minutes	85 Miles	
		Tier 3	140 Minutes	125 Miles	

Table 3-10 presents the provider specialties and facility types included in the NAV by provider tier.

Table 3-10—List of Provider Specialties and Facility Types by Tier

Tier 1	Individual Provider: Primary Care Provider (PCP), Primary Care Dentist (PCD), Mental Health Provider (MH Provider), Substance Use Disorder Provider (SUD Provider) Facility Provider: Pharmacy (Rx)
Tier 2	Individual Provider: Cardiology (CRD), Neurology (NEUR), Obstetrics/Gynecology (OB/GYN), Occupational Therapy (OT), Medical Oncology (M-ONC), Radiation Oncology (R-ONC), Ophthalmology (OPH), Optometry (OPT), Physical Therapy (PT), Podiatry (POD), Psychiatry (PSYC), Speech Language Pathology (SLP) Facility Provider: Durable Medical Equipment (DME), Hospital (HOSP), Methadone Clinic (MTD)

Tier 3

Individual Provider: Allergy & Immunology (ALIM), Dermatology (DERM), Endocrinology (END), Gastroenterology (GST), Hematology (HEM), Nephrology (NEPH), Otolaryngology (OTO), Pulmonology (PUL), Rheumatology (RHEU), Urology (URO)
Facility Provider: Skilled Nursing Facility (SNF),

Network Adequacy Indicator Validation Rating Determinations

HSAG evaluated the CCOs' ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support CCO and State network adequacy monitoring efforts.

HSAG used the CMS EQR Protocol 4, Worksheet 4.6—Assessment of MCP Network Adequacy Data, Methods, and Results (Worksheet 4.6) to evaluate and assess the data and methods used to calculate results generated for each network adequacy indicator. HSAG calculated each network adequacy indicator's validation score using the total number of *Met* or *Not Met* findings assigned to each element as described in Table 3-11.

Table 3-11—Validation Score Calculation

Worksheet 4.6 Summary
A. Total number of <i>Met</i> elements
B. Total number of <i>Not Met</i> elements
Validation Score = $A / (A + B) \times 100\%$
Number of <i>Not Met</i> elements determined to have significant bias on the results.

HSAG also used Worksheet 4.6 to generate a validation rating that reflected HSAG's overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators. The validation rating was assigned based on the network adequacy indicator's validation score as defined in Table 3-12.

Table 3-12—Indicator-Level Validation Confidence Rating Categories

Validation Score	Confidence Rating
90.0% or greater	<i>High Confidence</i>
50.0% to 89.9%	<i>Moderate Confidence</i>
10.0% to 49.9%	<i>Low Confidence</i>
Less than 10% and/or any <i>Not Met</i> element that has significant bias on the results	<i>No Confidence</i>

Significant bias was determined based on the magnitude of errors detected and not solely based on the number of elements *Met* or *Not Met*. HSAG determined that a *Not Met* element had significant bias on the results by:

- Working with the CCO to quantify the estimated impact of an error, omission, or other finding on the indicator calculation.
- Reviewing the root cause, proposed corrective action, timeline for corrections, and estimated impact, within HSAG’s NAV Oversight Review Committee, to determine the degree of bias.
- Finalizing a bias determination within the HSAG NAV Oversight Review Committee based on the following threshold:
 - The impact biased the reported network adequacy indicator result by more than 5 percentage points, the impact resulted in a change in network adequacy compliance (i.e., the indicator result changed from compliant to noncompliant or changed from noncompliant to compliant), or the impact was unable to be quantified and therefore was determined to have the potential for significant bias.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of health care services provided by the Medicaid CCOs, HSAG assigned each of the components reviewed for the NAV activities to one or more of three domains of care. This assignment to domains of care is depicted in Table 3-13.

Table 3-13—Assignment of NAV to the Quality, Timeliness, and Access Domains

Validation of Network Adequacy	Quality	Timeliness	Access
Review of ISCAT submission	✓	✓	
Validation of time and distance results			✓

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

Delivery System Network Evaluation

Background

The DSN Evaluation activity requires the CCO, in accordance with 42 CFR §438.206 and §438.207, to give assurances and provide supporting documentation to the State that demonstrates that it maintains a network of appropriate health care providers to ensure all services covered under the State plan are available and accessible to members in a timely manner. Each CCO must demonstrate the capacity to serve its current and expected membership within its service area and submit documentation to the State Medicaid authority.

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

- Conducted a review of the CCOs' network monitoring processes and procedures for ensuring the adequacy of its provider network, including members' access to care and the availability of services.
- Assessed the CCOs' network capacity and geographic distribution of providers relative to member populations.
- Evaluated, summarized, and presented aggregate findings based on provider capacity data and reports supplied by OHA.

HSAG conducted the DSN Evaluation in alignment with guidance outlined in CMS' network access and adequacy toolkit¹¹ and the CMS EQR Protocols released in February.

Objectives

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

- The CCOs' compliance with the OARs and contract requirements for monitoring CCO DSNs.
- The CCOs' network monitoring processes and procedures for ensuring the adequacy of provider networks, including members' access to care and the availability of services.
- The adequacy of CCO provider networks, network capacity, and geographic distribution of providers relative to member populations.
- The CCOs' compliance with OHA-defined time and distance access standards.
- Program-level recommendations for OHA, including future technical assistance and operational improvements for overseeing the adequacy of CCO provider networks.
- CCO-specific findings and recommendations necessary to improve network adequacy monitoring capabilities and compliance with OHA's network adequacy standards.

To accomplish its objectives, HSAG developed data collection tools, network adequacy summary metrics, and evaluation criteria. In 2024, HSAG's evaluation included three components:

- DSN Provider Narrative Review
- Network Capacity and Adequacy Assessment
- Network Availability and Accessibility Analysis

¹¹ Centers for Medicare & Medicaid Services. Promoting Access in Medicaid and CHIP Managed Care: A Toolkit for Ensuring Provider Network Adequacy and Service Availability, April 2017. Available at: <https://www.medicaid.gov/medicaid/downloads/adequacy-and-access-toolkit.pdf>. Accessed on: Feb 27, 2025.

Technical Methods of Data Collection

The key 2024 DSN Evaluation activities are described below.

1. **Protocol Development and Dissemination:** HSAG developed the 2024 DSN Evaluation protocol to describe the scope and methodology for conducting the DSN analysis and provide guidance to the CCOs on their participation. HSAG also developed data collection tools to support information gathering on the CCOs' network monitoring processes and procedures.
 - **2024 DSN Provider Narrative Template**—Standardized tool the CCOs used to submit documentation of compliance with key federal and State regulations and contract requirements across four domains: DSN Governance Structure, Member Needs and Population Management, DSN Monitoring and Analysis, and Network Response Strategy.
2. **DSN Technical Assistance Webinar:** HSAG hosted a webinar on May 15, 2024, for the CCOs to review the 2024 DSN Evaluation timeline, required documentation and submission guidelines, analysis, reporting processes, and to allow an opportunity for questions and answers.
3. **Documentation Submission:** The CCOs completed the 2024 *DSN Provider Narrative Template* and submitted all applicable supporting documentation. All requested data and documentation were due on or before July 31, 2024.
4. **Desk Review and Analysis:** HSAG conducted a desk review of each organization's documentation and data to evaluate the CCOs' network adequacy and compliance with the OARs and contract requirements for monitoring DSNs. The desk review enabled HSAG reviewers to increase their knowledge and understanding of each CCO's operations, identify areas needing clarification, and begin compiling information needed to make a formal assessment. HSAG performed an analysis of the quarterly provider capacity data to assess the adequacy, availability, and timeliness of access to providers and health care services. The evaluation incorporated a multi-dimensional approach using a series of measures to support DSN reporting.
5. **Follow-Up Communications:** HSAG conducted follow-up communication with organizations when desk review results or data analysis identified areas where additional information and/or clarification was required.
6. **Report Production:** HSAG compiled all information obtained from the desk review and data analysis to derive DSN findings for each CCO. HSAG summarized the results of its review and presented the findings to OHA in a draft report; the CCOs had the opportunity to review CCO-specific findings and recommendations. Upon receipt of feedback from OHA and the CCOs, HSAG drafted a final DSN Evaluation report for submission to OHA.

Description of Data Obtained

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

- *DSN Provider Narrative Template* tool and supplemental documentation describing the CCOs’ governance structure; membership and network monitoring; network monitoring, analysis, and reporting processes; and network response strategy. These data were used to assess compliance with OARs and CCO contract requirements.
- *DSN Provider Capacity Report* data files submitted by the CCOs to OHA for Quarter 1 (Q1) 2024 that represent an inventory of each individual (i.e., physician, mid-level practitioner, or other practitioners), facility, or business, whether employed by or under subcontract with a CCO, or paid FFS, that agrees to provide the described services, or items, to Medicaid CCO members. Member eligibility and enrollment files from OHA. These data were used in conjunction with DSN Provider Capacity data files to support the calculation of network adequacy metrics.
- *DSN Provider Capacity Report: Analysis & Review* reports submitted by OHA for Q1 2024 that include OHA’s assessment of the CCOs’ provider capacity data files.

How Data Were Aggregated and Analyzed

HSAG generated both qualitative and quantitative results based on submitted documentation in order to assess network adequacy during the 2024 DSN Evaluation.

DSN Provider Narrative Review

In alignment with Exhibit G of the CCO Contract, the DSN Provider Narrative Review assessed the CCOs’ compliance with the OARs and contract requirements for monitoring CCO delivery system networks. Data collection relied on CCO responses and supplemental documentation collected through the 2024 *DSN Provider Narrative Template*. In collaboration with OHA, the 2024 *DSN Provider Narrative Template* was revised to align with OHA’s overall objectives for monitoring network adequacy and the recently released CMS EQR protocol for validating network adequacy.

Table 3-14 describes the four domains that comprised the *DSN Provider Narrative Template*.

Table 3-14—DSN Provider Narrative Template Domains and Descriptions

Domain	Description
DSN Governance Structure	Required the CCO to provide documentation that described the operational infrastructure responsible for oversight and monitoring the adequacy of its delivery system network. Supporting documentation and responses included: • CCO organization charts, roles and responsibilities, and committee structure. • Policies, procedures, and processes outlining oversight of subcontractors’ delegated network-related managed care functions.

Domain	Description
Member Needs and Population Management	Required the CCO to provide documentation that described processes for monitoring current and anticipated membership and service needs. Supporting documentation and responses included: • Policies, procedures, and processes supporting member monitoring programs, population metrics, and reporting mechanisms. • Sample reports (e.g., service utilization, disease prevalence).
DSN Monitoring and Analysis	Required the CCO to provide documentation that described the CCO's processes for monitoring and analyzing its delivery system network, including the collection, calculation, and reporting of network performance measures. Supporting documentation and responses included: • Documentation of CCO network performance measures (e.g., technical specification, reporting templates). • Sample reports and network performance results (e.g., time and distance reports, provider-to-member ratios, appointment availability).
Network Response Strategy	Required the CCO to provide documentation that described actions taken to address network findings related to ongoing monitoring of network adequacy. Supporting documentation included: • Identification of barriers to access. • Short- and long-term interventions, including follow-up to findings. • Implementation of corrective actions based on prior DSN evaluations.

HSAG used the ratings of *Met*, *Partially Met*, and *Not Met*, as defined in Table 3-15, to indicate the degree to which each CCO addressed the reporting requirements and submitted the required documentation. A designation of *Not Applicable (NA)* was used when a specific reporting element on the review tool was not applicable to a CCO.

Table 3-15—DSN Provider Narrative Evaluation Rating Criteria

Rating	Rating Description
<i>Met</i>	Indicates <i>all</i> components were present and complete: • Narrative response fully addressed reporting requirements of the element; and • Required documentation/data (when applicable) was submitted, complete, and relevant to the elements and/or review period.
<i>Partially Met</i>	Indicates <i>at least one</i> component was missing or incomplete: • Narrative response fully addressed reporting requirements of the element, but required documentation/data was not submitted, complete, or relevant to the elements and/or review period. • Required documentation/data (when applicable) was submitted, complete, and relevant, but the narrative response did not fully address the reporting requirement.

Rating	Rating Description
<i>Not Met</i>	Indicates <i>none</i> of the components were present and complete: - Narrative response did not address the element or the CCO indicated the reporting requirement was not conducted; and - Required documentation/data (when applicable) was not submitted, complete, or relevant to the elements and/or review period.

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

Network Capacity and Adequacy Assessment

To understand the capacity and adequacy of CCO provider networks, HSAG assessed two interrelated dimensions of access: network capacity and geographic distribution. While network capacity addresses the underlying infrastructure of a provider network, geographic distribution addresses whether the distribution of available providers and services is adequate to facilitate access to all members. All analyses were limited to a subset of core individual and facility-based providers selected in collaboration with OHA to represent fundamental health services covered by the CCOs and relevant to OHA’s quality strategy and network adequacy objectives. Table 3-16 presents the provider types included in the 2024 DSN Evaluation.

Table 3-16—Provider Types Included in the 2024 DSN Evaluation

Individual Practitioners	Facility/Service Providers
- Primary Care Provider (PCP), Adult and Pediatric¹ - Primary Care Dentist (PCD), Adult and Pediatric² - Mental Health (MH) Provider, Adult and Pediatric¹ - Substance Use Disorder (SUD) Provider, Adult and Pediatric¹ - Specialty Providers, Adult and Pediatric^{1,4} - Allergy & Immunology (ALIM) - Cardiology (CRD) - Dermatology (DERM) - Endocrinology (END) - Gastroenterology (GST) - Hematology (HEM) - Medical Oncology (M-ONC) - Nephrology (NEPH)	- Durable Medical Equipment (DME) - Hospital³ (HOSP) - Methadone Clinic (MTD) - Pharmacy³ (Rx) - Skilled Nursing Facility (SNF)

Individual Practitioners	Facility/Service Providers
– Neurology (NEUR) – Obstetrics/Gynecology³ (OB/GYN) – Occupational Therapy (OT) – Ophthalmology (OPH) – Optometry (OPT) – Otolaryngology (OTO) – Physical Therapy (PT) – Podiatry (POD) – Psychiatry (PSYC) – Pulmonology (PUL) – Radiation Oncology (R-ONC) – Rheumatology (RHEU) – Speech-Language Pathology (SLP) – Urology (URO)	

¹ These provider types are defined in 42 CFR §438.68 and include stratification by providers serving adult and pediatric members.

² This provider type is defined in 42 CFR §438.68 for the pediatric population only. This provider type is defined in OAR 410-141-3515 and includes stratification by adult members.

³ These provider types were defined in 42 CFR §438.68 without stratification by adult or pediatric member populations.

⁴ Individual specialty providers included in the 2024 DSN Evaluation were based on OHA’s time and distance tier designations and alignment with OHA’s quality strategy and internal goals and objectives.

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

- **Provider Counts**—the number and percentage of providers and facilities by provider type.
- **Network Stability**—the percentage of change in provider counts (by provider type) between 2023 and 2024.
- **Provider-to-Member Ratios**—the number of providers relative to the number of members by provider type.

Key measures for assessing the geographic distribution of providers included time and distance analyses and compliance with network adequacy requirements. When combined with member and provider characteristics, these analyses determined the extent to which the supply of providers was distributed appropriately relative to the member population. HSAG assessed the geographic distribution of adult and pediatric providers relative to adult and pediatric member populations as the percentage of members having access within acceptable travel times and distances to the nearest provider.

Provider and member data used to calculate time and distance metrics were reviewed, cleaned, and prepared as follows:

- Providers included in the analysis had:
 - Office locations geocoded in Oregon or within 75 miles of the Oregon border.¹²
 - An active National Provider Identifier (NPI) on March 31, 2024.
 - An eligible provider type, or indicator, per designation on OHA’s *DSN Provider Specialty Matrix*.¹³
- Members included in the analysis:
 - Had an address within the State of Oregon and within the CCO’s service area.
 - Were actively enrolled with the CCO on March 31, 2024.
 - Did not have a date of death on or before March 31, 2024.

Effective January 1, 2024, the CCOs were required to align monitoring and reporting with updated travel times and distances. These requirements revised provider designations based on taxonomy, expanded urbanicity definitions, and acceptable travel times and distances based on urbanicity and a provider type’s access priority and frequency of member need, known as a “tier.” OHA’s network adequacy compliance standard threshold was 95 percent of adult (i.e., 19 years of age and older) and pediatric (i.e., less than 19 years of age) members with acceptable access to adult and pediatric providers, respectively. All study results were stratified by CCO, provider type, and member population.

Table 3-17 outlines acceptable travel times and distances.

Table 3-17—Acceptable Travel Time and Distance by Urbanicity and Provider Tier

Urbanicity Classification	Definition	Provider Tier	Acceptable Travel Time	Acceptable Travel Distance
Large Urban	Conjoined urban areas with a total population of at least 1 million people or with a population density greater than 1,000 people per square mile.	Tier 1	10 Minutes	5 Miles
		Tier 2	20 Minutes	10 Miles
		Tier 3	30 Minutes	15 Miles
Urban	An area with greater than 40,000 people within a 10-mile radius of a city center.	Tier 1	25 Minutes	15 Miles
		Tier 2	30 Minutes	20 Miles
		Tier 3	45 Minutes	30 Miles
Rural	An area greater than 10 miles from the center of an urban area.	Tier 1	30 Minutes	20 Miles
		Tier 2	75 Minutes	60 Miles
		Tier 3	110 Minutes	90 Miles
Extreme Access	County with a population density of 10 or fewer people per square mile.	Tier 1	40 Minutes	30 Miles
		Tier 2	95 Minutes	85 Miles
		Tier 3	140 Minutes	125 Miles

¹² Mile limit per OHA direction and in alignment with OAR 410-120-1180.

¹³ Oregon Health Authority. *DSN Provider Specialty Matrix*. Available at: <https://www.oregon.gov/oha/HSD/OHP/Pages/CCO-Contract-Forms.aspx>. The most current *DSN Provider Specialty Matrix* was used at the time of analysis for all provider category definitions.

Table 3-18 presents the provider specialties and facility types included in the 2024 DSN Evaluation by provider tier. See Appendix A for a detailed description of the specifications used to define each provider type.

Table 3-18—List of Provider Specialties and Facility Types by Tier

Tier 1	Individual Provider: PCP, PCD, MH Provider, SUD Provider Facility Provider: Rx
Tier 2	Individual Provider: CRD, NEUR, OB/GYN, OT, M-ONC, R-ONC, OPH, OPT, PT, POD, PSYC, SLP Facility Provider: DME, HOSP, MTD
Tier 3	Individual Provider: ALIM, DERM, END, GST, HEM, NEHP, OTO, PUL, RHEU, URO Facility Provider: SNF

Table 3-19 presents the provider types included in the 2024 DSN Evaluation. See Appendix A for a detailed description of the specifications used to define each provider type.

Table 3-19—Network Adequacy Standards

Provider Type	Provider Tier ¹	Definition	Compliance Standard
Individual Provider, Adult	Tier 1	Percentage of adult members (19 years and older) within acceptable driving time or distance ² to the nearest provider serving adults members. ³	95 percent
	Tier 2		
	Tier 3		
Individual Provider, Pediatric	Tier 1	Percentage of pediatric members (less than 19 years of age) within acceptable driving time or distance ² to the nearest provider serving pediatric members. ³	95 percent
	Tier 2		
	Tier 3		
Individual Provider, OB/GYN	Tier 2	Percentage of female members (13 years or older) within acceptable driving time or distance ² to the nearest provider.	95 percent
Facility Provider	Tier 1	Percentage of members within acceptable driving time or distance ² to the nearest provider.	95 percent
	Tier 2		
	Tier 3		

¹ See Table 3-18 for the specific provider specialties and facility types included in each tier.

² See Table 3-17 for the definition of acceptable driving time and distance.

³ Member populations served by providers are defined by the *Age Group* indicator reported by the CCOs in the Q1 *DSN Provider Capacity Report* data files.

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

Network Availability and Accessibility Analysis

Provider counts, panel status, and level of participation in a CCO's network describe the underlying infrastructure of each CCO's DSN, including whether health services are available to members through a sufficient supply and variety of providers. Together with key practitioner and office characteristics (e.g., prevalent non-English languages spoken), the results provide insight into the degree to which contracted providers and services are available and accessible to CCO members. As a proxy measure of accessibility, the number of providers who speak a prevalent non-English language is useful in understanding the ability of the CCOs' provider networks to render linguistically accessible and culturally responsive services. In alignment with prior evaluations, HSAG used network performance metrics within OHA's Q1 2024 *DSN Provider Capacity Report: Analysis & Review* reports ("DSN Provider Capacity Reports") to assess the extent to which providers were contracted, available, and accessible within the CCOs' provider networks. These performance metrics included the following:

- Availability
 - Percentage of active¹⁴ providers
 - Percentage of providers within the CCOs' service areas
 - Percentage of providers accepting new Medicaid patients
 - Overall PCP capacity
- Accessibility
 - Percentage of providers speaking a prevalent non-English language¹⁵

How Conclusions Were Drawn

HSAG used the DSN Provider Narrative responses to draw conclusions regarding the completeness, sufficiency, and accessibility of the provider networks. The Network Capacity and Adequacy Assessment was used to draw conclusions regarding provider counts and network stability, the CCOs' compliance with the State's time and distance access standards, and geographic distribution of providers relative to member populations. The Network Availability and Accessibility Analysis was used to inform conclusions about the extent to which providers were meaningfully accessible to members.

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

¹⁴ Providers were considered "active" if they were a participating provider within the CCO's network, located within Oregon or a bordering county, and were represented in claims and encounter data within the 21 months preceding the end of Q1 2024.

¹⁵ As defined in OAR 410-141-3575. Available at: <https://secure.sos.state.or.us/oard/viewSingleRule.action?ruleVrsnRsn=298884>. Accessed on: Feb 28, 2025.

Table 3-20—Assignment of the DSN Evaluation Activity to the Quality, Timeliness, and Access Domains

NAV Activity	Quality	Timeliness	Access
DSN Evaluation	✓	✓	✓

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

Revealed Telephone Survey

Background

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

During CY 2024, HSAG conducted a revealed telephone survey among PCPs and SUD providers contracted with one or more CCO. The primary purpose of the survey was to collect appointment availability for routine and urgent visits for OHP members.

Objectives

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

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

Technical Methods of Data Collection

To evaluate appointment availability, HSAG conducted a revealed telephone survey of providers' offices and facilities that offer routine and urgent primary care or SUD services for new and existing patients.

Study Population

HSAG used the CCOs' *DSN Provider Capacity Report* data (Q1 2024) submitted to OHA by the CCOs, to develop the stratified, random sample of PCP and SUD locations to be surveyed. The *DSN Provider Capacity Report* data reflected each CCO's active and contracted providers and any contracted providers pending Medicaid enrollment and/or credentialing as of March 31, 2024. The data included the following fields for use in the revealed telephone survey:

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

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

HSAG used the criteria noted in Table 3-21 to identify SUDs for CCOs. PCPs were identified using the PCP indicator found in the Q1 *DSN Provider Capacity Report* since OHA does not use taxonomy codes to identify PCPs in CCO networks.

Table 3-21—OP SUD Provider Identification Criteria for CCOs

Display Name	Taxonomy Code
OP SUD Providers	
Addiction (SUD Counselor	101YA0400X
Addiction Medicine (Family Medicine) Physician	207QA0401X
Addiction Medicine (Internal Medicine) Physician	207RA0401X
Addiction Medicine (Preventive Medicine) Physician	2083A0300X
Addiction Medicine (Psychiatry And Neurology) Physician	2084A0401X
Addiction Psychiatry Physician	2084P0802X
SUD Rehabilitation Clinic/Center	261QR0405X

Sampling Strategy

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

Step 1: HSAG assembled the sample frame using records from all outpatient BH service locations identified by each CCO. HSAG aggregated individual practitioner records into location-based cases.

- To minimize duplicated provider records within each CCO, HSAG standardized the providers’ address data to align with the United States Postal Service Coding Accuracy Support System (CASS). Address standardization did not affect the survey population; provider records requiring address standardization remained in the eligible population. The original provider address data values were retained for locations where potential CASS address changes may have impacted data validity (e.g., the address was standardized to a different city or county).
- Service locations that indicated they were not a participating provider (i.e., a provider with no contractual relationship with the CCO and is not on the CCO’s provider panel, otherwise known as “out of network”) were excluded from the sample frame. Participating providers were identified by the Participating_Ind = “Y” data field.
- Out-of-state service locations identified as bordering Oregon in California, Idaho, Washington, and Nevada were included in the sample frame.

Step 2: HSAG used the sample frame to determine the number of unique provider locations. In order to minimize the number of repeat phone calls to providers, HSAG identified locations based on unique phone numbers. If a phone number was associated with multiple addresses across CCOs, HSAG randomly assigned the phone number to any applicable CCO and standardized address.

Description of Data Obtained

Data obtained from OHA included:

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

How Data Were Aggregated and Analyzed

Telephone Survey Process

Trained interviewers collected survey responses using a standardized script approved by OHA and interviewers were instructed not to schedule actual appointments. Interviewers contacted each telephone number (“case”), abstracting data into a web-based data collection tool.¹⁶

¹⁶ To minimize the burden on the providers’ office staff, the survey script in the data collection tool allowed interviewers to efficiently obtain responses across CCOs for providers contracted with one or more CCO.

HSAG interviewers made three attempts to contact each survey case during standard business hours (i.e., 9 a.m. to 5 p.m. Pacific Daylight Time [PDT]).¹⁷ If put on hold at any point during the call, the caller waited on hold for five minutes before ending the call. If a call attempt was answered by an answering service or voicemail during normal business hours, the caller made a second and/or third call attempt on a different day and at a different time of day. A survey case was considered nonresponsive if any of the following criteria were met:

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

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

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

Survey Indicators

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

HSAG collected the following information pertaining to provider data accuracy:

- Telephone number
- Address
- Provider location's services

¹⁷ HSAG did not consider a call attempted when the interviewer reached an office outside of the office's usual business hours. For example, if the interviewer called and reached a recording that stated the office was closed for lunch, the call attempt did not count toward the two attempts to reach the office. The interviewer attempted to contact the office up to three times outside of the known lunch hour.

- Affiliation with OHP
- Affiliation with the requested CCO

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

- Information concerning whether the provider location was accepting new patients.
- Next available appointment date with any practitioner at the sampled location for a new or existing patient with a routine and an urgent issue.
- Assessed whether the appointment dates offered are compliant with the following appointment wait time standards:
 - Routine PCP visit: within four weeks (or 28 calendar days) of the request.
 - Urgent PCP visit: within 72 hours (or three calendar days) of the request.
 - Specialty BH care for prioritized population of pregnant members: immediate assessment and entry (or same day).
 - Opioid use disorder treatment: Assessment and entry within 72 hours (or three calendar days) of the request.
 - Routine BH care for a non-priority population¹⁸ within seven calendar days of the request.
 - Urgent BH care for all populations: within 24 hours (or one calendar day) of the request.
- Information concerning whether the provider location offered translation or interpreter services.
- Any limitations to accepting new patients or scheduling an appointment. Limitations included, but were not limited to, the following:
 - Location required a review of the member’s medical records prior to offering an appointment
 - Location required registration with the practice prior to offering an appointment
 - Location required verification of the member’s Medicaid eligibility prior to offering an appointment

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of health care services provided by the CCOs, HSAG assigned the revealed telephone survey activity to one or more of three domains of care. This assignment to domains of care is depicted in Table 3-22.

Table 3-22—Assignment of the Revealed Telephone Survey Activity to the Quality, Timeliness, and Access Domains

NAV Activity	Quality	Timeliness	Access
Revealed Telephone Survey	✓	✓	✓

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

¹⁸ Non-priority populations represent individuals who do not have “Special Health Care Needs” as defined in OAR 410-141-3500 (77).

Encounter Data Validation

Background

Pursuant to 42 CFR §438.242, OHA must ensure that each of its CCOs maintains 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. Furthermore, OHA must review and validate encounter data collected, maintained, and submitted by the CCOs, including encounter data submitted via their subcontracted vendors, to ensure that these data are a complete and accurate representation of the services provided to its Medicaid members. Accurate and complete encounter data are critical to the success of a managed care program; submission of high-quality encounter data can accurately and effectively monitor and improve the program's quality of care, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information.

During CY 2024, OHA contracted with HSAG to conduct an EDV study. HSAG's approach to conducting EDV studies is tailored to address the specific needs of its clients by customizing elements outlined and in alignment with the CMS EQR *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, February 2023 (CMS EQR Protocol 5).¹⁹

For CY 2024, the EDV study focused on the CCOs' delegated pharmacy benefit managers (PBMs) responsible for the administration, payment, and processing of pharmacy claims. HSAG conducted the following activities for the EDV study:

- Targeted assessment of encounter data information systems and processes—administered a targeted questionnaire to gather information and assess the CCOs' oversight of their PBMs' processes for collecting, adjudicating, submitting, and reporting all pharmacy claims data to OHA. This activity corresponds to *Activity 2: Review the MCO's Capability* in CMS EQR Protocol 5.
- Comparative analysis—conducted an analysis of OHA's pharmacy encounter data completeness and accuracy by comparing OHA's electronic pharmacy encounter data and the data extracted from the CCOs' PBMs' claims/adjudication systems. The goal of the comparative analysis is to evaluate the extent to which the pharmacy encounter data in OHA's data warehouse are complete and accurate. This activity corresponds to *Activity 3: Analyze Electronic Encounter Data* in CMS EQR Protocol 5.

¹⁹ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, February 2023. Available at: <https://www.medicare.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf>. Accessed on: Feb 27, 2025.

Objectives

The primary objectives of the EDV task were:

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

Technical Methods of Data Collection

Targeted Assessment of Encounter Data Information Systems and Processes

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

Comparative Analysis

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

HSAG developed data submission requirements documents to request pharmacy encounter/claims data from both OHA and the CCOs' PBMs. These documents included a brief description of the EDV study, a description of the review period, specifications of the pharmacy claims/encounter data, required data fields, and procedures for submitting the requested data files to HSAG. OHA and the CCOs' PBMs were requested to submit pharmacy claims and encounters with dates of service from January 1, 2023, through December 31, 2023, and only to include pharmacy claims and encounters that were in a final, fully adjudicated status as of May 31, 2024.

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

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

- Data extraction—Extracted based on the data requirements document.
- Percentage present—Required data fields are present in the file and have values in those fields.
- Percentage of valid values—The values are the expected values (e.g., valid National Drug Codes [NDCs]).
- Evaluation of matching claim numbers—The percentage of claim numbers matching between the data submitted by OHA and the data submitted by the CCOs' PBMs to HSAG.

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

Description of Data Obtained

Targeted Assessment of Encounter Data Information Systems and Processes

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

Comparative Analysis

HSAG obtained pharmacy claims and encounters from both OHA and the CCOs' PBMs. These claims and encounters covered the date of service period from January 1, 2023, to December 31, 2023, and encompassed pharmacy claims and encounters that had reached a final adjudicated status by May 31, 2024.

How Data Were Aggregated and Analyzed

Targeted Assessment of Encounter Data Information Systems and Processes

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

Comparative Analysis

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

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

Second, based on the number of records present in both data sources, HSAG further examined completeness and accuracy for the key data elements listed in Table 3-23. The analyses focused on an element-level comparison for each data element.

Table 3-23—Key Data Elements for Comparative Analysis

Key Data Elements
Member ID
Service Date (dispense date)
Billing Provider NPI
Prescribing Provider NPI
NDC
Drug Quantity
Days Supply
Paid Amount (by plan to provider)
Dispensing Fee
Paid Date

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

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

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

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

Technical Assistance

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

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of health care services provided by the CCOs, HSAG assigned each of the components reviewed for the EDV activities to one or more of three domains of care. This assignment to domains of care is depicted in Table 3-24.

Table 3-24—Assignment of EDV Activities to the Quality, Timeliness, and Access Domains

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

Mental Health Parity

Background

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

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

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

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

The 2024 analysis included a review of each CCO's and OHP FFS' attestation of continued compliance with parity requirements for MH/SUD and M/S benefits, with supplemental information provided by the CCOs and OHP FFS for prior year findings, a review of claims and utilization management (UM) data to identify key patterns and outcomes associated with the administration of covered benefits, an evaluation of the adequacy of the provider network and timeliness of access to MH/SUD treatment and services, and results from OHA's targeted evaluation assessing utilization of peer support services by and across the CCOs and OHP FFS, as well as an analysis of timeliness of payment for these services. For the purposes of this annual EQR technical report, only the CCO-specific methodology and results are presented.

Objectives

The primary objectives of the MHP activity were:

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

The 2024 MHP Evaluation identified and assessed the policies and standards, applied during CY 2023, governing limitations applied to MH/SUD services compared to M/S services. Differences in how limits were applied to MH/SUD services as compared to M/S services were evaluated for continued compliance with MHP regulations to ensure evidence-based, quality MH/SUD care.

Technical Methods of Data Collection

The 2024 MHP activities are described below.

1. **Protocol Development and Dissemination:** HSAG developed the 2024 MHP Evaluation Protocol to describe the scope and methodology in order to conduct the MHP Evaluation and provide guidance to OHA and the CCOs on their participation. The tools utilized for the analysis, identified below, were included with the protocol and were based on guidance outlined in CMS' *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*.²⁰
 - **MHP Treatment Limitation Attestation Tool**—A standardized questionnaire used by the CCOs to certify continued compliance with MHP requirements; collects information on the

²⁰ Centers for Medicare & Medicaid Services. *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*, January 17, 2017. Available at: <https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf>. Accessed on: Feb 28, 2025.

changes to the organization and its policies, procedures, and/or practices that could impact parity in the administration of MH/SUD and M/S benefits.

- **MHP Treatment Limitation Supplemental Questionnaire**—A questionnaire used by the CCOs to collect information on the policies, procedures, and/or practices that impact MH/SUD and M/S parity for implemented treatment limitations receiving a rating of *Partially Compliant* or *Not Compliant* in 2023; collects supplemental documentation and information to demonstrate compliance with parity requirements.
 - **MHP Data Submission Template**—A Microsoft Excel-based template used by the CCOs to report data on inpatient (IP), outpatient (OP), and pharmacy (Rx) claims and UM data; MH/SUD and M/S provider credentialing data; and member-level detail files.
2. **MHP Technical Assistance Webinar:** HSAG conducted a webinar to provide an overview of MHP regulations; details of the 2024 MHP Evaluation Protocol and tools; an overview of the MHP Evaluation timeline; a review of required documentation and submission guidelines, analysis, and reporting processes; and an opportunity for questions and answers. HSAG and OHA produced, and updated throughout the study, a Questions & Answers document to provide clarification to the CCOs on any questions received during and after the webinar.
 3. **Documentation Submission:** The CCOs were required to submit the *MHP Treatment Limitation Attestation Tool*, the *MHP Treatment Limitation Supplemental Questionnaire* (as applicable), and all applicable supporting documentation, as well as submit claims, UM, and credentialing data through the *MHP Data Submission Template*.
 4. **Desk Review and Analysis:** HSAG conducted a desk review of each CCO's submitted documentation and data to evaluate parity between MH/SUD and M/S services and benefits. HSAG performed an analysis of the claims, UM, and provider enrollment data to assess the impact of MH/SUD and M/S operations on claims and utilization decisions. Reported rates were validated against member-level detail files and used to develop an administrative profile for each CCO. HSAG also performed an assessment of the CCOs' MH/SUD provider networks to assess the adequacy, availability, and timeliness of access to MH/SUD services. The evaluation incorporated a multi-dimensional approach using a series of measures to support network reporting. Finally, in 2024, HSAG incorporated results from OHA's targeted evaluation assessing utilization of peer support services by and across the CCOs, as well as an analysis of the timeliness of payment for these services.
 - **Follow-Up Inquiries:** HSAG conducted follow-up with each CCO when desk review results or data analysis identified areas that required additional information and/or clarification.
 5. **Report Production:** HSAG compiled the information obtained from the desk review and data analysis to derive MHP findings for each CCO. Per HB 3046, HSAG summarized the results of its review and presented the findings to OHA and its community partners to solicit input on the assessment of the CCOs' and OHP FFS' compliance with the requirement for parity between MH/SUD and M/S covered benefits, identifying areas in which MHP was not achieved and corrective actions were required to ensure future parity. HSAG received feedback from OHA and its community partners and drafted a final MHP Evaluation Report for submission to OHA and the Oregon Legislature, no later than December 31, 2024.

Description of Data Obtained

To assess the CCOs' compliance with the federal, State, and contract requirements for parity between the MH/SUD and M/S covered benefits, HSAG obtained information from multiple documents and sources completed and submitted by each organization for the CY 2023 review period (i.e., January 1, 2023, through December 31, 2023), including, but not limited to:

- A completed *MHP Treatment Limitation Attestation Tool*, including narrative responses to all applicable questions and supplemental documentation.
- A completed *MHP Treatment Limitation Supplemental Questionnaire* (as applicable), including narrative responses and supplemental documentation to demonstrate compliance with parity requirements.
- A completed *MHP Data Submission Template*, including:
 - Membership counts.
 - Aggregated paid and denied claims counts for in-network and out-of-network providers.
 - A unique list of members associated with MH and SUD claims in CY 2023.
 - Aggregated UM data, including PA, denial, and appeals counts.
 - Member-level records associated with utilization decisions.
 - Provider enrollment and termination counts.
 - Member-level records associated with provider enrollment and termination decisions.
- CCO grievance logs.
- CCO provider network data based on quarterly DSN provider capacity data submitted to, and provided by, OHA to HSAG.
- Appointment availability results and updated monitoring methodology, including:
 - Results from the *CY 2023 Revealed Behavioral Health Telephone Survey Report*.²¹
- Results from OHA's analysis of CCOs peer support services utilization and timeliness to payment data submitted.

HSAG obtained additional information for the MHP Evaluation through interactions, discussions, and follow-up with each CCO's key staff members, as necessary. Furthermore, OHA convened meetings with three groups of community partners (i.e., consumers, CCOs, and providers) to solicit community input on the MHP Evaluation and future studies. Feedback from these meetings was submitted to HSAG to integrate in the 2024 MHP Evaluation Report.

²¹ Although incorporated into the 2024 MHP Evaluation, results from the *CY 2023 Revealed Behavioral Health Telephone Survey Report* have been excluded from Section 4 (Comparative Statewide Results) and Section 5 (CCO Individual Plan Results and Conclusions) as the information was previously reported in Oregon's 2023 EQR technical report in alignment with §438.358(b)(1). The full 2024 MHP Evaluation report, including findings from the survey, is available at <https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/2024-MHP-Report.pdf>. The 2023 Oregon EQR technical report is available at <https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/2023EQRTechnicalReport>.

How Data Were Aggregated and Analyzed

HSAG generated both qualitative and quantitative results based on submitted documentation in order to assess parity during the 2024 MHP Evaluation.

MHP Treatment Limitation Review Tool Analysis

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

- Whether the CCO reported and documented changes in its existing processes, policies, or procedures that support the administration of MH/SUD and M/S covered benefits.
- The extent to which changes, if documented, were compliant with federal and State parity requirements.

HSAG used the ratings of *Compliant*, *Partially Compliant*, and *Not Compliant*, as defined in Table 3-25, to indicate the degree to which changes identified by the CCOs and remained compliant with parity requirements or if the changes affected the comparability and stringency of processes, strategies, or evidentiary standards used in administering MH/SUD and M/S benefits. A designation of *Not Applicable (NA)* was used when a CCO was *Partially Compliant* or *Not Compliant* with an element in 2023, or if *Compliant*, indicated no change was made to organizational processes during the period covered by HSAG's review.

For its review of the *MHP Treatment Limitation Supplemental Questionnaire*, HSAG will assess each CCO's responses across the following evaluation domains:

- Whether the CCO described and provided documentation to address the *Partially Compliant* or *Not Compliant* rating in 2023.
- The degree to which implemented treatment limitations demonstrated:
 - The comparability of the processes, strategies, evidentiary standards, and other factors (in writing and in operation) used in applying treatment limitations to MH/SUD benefits and M/S benefits.
 - The stringency with which the processes, strategies, evidentiary standards, and other factors (in writing and operation) are applied to MH/SUD benefits and M/S benefits.

HSAG also used the ratings of *Compliant*, *Partially Compliant*, and *Not Compliant*, as defined in Table 3-25, to indicate the degree to which each CCO's performance was compliant with parity requirements based on whether the treatment limitations on MH/SUD benefits identified by the organization were comparable to and applied no more stringently than the limitations applied to M/S benefits. Both scoring methodologies are in alignment with CMS' *Parity Compliance Toolkit Applying Mental Health and*

*Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs.*²² HSAG reviewed all supportive documentation provided as well as information available from prior MHP analyses, as appropriate.

Table 3-25—Rating Definitions for MHP Compliance Determinations

Rating	Definition
<i>Compliant</i>	Indicates that the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was <i>comparable</i> with equivalent <i>stringency</i> .
<i>Partially Compliant</i>	Indicates that the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was: • <i>Comparable</i> but applied with different <i>stringency</i>, or • Not <i>comparable</i> but applied with equivalent <i>stringency</i>. OR • Documentation was incomplete (i.e., one or more evaluation elements were not addressed), but organizational structure was identified.
<i>Not Compliant</i>	Indicates that the organizational structure, including policies, procedures, strategies, and evidentiary standards used in administering MH/SUD and M/S benefits, was not <i>comparable</i> and applied with different <i>stringency</i> . If documentation and evidence was insufficient to demonstrate an adequately defined program, a rating of <i>Not Compliant</i> was also applied.

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

Administrative Data Profiles

To further understand the impact of CCO policies and procedures on the management of MH/SUD and M/S benefits, HSAG analyzed CCO data collected between January 1, 2023, and December 31, 2023, across three key domains. The data included aggregate counts for claims/encounters and UM decisions for MH/SUD and M/S services as well as MH/SUD provider enrollment data and identification of members representing the MH, SUD, and M/S claims. HSAG reviewed all submitted data for consistency and conducted a comparative analysis to identify trends between MH/SUD and M/S services and between CCOs and statewide. Data collected to support the Administrative Data Profiles

²² Centers for Medicare & Medicaid Services. *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*, January 17, 2017. Available at: <https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf>. Accessed on: Feb 28, 2025.

included services covered through four OHP benefit packages²³ (i.e., CCOA, CCOB, CCOE, and CCOB).

Although descriptive, the Administrative Data Profile was used to observe key patterns and outcomes associated with the administration of MH/SUD and M/S covered benefits. To further assess parity, HSAG evaluated the extent to which key claims/encounter and UM metrics differed between MH/SUD and M/S services. HSAG used deviation ratings of *None*, *Moderate*, and *Substantial*, as defined in Table 3-26, to indicate the degree to which each CCO's reported profile metrics differed across MH/SUD and M/S services.

Table 3-26—Deviation Rating Definitions for Administrative Data Profile

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

Adequacy of MH/SUD Provider Networks

The 2024 MHP Evaluation assessed the adequacy of the CCOs' MH/SUD provider networks by evaluating several interrelated measures of members' access to MH and SUD services.

Provider Network Capacity

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

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

Time and Distance

HSAG assessed the geographic distribution of MH and SUD providers relative to member populations as represented by the percentage of members having access to an MH and SUD provider within the acceptable travel times and distances defined by OHA. These requirements included the average travel

²³ OHP benefit levels include: CCOA (physical, behavioral, and oral health benefits), CCOB (i.e., physical and behavioral health benefits), CCOE (i.e., BH benefits only), and CCOG (i.e., behavioral and oral health benefits).

time (in minutes) and driving distance (in miles) to the nearest provider for each provider type. To refine the time and distance measures, CCO members were limited to members with an MH and/or SUD diagnosis as reported in the *MHP Data Submission Template* based on submitted MH/SUD claims. A threshold of 95 percent of members within the acceptable travel times and distances was used to identify CCOs with adequate access within given urbanities.²⁴ Table 3-27 outlines the acceptable travel times and distances by provider tier and urbanicity.²⁵

Table 3-27—Time and Distance Standards by Urbanicity and Provider Tier

Urbanicity Classification	Definition	Network Tier	Acceptable Time	Acceptable Distance
Large Urban	Conjoined urban areas with a total population of at least 1 million people or with a population density greater than 1,000 people per square mile.	Tier 1	10 Minutes	5 Miles
Urban	An area with greater than 40,000 people within a 10-mile radius of a city center.	Tier 1	25 Minutes	15 Miles
Rural	An area greater than 10 miles from the center of an urban area.	Tier 1	30 Minutes	20 Miles
Extreme Access	County with a population density of 10 or fewer people per square mile.	Tier 1	40 Minutes	30 Miles

Table 3-28 presents the provider types included in the evaluation of the adequacy of MH/SUD provider networks.

Table 3-28—MH and SUD Provider and Facility Type by Tier

Provider/ Facility Tier	Provider Type	Facility Type
Tier 1	MH Provider SUD Provider	NA

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

²⁴ Although OHA has established time and distance standards, CCO compliance is not assessed as part of this evaluation. OHA assesses CCO compliance to time and distance standards based on adult and pediatric provider types comprising three tiers; 95 percent or more pediatric and adult members must meet the acceptable travel time and distances to the nearest adult and pediatric provider, regardless of urbanicity.

²⁵ OHA's acceptable travel times and distances include a third tier (i.e., Tier 3) of specialty providers, including ALIM, DERM, END, GST, HEM, NEPH, OTO, PUL, RHEU, SNF, and URO providers. Tier 3 is excluded from the 2024 MHP Evaluation since no MH or SUD provider types are included in that tier.

Appointment Availability

HSAG incorporated results from OHA’s *CY 2023 Revealed Behavioral Health Telephone Survey Report* highlighting appointment availability for CCO members for BH outpatient provider locations. The findings from this survey assessed the accuracy of provider directory data (e.g., location, service offerings) and the ability of new and existing members to obtain both urgent and non-urgent appointments within established time frames. In accordance with 42 CFR §438.358(b)(1), which requires inclusion of results for all activities performed within 12 months preceding the finalization of the annual technical report, results from the CY 2023 Revealed Behavioral Health Telephone Survey activity were reported in Oregon’s 2023 EQR technical report and have not been repeated in this annual EQR technical report.²⁶

Access-Related Grievances

HSAG reviewed and assessed the percentage of access-related MH and SUD grievances to identify potential areas of concern with the availability of MH and SUD providers within each CCO’s network. Although descriptive, the review of access-related grievances was used to observe patterns that may be associated with the adequacy of MH/SUD and M/S provider networks. Additionally, to assess parity, HSAG evaluated the extent to which the grievance metrics differed between MH/SUD and M/S services. HSAG used deviation ratings of *None*, *Moderate*, and *Substantial*, as defined in Table 3-29, to indicate the degree to which each CCO’s reported profile metrics differed across MH/SUD and M/S services.

Table 3-29—Deviation Rating Definitions for Access-Related Grievances

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

²⁶ The full 2024 MHP Evaluation report, including findings from the survey, is available at <https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/2024-MHP-Report.pdf>. The Oregon 2023 EQR technical report is available at <https://www.oregon.gov/oha/HSD/OHP/DataReportsDocs/2023EQRTechnicalReport>.

Special Topic Evaluation—Peer Support Services

In CY 2023, OHA worked with the community partners to identify and select a topic for a targeted evaluation of an MH/SUD parity-related area of interest and/or concern. Based on the results of OHA's ranked choice survey of member community partners in November 2023, OHA determined that the 2024 MHP Evaluation special topic would target the utilization of peer support services across the CCOs as well as the timeliness of payment for the service.

As a baseline year, the primary objective of the special topic evaluation was to understand the utilization of peer support services by members with MH and/or SUD diagnoses by addressing the following questions:

- Were there differences in rates of peer support services utilization across counties and CCOs?
- Were there differences in the timeliness of payments for peer support services across counties and CCOs?
- Were there differences in the percentages of paid MH and SUD peer support services claims across counties and CCOs?

OHA extracted paid and denied claims in June 2024 for peer services (Healthcare Common Procedure Coding System [HCPCS] = H0038, or self-help/peer services per 15 minutes) with dates of service between January 1, 2023, and December 31, 2023, for members with a primary diagnosis of MH or SUD.²⁷ Data were extracted and aggregated, by county and organization (i.e., 16 CCOs), to support the derivation of three metrics:

- Utilization of peer support services per 1,000 member months (MM)
- Percentage of paid peer support services claims
- Timeliness of payment for peer support services claims

HSAG used the aggregate data to present findings and address the evaluation objectives. The results from this review establish a baseline measurement and will be used to direct future deep dive investigations.

²⁷ MH and SUD diagnoses were based on International Classification of Diseases, 10th Revision (ICD-10) classifications: MH = F01-F09 and F20-F99 | SUD = F10-F19.

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of health care services provided by the Medicaid CCOs, HSAG assigned each of the components reviewed for the MHP evaluation activity to one or more of three domains of care. This assignment to domains of care is depicted in Table 3-30.

Table 3-30—Assignment of MHP Evaluation Activities to the Quality, Timeliness, and Access Domains

MHP Evaluation Activity	Quality	Timeliness	Access
MHP Treatment Limitation Review	✓	✓	✓
Administrative Data Profile Analysis	✓	✓	✓
Adequacy of MH/SUD Provider Networks		✓	✓
Appointment Availability Review		✓	✓
Access-Related Grievances Analysis		✓	✓
Special Topic Evaluation Results—Peer Support Services		✓	✓

4. Comparative Statewide Results

Compliance Monitoring Review

Results for Compliance Review

HSAG calculated the overall CCO performance for each of the six standards reviewed. Table 4-1 displays CCO percentage-of-compliance scores for each standard reviewed as well as the total percentage-of-compliance score and overall confidence rating across the six standards. Appendix A. Compliance Monitoring Review Results provides a summary of CCO compliance findings for the past three reporting cycles (2021–2022, 2022–2023, and 2023–2024). Appendix B. Summary of Unresolved Compliance Review Findings shows unresolved compliance review findings from the past two reporting cycles based on HSAG’s assessment of the CCOs’ improvement plans, which were reviewed as part of the CY 2024 CMR activity. Due to the small number of elements associated with individual standards, a single *Partially Met* or *Not Met* rating may lead to substantive changes in the confidence rating. As such, results at the standard level should be viewed as informational in support of the CCO’s overall compliance score and confidence rating.

Table 4-1—Summary of CY 2024 CCO CMR Results

CCO	Standard I— Assurance of Adequate Capacity and Availability of Services	Standard V— Provider Selection	Standard VI— Subcontractual Relationships and Delegation	Standard XI— Practice Guidelines	Overall Compliance Score	Overall Confidence Rating
AH	86.8%	91.7%	87.5%	100%	89.1%	<i>Moderate</i>
AllCare	71.1%	75.0%	62.5%	100%	73.4%	<i>None</i>
CHA	71.1%	58.3%	62.5%	83.3%	68.8%	<i>None</i>
CPCCO	76.3%	75.0%	87.5%	83.3%	78.1%	<i>Low</i>
EOCCO	89.5%	83.3%	87.5%	16.7%	81.3%	<i>Low</i>
HSO	55.3%	58.3%	75.0%	33.3%	56.3%	<i>None</i>
IHN	89.5%	91.7%	75.0%	100%	89.1%	<i>Moderate</i>
JCC	76.3%	75.0%	87.5%	83.3%	78.1%	<i>Low</i>
PCS-CO	89.5%	83.3%	75.0%	83.3%	85.9%	<i>Moderate</i>
PCS-CG	89.5%	83.3%	75.0%	83.3%	85.9%	<i>Moderate</i>
PCS-LN	89.5%	83.3%	75.0%	83.3%	85.9%	<i>Moderate</i>
PCS-MP	89.5%	83.3%	75.0%	83.3%	85.9%	<i>Moderate</i>
TCHP-SW	86.8%	75.0%	87.5%	100%	85.9%	<i>Moderate</i>
TCHP-TC	86.8%	75.0%	87.5%	100%	85.9%	<i>Moderate</i>

CCO	Standard I— Assurance of Adequate Capacity and Availability of Services	Standard V— Provider Selection	Standard VI— Subcontractual Relationships and Delegation	Standard XI— Practice Guidelines	Overall Compliance Score	Overall Confidence Rating
UHA	78.9%	66.7%	87.5%	100%	79.7%	<i>Low</i>
YCCO	84.2%	91.7%	87.5%	100%	87.5%	<i>Moderate</i>
Statewide CCO Compliance Rate	81.9%	78.1%	79.7%	83.3%	81.1%	Low

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

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

For the CCOs statewide, the following conclusions were made:

- The statewide CCO compliance rates for all standards reviewed in CY 2024 ranged from 78.1 percent (Standard V—Provider Selection) to 83.3 percent (Standard XI—Practice Guidelines) with overall compliance scores for the CCOs individually ranging from 56.3 percent (HSO) to 89.1 percent (AH and IHN), revealing numerous opportunities for improvement with organizational structures, processes, and monitoring activities.
- Overall, CCO compliance scores resulted in the assignment of a *No Confidence* level for AllCare, CHA, and HSO; *Moderate Confidence* levels for AH, IHN, PCS-CO, PCS-CG, PCS-LN, PCS-MP, TCHP-SW, TCHP-TC, and YCCO; and *Low Confidence* levels for CPCCO, EOCCO, JCC, and UHA. None of the CCOs received a *High Confidence* level.
- Individual CCO compliance scores ranged from 55.3 percent to 89.5 percent (Standard I—Assurance of Adequate Capacity and Availability of Services), 58.3 percent to 91.7 percent (Standard V—Provider Selection), 62.5 percent to 87.5 percent (Standard VI—Subcontractual Relationships and Delegation), and 16.7 percent to 100 percent (Standard XI—Practice Guidelines).
- Seven CCOs (AH, AllCare, IHN, TCHP-SW, TCHP-TC, UHA, and YCCO) achieved full compliance (100 percent) in Standard XI—Practice Guidelines.
- HSAG noted numerous best practices among the CCOs related to health equity initiatives with respect to the availability of services and member-focused practices when adopting and reviewing practice guidelines.
- AH scored 85 percent compliance or higher for all standards reviewed and, along with IHN, achieved the highest overall compliance score (89.1 percent) compared to the other CCOs.
- HSO performed at or below 75 percent compliance for all standards reviewed, and its overall compliance score (56.3 percent) fell below the statewide CCO compliance rate by 24.8 percentage points.
- All CCOs were required to develop an improvement plan based on the CY 2024 compliance review.

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

- Insufficient documentation to support operations and ensure compliance with federal and State requirements, the inability to demonstrate implementation of established processes, and deficiencies within its monitoring activities impacting the CCO's ability to ensure timely access to care and services.
- Lack of policies and procedures for selecting and retaining network providers.
- Inability to demonstrate sufficient implementation of established processes impacting the CCO's ability to meet federal and State requirements for selecting, retaining, and credentialing network providers.
- Inadequate contractual arrangements resulting in noncompliance with federal requirements for written agreements between the CCO and its subcontractors.
- Failure to resolve findings from CY 2021 through CY 2023 CMR activities. All CCOs had unresolved findings following HSAG's assessment of the CCOs' improvement plans during the CY 2024 CMR activity. The number of unresolved findings ranged from one for UHA to 59 for HSO. All CCOs, with the exception of EOCCO and IHN, continued to have unresolved findings from the CY 2021 review; nearly half of the CCOs (CPCCO, EOCCO, HSO, JCC, TCHP-SW, TCHP-TC, and YCCO) had at least one unresolved finding from the CY 2022 review; and all plans, with the exception of UHA, had at least one unresolved finding from the CY 2023 review. See Appendix B. Summary of Unresolved Compliance Review Findings for the summary of unresolved compliance review findings from the past three reporting cycles.

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

- Revise policies, procedures, and member and provider communications to align with federal and State requirements.
- Develop and implement methodologies for monitoring and maintaining a provider network that is sufficient to provide adequate access to all services covered under the CCO Contract for all members, including those with limited English proficiency or physical or mental disabilities.
- Develop written policies and procedures for selecting and retaining providers and demonstrate credentialing and recredentialing of providers in accordance with State requirements.
- Implement appropriate oversight and monitoring of subcontractors to ensure accountability with contractual obligations.
- Revise contracts between the CCOs and subcontractors to align with federally-required language for written agreements.
- Develop and implement processes that align with federal and State requirements for adopting, reviewing, and disseminating clinical practice guidelines and ensure decision making is aligned with the adopted guidelines.
- Ensure a clear understanding of actions required to resolve noncompliant findings and seek technical assistance from HSAG, as needed, to ensure all EQR recommendations are fully addressed.

Validation of Performance Improvement Projects

Results for Performance Improvement Project Validations

The CCOs submitted baseline, RY 1, and RY 2 results of the statewide *Mental Health Service Access Monitoring* PIP in CY 2024 along with baseline and RY 1 results of the statewide *Substance Use Disorder* PIP. The HSAG PIP review team scored each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designated some of the evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements had to be *Met*.

Table 4-2 displays the validation scores and confidence ratings HSAG assigned to each CCO's PIP submissions for the statewide *Mental Health Service Access Monitoring* PIP.

Table 4-2—2024 Statewide *Mental Health Service Access Monitoring* PIP Validation Results by CCO

CCO	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements <i>Met</i> ¹	Percentage Score of Critical Elements <i>Met</i> ²	Confidence Rating ³	Percentage Score of Evaluation Elements <i>Met</i> ¹	Percentage Score of Critical Elements <i>Met</i> ²	Confidence Rating ³
AH	100%	100%	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>
AllCare	100%	100%	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>
CHA	100%	100%	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>
CPCCO	100%	100%	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>
EOCCO	100%	100%	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>
HSO	100%	100%	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>
IHN	100%	100%	<i>High Confidence</i>	67%	100%	<i>Moderate Confidence</i>
JCC	100%	100%	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>

CCO	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements <i>Met</i> ¹	Percentage Score of Critical Elements <i>Met</i> ²	Confidence Rating ³	Percentage Score of Evaluation Elements <i>Met</i> ¹	Percentage Score of Critical Elements <i>Met</i> ²	Confidence Rating ³
PCS-CO	100%	100%	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>
PCS-CG	100%	100%	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>
PCS-LN	100%	100%	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>
PCS-MP	100%	100%	<i>High Confidence</i>	67%	100%	<i>Moderate Confidence</i>
TCHP-SW	100%	100%	<i>High Confidence</i>	67%	100%	<i>Moderate Confidence</i>
TCHP-TC	100%	100%	<i>High Confidence</i>	33%	100%	<i>No Confidence</i>
UHA	100%	100%	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>
YCCO	93%	100%	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>

¹ **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

² **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

³ **Confidence Rating**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

Table 4-3 displays each CCO’s *Mental Health Service Access Monitoring* PIP baseline and RY 1 performance indicator results, associated interventions, whether the CCO’s PIP showed statistically significant (i.e., $p < 0.05$, 95 percent confidence interval) improvement in performance over baseline, and whether improvement was sustained for the subsequent RY 2. Green “g” shading for RY 1 (01/01/2022–12/31/2022) and RY 2 (01/01/2023–12/31/2023) results indicates the CCO showed improvement over baseline, and the upward arrows (▲) represent statistically significant improvement in performance indicator results from baseline year (BY) to RY 1 and/or RY 2.

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

PIP Topic: Statewide <i>Mental Health Service Access Monitoring</i> PIP Validation Results by CCO				
CCO	BY 01/01/2021– 12/31/2021	RY 1 Results 01/01/2022– 12/31/2022	RY 2 Results 01/01/2023– 12/31/2023	Sustained Improvement*
AH	55.3%	57.3% ▲	59.6% ▲	Yes
Interventions:				
- Promoted and financially supported recruitment and retention of providers in rural areas and providers representing diverse populations to increase equitable care. - Developed and distributed a “Quick Guide” member resource to clearly communicate BH benefits.				
AllCare	49.4%	51.2% ▲	54.3% ▲	Yes
Interventions:				
- Expanded the number of direct contracts with BH providers to provide member services. - Developed a data exchange process with BH providers to increase BH data accuracy. - Identified low-performing PCPs and delivered targeted in-person education via Provider Relations staff to identified PCPs on steps they can take to increase access to BH service for members.				
CHA	59.6%	58.9%	63.5% ▲	No
Interventions:				
Initiated text message BH education campaign targeting members of all ages.				
CPCCO	54.9%	55.5% ▲	58.4% ▲	Yes
Interventions:				
- Initiated grant-based program for clinics to expand services (e.g., crisis intervention screening, outreach, skills training) for members waiting to engage in formal BH treatment. - Directly contracted with telehealth agencies to increase equitable access to care by providing remote BH services for members in rural or frontier geographic areas. - Conducted BH provider rate setting and cost study to ensure adequate BH providers who offer culturally and linguistically specific care are recruited and retained. - Initiated BH service access dashboard to support coordination of BH care by providing centralized access to member data on BH treatment episodes through the online provider portal.				
EOCCO	58.5%	56.1%	61.1% ▲	No
Interventions:				
- Collaborated with integrated care clinics, pediatric clinics, and the local community mental health provider (CMHP), providing outreach materials to educate and engage members in BH services in the primary care setting. - Offered the Unite Us online platform for members to access social services and supports and provide a BH service referral route from social service providers to CMHPs.				

PIP Topic: Statewide Mental Health Service Access Monitoring PIP Validation Results by CCO				
CCO	BY 01/01/2021– 12/31/2021	RY 1 Results 01/01/2022– 12/31/2022	RY 2 Results 01/01/2023– 12/31/2023	Sustained Improvement*
- Launched “Come Care with Us” workforce development campaign, in collaboration with 12 county-based CMHPs, to recruit potential provider candidates by promoting advantages to working in behavioral health and living in eastern Oregon. - Provided technical assistance and training to Patient-Centered Primary Care Homes to support accurate coding and reporting of encounter BH services in integrated clinics to ensure claims are submitted and received for all provided services.				
HSO	57.7%	58.5% ▲	60.3% ▲	Yes
Interventions: - Deployed and began monitoring of Epic’s Compass Rose as a new care coordination platform for over 200 care coordinators to support daily reporting of care coordination activities for members with MH diagnoses. - PCP outreach and collaboration on establishing effective workflows for treating members with new and existing MH diagnoses. - Deployed and began monitoring of a MH provider access and capacity dashboard to better understand and improve provider-specific timeliness of care and volume of MH services.				
IHN	57.6%	56.3%	58.1%	No
Interventions: - IHC-CCO Health Equity Liaison conducted targeted education for community partners who work with historically marginalized populations to promote and increase engagement in BH care coordination services. - Initiated the Behavioral Health Home pilot in east Linn County to provide comprehensive, person-centered, integrated physical and BH care services in a single facility. - Partnered with community organizations to increase BH care awareness and access for members 2 to 5 years of age and their parents/caregivers.				
JCC	58.8%	58.5%	61.7% ▲	No
Interventions: - Initiated a grant-based program for clinics to expand services (e.g., crisis intervention screening, outreach, skills training) for members waiting to engage in formal BH treatment. - Directly contracted with telehealth agencies to increase equitable access to care by providing remote BH services for members in rural or frontier geographic areas. - Conducted BH provider rate setting and cost study to ensure adequate BH providers who offer culturally, and linguistically specific care are recruited and retained. - Initiated a BH service access dashboard to support coordination of BH care by providing centralized access to member data on BH treatment episodes through the online provider portal.				

PIP Topic: Statewide Mental Health Service Access Monitoring PIP Validation Results by CCO				
CCO	BY 01/01/2021– 12/31/2021	RY 1 Results 01/01/2022– 12/31/2022	RY 2 Results 01/01/2023– 12/31/2023	Sustained Improvement*
PCS-CO	63.4%	63.2%	64.8% ▲	No
Interventions: - Developed an emotional health campaign to improve outreach and education on BH service benefits and help reduce stigma of mental illness among the Latino/a/x population. - Deployed the BH Navigation Team, which identifies available BH providers and appointments, and aids providers and members in accessing and scheduling BH service appointments, referrals, and SDOH supports. - Engaged personal health navigators as part of the care management team for targeted outreach to members 65 years of age and older who have an emergency department (ED) visit with a BH-related diagnosis. The outreach includes depression screening, SDOH screening, and assistance in addressing barriers to follow-up BH care.				
PCS-CG	55.7%	55.3%	59.2% ▲	No
Interventions: - Developed an emotional health campaign to improve outreach and education on BH service benefits and help reduce stigma of mental illness among the Latino/a/x population. - Partnered with CMHPs and PCPs to educate and engage members in the use of non-emergent medical transportation (NEMT) benefits to reduce transportation barriers to BH care access. - Deployed the BH Navigation Team, which identifies available BH providers and appointments and aids providers and members in accessing and scheduling BH service appointments, referrals, and SDOH supports. - Engaged personal health navigators as part of the care management team for targeted outreach to members 65 years of age and older who have an ED visit with a BH-related diagnosis. The outreach includes depression screening, SDOH screening, and assistance in addressing barriers to follow-up BH care.				
PCS-LN	64.5%	63.4%	66.9% ▲	No
Interventions: - Developed an emotional health campaign to improve outreach and education on BH service benefits and help reduce stigma of mental illness among the Latino/a/x population. - Deployed the BH Navigation Team, which identifies available BH providers and appointments, and aids providers and members in accessing and scheduling MH service appointments, referrals, and SDOH supports. - Engaged personal health navigators as part of the care management team for targeted outreach to members 65 years of age and older who have an ED visit with a BH-related diagnosis. The outreach includes depression screening, SDOH screening, and assistance in addressing barriers to follow-up BH care.				
PCS-MP	58.0%	56.8%	58.6%	No
Interventions: Developed an emotional health campaign to improve outreach and education on BH service benefits and help reduce stigma of mental illness among the Latino/a/x population.				

PIP Topic: Statewide Mental Health Service Access Monitoring PIP Validation Results by CCO				
CCO	BY 01/01/2021– 12/31/2021	RY 1 Results 01/01/2022– 12/31/2022	RY 2 Results 01/01/2023– 12/31/2023	Sustained Improvement*
- Collaborated with Willamette Health Council to promote referrals to school-based health centers to provide BH care access for school-aged members. - Deployed the BH Navigation Team, which identifies available BH providers and appointments, and aids providers and members in accessing and scheduling MH service appointments, referrals, and SDOH supports. - Engaged personal health navigators as part of the care management team for targeted outreach to members 65 years of age and older who have an ED visit with a BH-related diagnosis. The outreach includes depression screening, SDOH screening, and assistance in addressing barriers to follow-up BH care.				
TCHP-SW	58.9%	58.4%	59.1%	No
Interventions: - Developed a career technical education program, offering mentoring and career development opportunities, specific to BH careers for Black, Indigenous, and People of Color (BIPOC) students. - Increased provider reimbursement rates for MH and SUD services. - Initiated an online platform to provide an enhanced closed loop referral process for care managers to better coordinate care and resources for members. - Expanded a provider incentive program to provide financial incentives to BH providers for addressing member care gaps. - Supported the Oregon Psychiatric Assistance Line to expand provider access to timely psychiatric consultation via telephone, provider education, and connection with MH professionals across the State.				
TCHP-TC	61.1%	52.1%	55.1%	No
Interventions: - Initiated an online platform to provide an enhanced closed loop referral process for care managers to better coordinate care and resources for members. - Partnered with a contracted provider who specializes in offering culturally specific SUD services for the African-American community. - Increased provider reimbursement rates for MH and SUD services. - Expanded a provider incentive program to provide financial incentives to BH providers for addressing member care gaps. - Offered a career technical education program, including mentoring and career development opportunities, specific to BH careers for BIPOC students.				
UHA	60.2%	62.0% ▲	63.8% ▲	Yes
Interventions: - Offered CLAS training and other language access resources offered to peer support specialists and other contracted providers to address the need for MH services among Spanish-speaking members. - Expanded MH telehealth providers with prioritization of providers from diverse backgrounds, culturally specific practices, and language accessibility services.				

PIP Topic: Statewide Mental Health Service Access Monitoring PIP Validation Results by CCO				
CCO	BY 01/01/2021– 12/31/2021	RY 1 Results 01/01/2022– 12/31/2022	RY 2 Results 01/01/2023– 12/31/2023	Sustained Improvement*
- Provided care coordination for children up to 5 years of age with high medical complexity. - Partnered with the community mental health center (CMHC) to engage members in the criminal justice system with MH and SUD services and reduce ED utilization among these members.				
YCCO	58.3%	58.3%	61.3% ▲	No
Interventions: - Established a contract request process and offer provider training and certification support to expand the MH provider network. - Conducted provider trainings on MH service documentation requirements. - Expanded MH provider network to include additional providers who speak a language other than English. - Increased meaningful language service access by connecting members with culturally appropriate service providers.				

▲ indicates statistically significant ($p < 0.05$, 95 percent confidence interval) improvement in performance indicator results from baseline to RY 1.

***Sustained Improvement:** Statistically significant improvement over baseline performance indicator results was demonstrated at RY 1 and, for a subsequent remeasurement period, at RY 2.

Table 4-4 displays the validation scores and confidence ratings HSAG assigned to each CCO's PIP submissions for the statewide *Substance Use Disorder* PIP.

Table 4-4—2024 Statewide Substance Use Disorder PIP Validation Results by CCO

CCO	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements Met ¹	Percentage Score of Critical Elements Met ²	Confidence Rating ³	Percentage Score of Evaluation Elements Met ¹	Percentage Score of Critical Elements Met ²	Confidence Rating ³
AH	100%	100%	High Confidence	67%	100%	Moderate Confidence
AllCare	100%	100%	High Confidence	67%	100%	Moderate Confidence
CHA	100%	100%	High Confidence	33%	100%	Low Confidence
CPCCO	100%	100%	High Confidence	33%	100%	Low Confidence

CCO	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements <i>Met</i> ¹	Percentage Score of Critical Elements <i>Met</i> ²	Confidence Rating ³	Percentage Score of Evaluation Elements <i>Met</i> ¹	Percentage Score of Critical Elements <i>Met</i> ²	Confidence Rating ³
EOCCO	100%	100%	<i>High Confidence</i>	33%	100%	<i>No Confidence</i>
HSO	100%	100%	<i>High Confidence</i>	100%	100%	<i>High Confidence</i>
IHN	100%	100%	<i>High Confidence</i>	33%	100%	<i>No Confidence</i>
JCC	100%	100%	<i>High Confidence</i>	67%	100%	<i>Moderate Confidence</i>
PCS-CO	100%	100%	<i>High Confidence</i>	67%	100%	<i>Moderate Confidence</i>
PCS-CG	100%	100%	<i>High Confidence</i>	33%	100%	<i>No Confidence</i>
PCS-LN	100%	100%	<i>High Confidence</i>	33%	100%	<i>No Confidence</i>
PCS-MP	100%	100%	<i>High Confidence</i>	67%	100%	<i>Moderate Confidence</i>
TCHP-SW	100%	100%	<i>High Confidence</i>	33%	100%	<i>Low Confidence</i>
TCHP-TC	100%	100%	<i>High Confidence</i>	67%	100%	<i>Moderate Confidence</i>
UHA	100%	100%	<i>High Confidence</i>	33%	100%	<i>No Confidence</i>
YCCO	100%	100%	<i>High Confidence</i>	33%	100%	<i>Low Confidence</i>

¹ **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and non-critical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met*).

² **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

³ **Confidence Rating**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

Table 4-5 displays each CCO’s statewide *Substance Use Disorder* PIP baseline and RY 1 performance indicator results, associated interventions, and whether the CCO’s PIP showed statistically significant improvement (i.e., $p < 0.05$, 95 percent confidence interval) in performance over baseline. Green “g” shading for RY 1 (01/01/2023–12/31/2023) results indicates the CCO showed improvement over baseline, and the upward arrows (▲) represent statistically significant improvement in performance indicator results from BY to RY 1.

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

PIP Topic: Statewide <i>Substance Use Disorder</i> PIP Validation Results by CCO				
CCO	Performance Indicator 1: <i>Percentage of new SUD episodes that result in treatment and initiation within 14 days.</i>		Performance Indicator 2: <i>Percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.</i>	
	BY (01/01/2022-12/31/2022)	RY 1 (01/01/2023-12/31/2023)	BY (01/01/2022-12/31/2022)	RY 1 (01/01/2023-12/31/2023)
AH	34.1%	37.2%	11.8%	11.9%
Interventions:				
- Targeted outreach to members with SUD diagnoses and high ED utilization by care management staff to support and facilitate re-engagement in SUD treatment. - Integrated peer support specialists to facilitate SUD treatment in alternative settings targeting services for youth, elderly, and members without stable housing. - Developed Coos Sobering Center—a safe place for members to receive housing if needed and to initiate and engage in SUD treatment.				
AllCare	BY (01/01/2022-12/31/2022)	RY 1 (01/01/2023-12/31/2023)	BY (01/01/2022-12/31/2022)	RY 1 (01/01/2023-12/31/2023)
	35.1%	37.7% ▲	13.7%	14.9%
Interventions:				
- Identified members who have received SUD assessment services but have not initiated treatment and are waiting on access to residential treatment services. Partnered with SUD agencies to engage these members in accessing available SUD treatment options while they are waiting for access to higher levels of care. - Offered incentives through AllCare’s alternative payment model for primary care and BH agencies that improve performance in SUD treatment initiation and engagement through member outreach, peer support services, and “warm handoff” referrals for SUD treatment. - Enhanced provider outreach to offer support to provider offices in improving SUD treatment initiation and engagement performance by providing care gap lists, providing SUD treatment agency resources, and educating on available referral pathways for SUD treatment services.				

PIP Topic: Statewide Substance Use Disorder PIP Validation Results by CCO				
CCO	Performance Indicator 1: Percentage of new SUD episodes that result in treatment and initiation within 14 days.		Performance Indicator 2: Percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.	
CHA	BY (01/01/2022-12/31/2022)	RY 1 (01/01/2023-12/31/2023)	BY (01/01/2022-12/31/2022)	RY 1 (01/01/2023-12/31/2023)
	45.0%	46.7%	23.5%	22.7%
Interventions:				
Established an automated system to notify PCPs when members have an SUD diagnosis event.				
CPCCO	BY (01/01/2022-12/31/2022)	RY 1 (01/01/2023-12/31/2023)	BY (01/01/2022-12/31/2022)	RY 1 (01/01/2023-12/31/2023)
	40.2%	37.2%	13.9%	14.1%
Interventions:				
- Partnered with community mental health programs, public health agencies, and SUD treatment programs to increase prescribing of medication-assisted treatment for opioid use disorder and alcohol use disorder. - Partnered with hospitals, EDs, and providers to develop a workflow for increasing initiation of SUD treatment after an SUD-related ED visit.				
EOCCO	BY (01/01/2022-12/31/2022)	RY 1 (01/01/2023-12/31/2023)	BY (01/01/2022-12/31/2022)	RY 1 (01/01/2023-12/31/2023)
	37.8%	37.1%	14.7%	14.1%
Interventions:				
- Conducted weekly targeted provider outreach to coordinate SUD treatment initiation services for members who have a new SUD diagnosis. - Facilitated a provider learning collaborative that included information on how SUD treatment initiation and engagement performance is measured, as well as shared strategies for improving provider performance on measures, including provider outreach and peer sharing of successful treatment referral workflows.				
HSO	BY (01/01/2022-12/31/2022)	RY 1 (01/01/2023-12/31/2023)	BY (01/01/2022-12/31/2022)	RY 1 (01/01/2023-12/31/2023)
	42.5%	45.7% ▲	15.3%	17.2% ▲
Interventions:				
Developed, distributed, and monitored an Initiation and Engagement in Treatment (IET) Dashboard used for monitoring of initiation and engagement services for SUD treatment by HSO plan partners.				

PIP Topic: Statewide Substance Use Disorder PIP Validation Results by CCO				
CCO	Performance Indicator 1: Percentage of new SUD episodes that result in treatment and initiation within 14 days.		Performance Indicator 2: Percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.	
• Provided technical assistance on best practices for SUD treatment and medication-assisted opioid use disorder treatment to ED providers. • Expanded ED SUD pilot focusing on initiation of medications for opioid use disorder in the ED combined with peer support services. • Disseminated an alcohol use disorder tip sheet for providers and clinics. • Expanded access to the Addiction Consult Service, an integrated care team imbedded in inpatient facilities to support addiction treatment.				
IHN	BY (01/01/2022-12/31/2022)	RY 1 (01/01/2023-12/31/2023)	BY (01/01/2022-12/31/2022)	RY 1 (01/01/2023-12/31/2023)
	39.6%	37.8%	19.7%	18.8%
Interventions: • Initiated the Behavioral Health Home pilot in east Linn County to provide comprehensive, person-centered, integrated physical and BH care services in a single facility. • Expanded provider education on IET measure requirements, SUD treatment modalities that meet the requirements for the measure, and best practices for supporting member access to SUD treatment. • Partnered with Affect Therapeutics to provide structured, individualized SUD treatment for members, which includes telehealth, medication management, group and individual therapy, and a digital app for monitoring treatment				
JCC	BY (01/01/2022-12/31/2022)	RY 1 (01/01/2023-12/31/2023)	BY (01/01/2022-12/31/2022)	RY 1 (01/01/2023-12/31/2023)
	39.2%	41.0%	14.5%	15.1%
Interventions: • Partnered with CMHPs, public health agencies, and SUD treatment programs to increase prescribing of medication-assisted treatment for opioid use disorder and alcohol use disorder. • Developed an “SUD in the ED” pilot program that offers training and technical assistance to ED providers on SUD treatment best practices and medication-assistant treatment options. The program also provides funding for SUD treatment navigators to be based in local hospitals. • Partnered with the Oasis Center of the Rogue Valley, a community clinic that supports parents with SUD and their young children, JCC provided incentives to members who are engaged in medication-assisted treatment for opiate use disorder.				

PIP Topic: Statewide Substance Use Disorder PIP Validation Results by CCO				
CCO	Performance Indicator 1: Percentage of new SUD episodes that result in treatment and initiation within 14 days.		Performance Indicator 2: Percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.	
PCS-CO	BY (01/01/2022-12/31/2022)	RY 1 (01/01/2023-12/31/2023)	BY (01/01/2022-12/31/2022)	RY 1 (01/01/2023-12/31/2023)
	39.7%	42.1%	16.7%	16.9%
Interventions:				
- Conducted provider education to increase provider confidence in discussing initiation of SUD treatment with members and connecting members to appropriate treatment services. - Implemented a live, staffed telephone service available to members, community-based organizations, and providers seeking assistance in connecting members with SUD treatment services. - Provided an OHA-approved qualified health care interpreter (QHCI) training program to increase availability of QHCIs for facilitating SUD treatment options for members speaking a language other than English. - Conducted provider education, coaching, and resources to increase provider knowledge of appropriate coding for SUD treatment initiation and engagement services.				
PCS-CG	BY (01/01/2022-12/31/2022)	RY 1 (01/01/2023-12/31/2023)	BY (01/01/2022-12/31/2022)	RY 1 (01/01/2023-12/31/2023)
	41.6%	39.4%	15.1%	14.7%
Interventions:				
- Conducted provider education to increase provider confidence in discussing initiation of SUD treatment with members and connecting members to appropriate treatment services. - Implemented a live, staffed telephone service available to members, community-based organizations, and providers seeking assistance in connecting members with SUD treatment services. - Provided an OHA-approved QHCI training program to increase availability of QHCIs for facilitating SUD treatment options for members speaking a language other than English. - Conducted provider education, coaching, and resources to increase provider knowledge of appropriate coding for SUD treatment initiation and engagement services.				
PCS-LN	BY (01/01/2022-12/31/2022)	RY 1 (01/01/2023-12/31/2023)	BY (01/01/2022-12/31/2022)	RY 1 (01/01/2023-12/31/2023)
	43.8%	41.5%	17.9%	17.1%
Interventions:				
Conducted provider education to increase provider confidence in discussing initiation of SUD treatment with members and connecting members to appropriate treatment services.				

PIP Topic: Statewide Substance Use Disorder PIP Validation Results by CCO				
CCO	Performance Indicator 1: Percentage of new SUD episodes that result in treatment and initiation within 14 days.		Performance Indicator 2: Percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.	
- Implemented a live, staffed telephone service available to members, community-based organizations, and providers seeking assistance in connecting members with SUD treatment services. - Provided an OHA-approved QHCI training program to increase availability of QHCIs for facilitating SUD treatment options for members speaking a language other than English. - Conducted provider education, coaching, and resources to increase provider knowledge of appropriate coding for SUD treatment initiation and engagement services.				
PCS-MP	BY (01/01/2022-12/31/2022)	RY 1 (01/01/2023-12/31/2023)	BY (01/01/2022-12/31/2022)	RY 1 (01/01/2023-12/31/2023)
	40.8%	41.3%	18.2%	19.3%
Interventions: - Conducted provider education to increase provider confidence in discussing initiation of SUD treatment with members and connecting members to appropriate treatment services. - Implemented a live, staffed telephone service available to members, community-based organizations, and providers seeking assistance in connecting members with SUD treatment services. - Provided an OHA-approved QHCI training program to increase availability of QHCIs for facilitating SUD treatment options for members speaking a language other than English. - Conducted provider education, coaching, and resources to increase provider knowledge of appropriate coding for SUD treatment initiation and engagement services.				
TCHP-SW	BY (01/01/2022-12/31/2022)	RY 1 (01/01/2023-12/31/2023)	BY (01/01/2022-12/31/2022)	RY 1 (01/01/2023-12/31/2023)
	42.2%	42.5%	16.5%	16.4%
Interventions: - Collaborated with health care and education community partners to develop a career technical education program, offering mentoring and career development opportunities specific to BH careers for BIPOC students. - Increased reimbursement rates for BH services, including SUD treatment services. - Implemented provider incentive program for closing SUD treatment care gaps for members, and provider outreach promoting the program. - Conducted member outreach by case management staff to address members’ SUD treatment needs. - Provided funding for members to continue staying at a sober living facility to allow stabilization of recovery and ongoing engagement in SUD treatment.				

PIP Topic: Statewide Substance Use Disorder PIP Validation Results by CCO

CCO	Performance Indicator 1: <i>Percentage of new SUD episodes that result in treatment and initiation within 14 days.</i>		Performance Indicator 2: <i>Percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.</i>	
- Implemented Health Assistance, Linkage, and Outreach (HALO), a quality-based integrated care model focused on identifying and supporting members with SUD treatment needs through collaborative provider-community partnerships. - Launched Connect Oregon/Unite Us online platform to provide an enhanced closed-loop referral process for care managers to better coordinate SUD treatment services and resources for members.				
TCHP-TC	BY (01/01/2022-12/31/2022)	RY 1 (01/01/2023-12/31/2023)	BY (01/01/2022-12/31/2022)	RY 1 (01/01/2023-12/31/2023)
	40.9%	45.7% ▲	15.3%	17.8%
Interventions: - Collaborated with health care and education community partners to develop a career technical education program, offering mentoring and career development opportunities specific to BH careers for BIPOC students. - Increased reimbursement rates for BH services, including SUD treatment services. - Implemented provider incentive program for closing SUD treatment care gaps for members, and provider outreach promoting the program. - Conducted member outreach by case management staff to address members’ SUD treatment needs. - Provided funding for members to continue staying at a sober living facility to allow stabilization of recovery and ongoing engagement in SUD treatment. - Implemented HALO, a quality-based integrated care model focused on identifying and supporting members with SUD treatment needs through collaborative provider-community partnerships. - Launched Connect Oregon/Unite Us online platform to provide an enhanced closed-loop referral process for care managers to better coordinate SUD treatment services and resources for members.				
UHA	BY (01/01/2022-12/31/2022)	RY 1 (01/01/2023-12/31/2023)	BY (01/01/2022-12/31/2022)	RY 1 (01/01/2023-12/31/2023)
	39.9%	39.3%	16.5%	14.9%
Interventions: - Promoted and incentivized provider use of PointClickCare, an electronic health information exchange platform that allows providers to identify when their patients have an ED visit or hospitalization, to facilitate initiation and engagement in SUD treatment. - Partnered with a local hospital and CMHC to facilitate effective SUD treatment referral pathways. - Conducted provider and member education on peer-delivered SUD treatment services in partnership with Adapt Peer Support Specialists and Rely Health Patient Care Navigators.				

PIP Topic: Statewide <i>Substance Use Disorder</i> PIP Validation Results by CCO				
CCO	Performance Indicator 1: <i>Percentage of new SUD episodes that result in treatment and initiation within 14 days.</i>		Performance Indicator 2: <i>Percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.</i>	
Funded a scholarship for providers and staff to complete the OHA-approved QHCI training program to address the need for care that is provided in languages other than English.				
YCCO	BY (01/01/2022-12/31/2022)	RY 1 (01/01/2023-12/31/2023)	BY (01/01/2022-12/31/2022)	RY 1 (01/01/2023-12/31/2023)
	41.3%	42.0%	16.6%	15.7%
Interventions: - Partnered with the Center for Addictions Triage and Treatment project to increase access to higher-level SUD care. - Enhanced SUD service directory based on lessons learned from the service director pilot program. - Conducted provider education on SUD treatment initiation and engagement timeliness and measure requirements.				

▲ indicates statistically significant ($p < 0.05$, 95 percent confidence interval) improvement in performance indicator results from baseline to RY 1.

***Sustained Improvement:** Statistically significant improvement over baseline performance indicator results was demonstrated at RY 1 and, for a subsequent remeasurement period, at RY 2.

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

For the CCOs statewide, the following conclusions were made:

- The CCOs continued two statewide PIPs with methodologically sound designs. The *Mental Health Service Access Monitoring* PIP responds to member needs identified as priorities for the State in response to the coronavirus disease 2019 (COVID-19) public health emergency (PHE). The *Substance Use Disorder* PIP allows the CCOs to further focus efforts on improving treatment for members with SUD as part of the broader efforts included in the Substance Use Disorder 1115 Demonstration waiver.
- All CCOs received a *High Confidence* rating for their overall confidence of adherence to acceptable methodology for all phases of the *Mental Health Service Access Monitoring* PIP as well as the *Substance Use Disorder* PIP. All CCOs also conducted methodologically sound improvement strategies for both statewide PIPs.
- With the exception of YCCO, the CCOs conducted accurate and complete data analyses and interpretation of RY 2 indicator results for the *Mental Health Service Access Monitoring* PIP, and all CCOs conducted accurate and complete data analyses and interpretation of RY 1 results for the *Substance Use Disorder* PIP.

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

- In the Outcomes stage for the *Mental Health Service Access Monitoring* PIP, four CCOs (IHN, PCS-MP, TCHP-SW, and TCHP-TC) had opportunities for improvement in the Outcomes stage, reporting RY 2 indicator results that did not demonstrate statistically significant improvement over baseline results.
- In the Outcomes stage for the *Substance Use Disorder* PIP, HSO was the only CCO to achieve statistically significant improvement from baseline to RY 1 for both performance indicators.

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

- OHA should continue to foster a collaborative environment for the CCOs and continue providing regular opportunities for the CCOs to exchange ideas, and the CCOs should continue to work together and with OHA to identify barriers to improving access to MH services and improving initiation, engagement, and treatment of alcohol and other drug use disorders for members with an identified need.
- The CCOs should ensure a clear understanding of the performance indicator data files received from OHA so that progress toward improvement goals can be effectively assessed and reported throughout the duration of the project. The CCOs should reach out to OHA for clarification on data files, if needed.
- OHA, with support from HSAG, should provide technical assistance and training to the CCOs on robust QI tools and processes for conducting root cause analyses, barrier prioritization, intervention selection, and intervention evaluations. The CCOs, specifically those who have not achieved significant improvement of PIP outcomes, should ensure attendance at the technical assistance sessions offered by OHA and HSAG.
- The CCOs should revisit root cause analyses identifying barriers to improving access to MH services and improving initiation, engagement, and treatment of alcohol and other drug use disorders to determine which barriers to improvement were not addressed.
- OHA, with support from HSAG, should facilitate the CCOs' use of timely intervention-specific evaluation results to guide decisions about continuing, revising, or discontinuing interventions to promote effective resource use and achievement of improvement goals. The CCOs should conduct intervention-specific evaluations throughout the measurement year to allow mid-course corrections and drive improvement, prior to the end of each annual measurement period.

Performance Measure Validation

Results From Information Systems Standards Review

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

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

Results for Performance Measures

Table 4-6 shows the summary of validation results for OHA’s incentive measure rates validated during the CY 2024 PMV activity.

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

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

* HSAG did not audit MY 2021 *Initiation and Engagement of Substance Use Disorder Treatment* rates for the *Ages 13 to 17 Years* or *Ages 18 Years and Older* measure indicators. Additionally, OHA incentivizes CCO performance for this measure only for the *Ages 18 Years and Older* indicator.

R—Reportable; measures were compliant with OHA specifications.

Table 4-7 through Table 4-11 display the final OHA-calculated rates audited by HSAG for each of the four performance measures. Each table presents MY 2021, MY 2022, and MY 2023 rates for individual CCOs, the statewide aggregate rate for each measurement year, the OHA benchmark for each measurement year, and the magnitude of change in performance between measurement years. The larger the number, the greater the difference between the MY 2022 and MY 2023 rates. For all measurement years, green “g” shading indicates a rate that was substantially greater than the statewide aggregate (i.e., 5 percentage points or more), while yellow “y” shading indicates a rate greater than the statewide aggregate (i.e., greater than, but less than 5 percentage points). The tables also indicate, for each CCO, whether the change from MY 2022 to MY 2023 resulted in substantial improvement (i.e., ▲ or 5 percentage points) or decline (i.e., ▼ or 5 percentage points) in performance. Note that for the

Initiation and Engagement of Substance Use Disorder Treatment measure, HSAG did not audit MY 2021 rates for the 13 to 17 years or 18 years and older age groups. Additionally, OHA incentivizes CCO performance only for the 18 years and older age group for this measure.

Table 4-7 outlines performance results for each of the participating CCOs regarding *Child and Adolescent Well-Care Visits—Ages 3 to 6 Years*, which measures the percentage of children ages 3 to 6 years who had at least one well-care visit with a PCP or OB/GYN during the measurement year.

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

CCO	MY 2021	MY 2022	MY 2023	Difference ¹
Statewide Aggregate	64.1%	63.1%	65.4%	2.3%
OHA Benchmark²	54.6%	64.1%	68.6%	4.5%
AH	64.2%	64.8%	67.4%	2.6%
AllCare	55.3%	55.3%	62.1%	6.8% ▲
CHA	59.8%	56.6%	66.2%	9.6% ▲
CPCCO	55.1%	59.3%	59.7%	0.4%
EOCCO	64.2%	64.6%	67.4%	2.8%
HSO	65.6%	64.4%	66.1%	1.7%
IHN	65.2%	64.5%	65.5%	1.0%
JCC	63.7%	58.0%	66.6%	8.6% ▲
PCS-CO	68.4%	69.3%	70.5%	1.2%
PCS-CG	71.4%	76.0%	74.4%	-1.6%
PCS-LN	59.5%	57.8%	61.3%	3.5%
PCS-MP	66.2%	62.9%	64.2%	1.3%
TCHP-SW	51.5%	51.9%	51.4%	-0.5%
TCHP-TC	45.6%	46.3%	41.5%	-4.8%
UHA	65.1%	71.0%	70.7%	-0.3%
YCCO	65.3%	68.2%	73.3%	5.1% ▲

¹ For this measure, substantial improvement or decline in performance between the measurement years is defined as an increase or decrease of 5 percentage points or more between MY 2022 and MY 2023 rates.

² The MY 2021 benchmark (2020 CCO 25th percentile) was reduced by OHA due to PHE-related external factors (Source: OHA 2021 CCO Performance Metrics Dashboard). The MY 2022 benchmark set by OHA is the 2020 CCO 75th percentile for the 3 to 6 years age group. The MY 2023 benchmark set by OHA is the 2019 CCO average for the 3 to 6 years age group.

Table 4-8 outlines performance results for each of the participating CCOs regarding *Initiation and Engagement of Substance Use Disorder Treatment—Ages 13 to 17 Years*, which measures the percentage of members ages 13 to 17 years who were diagnosed with a substance use disorder and:

- *Initiation of SUD Treatment*: Initiated treatment through an inpatient SUD admission, OP visit, intensive OP encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis during the measurement year; and
- *Engagement of SUD Treatment*: Have evidence of treatment engagement within 34 days of initiation during the measurement year.

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

CCO	Initiation of SUD Treatment (Ages 13 to 17 Years)			Engagement of SUD Treatment (Ages 13 to 17 Years)		
	MY 2022	MY 2023	Difference ¹	MY 2022	MY 2023	Difference ¹
Statewide Aggregate	36.7%	38.5%	1.8%	20.3%	22.3%	2.0%
OHA Benchmark²	NA	NA	NA	NA	NA	NA
AH	17.6%	20.0%	2.4%	5.9%	10.9%	5.0% ▲
AllCare	35.5%	41.8%	6.3% ▲	21.1%	7.6%	-13.5% ▼
CHA	34.0%	44.1%	10.1% ▲	28.3%	20.3%	-8.0% ▼
CPCCO	52.8%	36.5%	-16.3% ▼	33.3%	15.4%	-17.9% ▼
EOCCO	29.9%	39.4%	9.5% ▲	11.1%	15.7%	4.6%
HSO	38.9%	35.4%	-3.5%	19.5%	21.4%	1.9%
IHN	29.9%	39.1%	9.2% ▲	20.1%	23.7%	3.6%
JCC	26.7%	25.0%	-1.7%	16.0%	13.5%	-2.5%
PCS-CO	36.5%	43.6%	7.1% ▲	20.3%	26.2%	5.9% ▲
PCS-CG	46.2%	22.2%	-24.0% ▼	30.8%	16.7%	-14.1% ▼
PCS-LN	44.1%	41.4%	-2.7%	17.6%	22.1%	4.5%
PCS-MP	35.1%	44.6%	9.5% ▲	22.2%	31.3%	9.1% ▲
TCHP-SW	29.5%	44.1%	14.6% ▲	15.9%	11.8%	-4.1%
TCHP-TC	30.0%	45.8%	15.8% ▲	30.0%	33.3%	3.3%
UHA	51.3%	41.8%	-9.5% ▼	33.8%	20.9%	-12.9% ▼
YCCO	35.5%	46.6%	11.1% ▲	23.7%	23.9%	0.2%

* The NCQA recommended a break in trending for the *Initiation and Engagement of Substance Use Disorder Treatment* measure due to major specification changes for MY 2022.²⁸ This table presents only the CCOs' MY 2022 and MY 2023 rates on the measure.

¹ For this measure, substantial improvement or decline in performance between the measurement years is defined as an increase or decrease of 5 percentage points or more between MY 2022 and MY 2023 rates.

² The MY 2022 benchmarks set by OHA are the 2020 national Medicaid median for the applicable age groups. The MY 2023 benchmark set by OHA is the 2021 CCO 90th percentile for the applicable age groups. Note that OHA incentivizes CCO performance only for the 18 years and older age group.

²⁸ HEDIS® MY 2022 Measure Trending Determinations, June 2022. Available at: <https://www.ncqa.org/wp-content/uploads/2022/06/HEDIS-MY2022-Measure-Trending-Determinations.pdf>. Accessed on: Mar 3, 2025.

Table 4-9 outlines performance results for each of the participating CCOs regarding *Initiation and Engagement of Substance Use Disorder Treatment—Ages 18 Years and Older*, which measures the percentage of members ages 18 years or older who were diagnosed with a substance use disorder and:

- *Initiation of SUD Treatment*: Initiated treatment through an inpatient SUD admission, OP visit, intensive OP encounter or partial hospitalization, telehealth, or medication treatment within 14 days of the diagnosis during the measurement year; and,
- *Engagement of SUD Treatment*: Have evidence of treatment engagement within 34 days of initiation during the measurement year.

Table 4-9—CCO Results for Initiation and Engagement of Substance Use Disorder Treatment—Ages 18 Years and Older

CCO	Initiation of SUD Treatment (Ages 18 Years and Older)			Engagement of SUD Treatment (Ages 18 Years and Older)		
	MY 2022	MY 2023	Difference ¹	MY 2022	MY 2023	Difference ¹
Statewide Aggregate	42.4%	42.3%	-0.1%	16.1%	16.6%	0.5%
OHA Benchmark²	43.0%	43.3%	0.3%	13.9%	16.3%	2.4%
AH	34.5%	37.8%	3.3%	11.6%	11.9%	0.3%
AllCare	34.5%	37.6%	3.1%	13.3%	14.8%	1.5%
CHA	45.2%	46.9%	1.7%	23.0%	21.4%	-1.6%
CPCCO	39.2%	37.2%	-2.0%	13.4%	14.0%	0.6%
EOCCO	38.5%	37.0%	-1.5%	14.9%	14.0%	-0.9%
HSO	42.9%	46.1%	3.2%	15.4%	17.0%	1.6%
IHN	39.7%	37.7%	-2.0%	19.2%	18.6%	-0.6%
JCC	38.6%	41.6%	3.0%	14.1%	15.2%	1.1%
PCS-CO	47.1%	42.0%	-5.1% ▼	17.0%	16.4%	-0.6%
PCS-CG	46.2%	40.0%	-6.2% ▼	15.4%	14.6%	-0.8%
PCS-LN	50.0%	41.5%	-8.5% ▼	18.7%	16.9%	-1.8%
PCS-MP	46.3%	41.1%	-5.2% ▼	18.1%	18.8%	0.7%
TCHP-SW	42.6%	42.5%	-0.1%	16.5%	16.4%	-0.1%
TCHP-TC	41.2%	45.7%	4.5%	15.6%	17.6%	2.0%
UHA	40.8%	39.3%	-1.5%	16.2%	14.7%	-1.5%
YCCO	42.4%	41.7%	-0.7%	16.5%	15.1%	-1.4%

* The NCQA recommended a break in trending for the *Initiation and Engagement of Substance Use Disorder Treatment* measure due to major specification changes for MY 2022.²⁹ This table presents only the CCOs' MY 2022 and MY 2023 rates on the measure.

¹ For this measure, substantial improvement or decline in performance between the measurement years is defined as an increase or decrease of 5 percentage points or more between MY 2022 and MY 2023 rates.

² The MY 2022 benchmarks set by OHA are the 2020 national Medicaid median for the applicable age groups. The MY 2023 benchmark set by OHA is the 2021 CCO 90th percentile for the applicable age groups. Note that OHA incentivizes CCO performance only for the 18 years and older age group.

²⁹ HEDIS® MY 2022 Measure Trending Determinations, June 2022. Available at: <https://www.ncqa.org/wp-content/uploads/2022/06/HEDIS-MY2022-Measure-Trending-Determinations.pdf>. Accessed on: Mar 3, 2025.

Table 4-10 outlines performance results for each of the participating CCOs regarding *Members Receiving Preventive Dental or Oral Health Services—Ages 1 to 5 Years* and *Ages 6 to 14 Years*, which measures children ages one to five years and ages six to 14 years who received preventive dental or oral health services during the measurement year.

Table 4-10—CCO Results for the *Members Receiving Preventive Dental or Oral Health Services—Ages 1 to 5 Years* and *Ages 6 to 14 Years*

CCO	Ages 1 to 5 Years				Ages 6 to 14 Years			
	MY 2021	MY 2022	MY 2023	Difference ¹	MY 2021	MY 2022	MY 2023	Difference ¹
Statewide Aggregate	47.2%	49.9%	56.0%	6.1%	54.8%	59.0%	61.8%	2.8%
OHA Benchmark ²	33.7%	43.1%	47.2%	4.1%	43.1%	52.0%	54.8%	2.8%
AH	44.9%	52.3%	59.6%	7.3% ▲	47.8%	60.4%	66.0%	5.6% ▲
AllCare	50.5%	57.5%	61.6%	4.1%	52.2%	60.0%	59.9%	-0.1%
CHA	55.9%	54.1%	58.8%	4.7%	47.9%	61.0%	64.5%	3.5%
CPCCO	42.1%	42.4%	47.2%	4.8%	45.3%	53.3%	55.6%	2.3%
EOCCO	45.9%	48.2%	60.7%	12.5% ▲	58.5%	64.8%	65.6%	0.8%
HSO	45.3%	49.0%	55.1%	6.1% ▲	53.4%	54.8%	58.0%	3.2%
IHN	52.5%	53.2%	56.8%	3.6%	53.9%	56.4%	61.5%	5.1% ▲
JCC	47.5%	53.6%	60.5%	6.9% ▲	54.5%	61.0%	62.9%	1.9%
PCS-CO	43.5%	48.0%	58.5%	10.5% ▲	51.5%	57.2%	63.5%	6.3% ▲
PCS-CG	40.9%	40.9%	50.0%	9.1% ▲	60.4%	59.0%	63.5%	4.5%
PCS-LN	53.3%	51.0%	56.0%	5.0% ▲	60.2%	65.6%	69.0%	3.4%
PCS-MP	50.1%	52.8%	56.2%	3.4%	62.7%	68.6%	68.5%	-0.1%
TCHP-SW	49.8%	47.0%	55.8%	8.8% ▲	49.4%	53.8%	60.4%	6.6% ▲
TCHP-TC ³	26.1%	33.6%	36.8%	3.2%	28.1%	32.8%	38.9%	6.1% ▲
UHA	40.4%	44.3%	51.0%	6.7% ▲	50.8%	56.1%	61.5%	5.4% ▲
YCCO	48.9%	48.3%	56.7%	8.4% ▲	56.4%	59.7%	59.9%	0.2%

¹ For this measure, substantial improvement or decline in performance between the measurement years is defined as an increase or decrease of 5 percentage points or more between MY 2022 and MY 2023 rates.

² The MY 2021 benchmark (2020 CCO 25th percentile) was reduced by OHA due to PHE-related external factors (Source: OHA 2021 CCO Performance Metrics Dashboard). The MY 2022 benchmark set by OHA is the 2020 CCO 75th percentile for the 1 to 5 years and 6 to 14 years age groups. The MY 2023 benchmark set by OHA is the 2021 CCO average for the 1 to 5 years and 6 to 14 years age groups.

Table 4-11 outlines performance results for each of the participating CCOs regarding *Oral Evaluation for Adults With Diabetes*, which measures the percentage of members ages 18 years or older who had a diabetes diagnosis and received a comprehensive, periodic or periodontal oral evaluation in the measurement year.

Table 4-11—CCO Results for the *Oral Evaluation for Adults With Diabetes*

CCO	MY 2021	MY 2022	MY 2023	Difference ¹
Statewide Aggregate	24.7%	24.6%	26.8%	2.2%
OHA Benchmark²	17.3%	20.4%	26.4%	6.0%
AH	18.4%	22.1%	25.4%	3.3%
AllCare	22.2%	21.4%	21.2%	-0.2%
CHA	19.7%	20.5%	20.1%	-0.4%
CPCCO	21.3%	24.7%	25.1%	0.4%
EOCCO	22.1%	23.0%	27.5%	4.5%
HSO	28.8%	27.6%	29.8%	2.2%
IHN	21.5%	20.4%	23.0%	2.6%
JCC	22.2%	23.5%	25.2%	1.7%
PCS-CO	21.2%	25.2%	23.5%	-1.8%
PCS-CG	33.2%	30.4%	32.0%	1.6%
PCS-LN	23.2%	23.4%	27.5%	4.1%
PCS-MP	23.9%	23.1%	23.9%	0.8%
TCHP-SW	20.1%	20.2%	25.9%	5.7% ▲
TCHP-TC	22.7%	20.6%	19.3%	-1.3%
UHA	20.8%	25.2%	31.3%	6.1% ▲
YCCO	23.6%	24.9%	30.5%	5.6% ▲

¹ For this measure, substantial improvement or decline in performance between the measurement years is defined as an increase or decrease of 5 percentage points or more between MY 2022 and MY 2023 rates.

² The MY 2021 benchmark (2020 CCO 25th percentile) was reduced by OHA due to PHE-related external factors (Source: OHA 2021 CCO Performance Metrics Dashboard). The MY 2022 benchmark set by OHA is the 2020 CCO 75th percentile. The MY 2023 benchmark set by OHA is the 90th percentile.

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

For the CCOs statewide, the following conclusions were made:

- Based on HSAG's analysis and review of OHA's data integration, data controls, and documentation on performance measures, HSAG determined that rates for all four performance measures in the CY 2024 PMV scope were *Reportable*.
- The CCOs' performance on the *Child and Adolescent Well-Care Visits* measure increased statewide from MY 2022 (63.1 percent) to MY 2023 (65.4 percent) which was also greater than statewide performance in MY 2021 (64.1 percent). Ten CCOs (AH, CHA, EOCCO, HSO, IHN, JCC, PCS-CO, PCS-CG, UHA, and YCCO) demonstrated MY 2023 rates that were greater than the statewide aggregate rate. One CCO (PCS-CG) continued to perform well on the measure, with three consecutive years of rates substantially greater than the statewide aggregate rate. Three additional CCOs (PCS-CO, UHA, and YCCO) demonstrated MY 2023 rates substantially greater than the statewide aggregate rate. Of these three CCOs, PCS-CG and UHA demonstrated a slight decrease in their rates from MY 2022 to MY 2023. The performance of two other CCOs (TCHP-SW and TCHP-TC) also declined in MY 2023 compared to MY 2022. Additionally, four CCOs (AllCare, CHA, JCC, and YCCO) demonstrated a substantial increase in rates from MY 2022 to MY 2023, though AllCare was still below the statewide aggregate rate. Despite increased performance, the statewide aggregate rate did not meet the set performance benchmark for MY 2023.
- Among members ages 13 to 17 years, the CCOs' performance on the *Initiation of SUD Treatment* measure indicator remained stable statewide from MY 2022 (36.7 percent) to MY 2023 (38.5 percent). Eleven CCOs (AllCare, CHA, CPCCO, IHN, PCS-CO, PCS-LN, PCS-MP, TCHP-SW, TCHP-TC, UHA, and YCCO) demonstrated MY 2023 rates that were greater than the statewide aggregate rate on the *Initiation of SUD Treatment* measure indicator. Of these 11 CCOs, seven (CHA, PCS-CO, PCS-MP, TCHP-SW, TCHP-TC, UHA, and YCCO) had MY 2023 rates that were substantially greater than the statewide aggregate rate. Nine CCOs (AllCare, CHA, EOCCO, IHN, PCS-CO, PCS-MP, TCHP-SW, TCHP-TC, and YCCO) demonstrated a substantial improvement in rates from MY 2022 to MY 2023 on the *Initiation of SUD Treatment* measure indicator. Three CCOs (CPCCO, PCS-CG, and UHA) demonstrated a substantial decline in rates from MY 2022 to MY 2023 on the *Initiation of SUD Treatment* measure indicator.
- Among members ages 13 to 17 years, the CCOs' performance on the *Engagement of SUD Treatment* measure indicator also increased slightly statewide (2.3 percent) from MY 2022 (20.3 percent) to MY 2023 (22.3 percent). Five CCOs (IHN, PCS-CO, PCS-MP, TCHP-TC, and YCCO) demonstrated MY 2023 rates that were greater than the statewide aggregate on the *Engagement of SUD Treatment* measure indicator. Of these five CCOs, two (PCS-MP and TCHP-TC) had MY 2023 rates that were substantially greater than the statewide aggregate rate. Three CCOs (AH, PCS-CO, and PCS-MP) demonstrated a substantial improvement in rates from MY 2022 to MY 2023 on the *Engagement of SUD Treatment* measure indicator. Five CCOs (AllCare, CHA, CPCCO, PCS-CG, and UHA) demonstrated a substantial decline in rates from MY 2022 to MY 2023 on the *Engagement of SUD Treatment* measure indicator.

- Among members ages 18 years and older, the CCOs' performance on the *Initiation of SUD Treatment* measure indicator declined slightly statewide (-0.1 percent) from MY 2022 (42.4 percent) to MY 2023 (42.3 percent). Four CCOs (CHA, HSO, TCHP-SW, and TCHP-TC) demonstrated MY 2023 rates that were greater than the statewide aggregate rate on the *Initiation of SUD Treatment* measure indicator. No CCOs achieved an MY 2023 rate substantially greater than the statewide aggregate. Additionally, four CCOs (PCS-CO, PCS-CG, PCS-LN, and PCS-MP) demonstrated a substantial decline in rates from MY 2022 to MY 2023 on the *Initiation of SUD Treatment* measure indicator and the statewide aggregate rate did not meet the set performance benchmark for MY 2023.
- Among members ages 18 years and older, the CCOs' performance on the *Engagement of SUD Treatment* measure indicator increased slightly statewide (0.5 percent) from MY 2022 (16.1 percent) to MY 2023 (16.6 percent). Six CCOs (CHA, HSO, IHN, PCS-LN, PCS-MP, and TCHP-TC) demonstrated MY 2023 rates that were greater than the statewide aggregate rate on the *Engagement of SUD Treatment* measure indicator. No CCOs achieved an MY 2023 rate substantially greater than the statewide aggregate. Additionally, no CCOs demonstrated a substantial increase or decline in rates from MY 2022 to MY 2023 on the *Engagement of SUD Treatment* measure indicator. Overall, the statewide aggregate rate exceeded the set performance benchmark for MY 2023 for the *Engagement of SUD Treatment* measure indicator.
- The CCOs' performance on the *Members Receiving Preventive Dental or Oral Health Services* measure greatly improved statewide from MY 2022 (49.9 percent) to MY 2023 (56.0 percent) among members ages 1 to 5 years. Ten CCOs (AH, AllCare, CHA, EOCCO, IHN, JCC, PCS-CO, PCS-LN, PCS-MP, and YCCO) demonstrated MY 2023 rates that were greater than the statewide aggregate rate, with one CCO (AllCare) demonstrating an MY 2023 rate substantially greater than the statewide aggregate. Of these nine CCOs, five (AH, EOCCO, JCC, PCS-CO, and YCCO) demonstrated substantial improvement in their rates from MY 2022 to MY 2023. HSO, PCS-CG, TCHP-SW, and UHA also demonstrated a substantial improvement in rates from MY 2022 to MY 2023. Overall, the statewide aggregate rate exceeded the set performance benchmark for MY 2023 among members ages 1 to 5 years.
- Among members ages 6 to 14 years, the CCOs' performance on the *Members Receiving Preventive Dental or Oral Health Services* measure increased statewide (2.8 percent) from MY 2022 (59.0 percent) to MY 2023 (61.8 percent). Overall, eight CCOs (AH, CHA, EOCCO, JCC, PCS-CO, PCS-CG, PCS-LN, and PCS-MP) demonstrated MY 2023 rates that were greater than the statewide aggregate rate. Two CCOs (PCS-LN and PCS-MP) continued to perform well on the measure, with three consecutive years of rates substantially greater than the statewide aggregate rate. Additionally, six CCOs (AH, IHN, PCS-CO, TCHP-SW, TCHP-TC, and UHA) demonstrated substantial improvement in their rates from MY 2022 to MY 2023. Overall, the statewide aggregate rate exceeded the set performance benchmark for MY 2023 among members ages 6 to 14 years.
- The CCOs' performance on the *Oral Evaluation for Adults With Diabetes* measure increased statewide (2.2 percent) from MY 2022 (24.6 percent) to MY 2023 (26.6 percent). One CCO (PCS-CG) continued its strong performance on the measure, with three consecutive years of rates substantially greater than the statewide aggregate rate. Five additional CCOs (EOCCO, HSO, PCS-LN, UHA, and YCCO) demonstrated an MY 2023 rate that was greater than the statewide aggregate

rate. Of these five CCOs, all demonstrated an increase in performance from MY 2022 to MY 2023. Three CCOs (TCHP-SW, UHA, YCCO) demonstrated a substantial improvement in performance in MY 2023 relative to MY 2022. In total, the performance of four CCOs (AllCare, CHA, PCS-CO, and TCHP-TC) declined slightly in MY 2023 compared to MY 2022. Overall, the statewide aggregate rate exceeded the set performance benchmark for MY 2023.

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

- Of the 16 CCOs reporting on the *Child and Adolescent Well-Care Visits* measure, four CCOs (25.0 percent) performed worse on the measure in MY 2023 compared to MY 2022. Additionally, the MY 2023 statewide aggregate fell below the MY 2023 benchmark set by OHA for this measure.
- The statewide CCO performance on the *Initiation of SUD Treatment—Ages 18 Years and Older* measure indicator declined slightly (0.1 percent) between MY 2022 and MY 2023. Of the 16 CCOs reporting on the *Initiation of SUD Treatment—Ages 18 Years and Older* measure indicator, eight CCOs (50.0 percent) performed worse on this measure indicator in MY 2023 compared to MY 2022. The performance of two of these eight CCOs (PCS-LN and PCS-MP) decreased by more than 5 percentage points between MY 2022 and MY 2023. Additionally, the MY 2023 statewide aggregate fell below the MY 2023 benchmark set by OHA for this measure indicator.
- Even though the statewide aggregate on *Initiation of SUD Treatment—Ages 13 to 17 Years* demonstrated an improvement between MY 2022 and MY 2023 (1.8 percentage points), six CCOs (37.5 percent) performed worse on this measure indicator in MY 2023 compared to MY 2022. The performance of three of these six CCOs (CPCCO, PCS-CG, and UHA) decreased by more than 5 percentage points between MY 2022 and MY 2023 for this measure indicator. The statewide aggregate on *Engagement of SUD Treatment—Ages 13 to 17 Years* also demonstrated an improvement between MY 2022 and MY 2023 (2.0 percentage points). Nevertheless, seven CCOs (43.8 percent) performed worse on this measure indicator in MY 2023 compared to MY 2022. The performance of five of these seven CCOs (AllCare, CHA, CPCCO, PCS-CG, and UHA) decreased by more than 5 percentage points between MY 2022 and MY 2023 for this measure indicator.

For the CCOs statewide, the following recommendations were identified:

- The performance on the *Child and Adolescent Well-Care Visits* measure suggests that some eligible members (i.e., children ages 3 to 6 years) did not have a well-care visit with a PCP in MY 2023. HSAG recommends that the CCOs whose performance declined in MY 2023 conduct a root cause analysis to identify the member, provider, or operational factors affecting their performance on this measure. Based on the results of this review, the CCOs should design, implement, and assess appropriate interventions to improve the delivery of services to children.
- HSAG recommends that the CCOs performing below the benchmark for the *Initiation of SUD Treatment—Ages 18 Years and Older* measure indicator conduct root cause analyses to identify specific factors affecting performance and develop, implement, and evaluate targeted interventions to ensure improvement strategies are adopted. If a CCO has already conducted a root cause analysis, a thorough review of the currently identified barriers should be completed to ensure continued appropriate strategies for improvement. HSAG further recommends that the CCOs with declining

performance in MY 2023 for the *Initiation of SUD Treatment—Ages 13 to 17 Years* and *Engagement of SUD Treatment—Ages 13 to 17 Years* measure indicators evaluate strategies and consider implementing interventions for this age group to improve performance. Additionally, the CCOs should monitor their provider networks to identify gaps in access to care and work with providers to identify alternative approaches for ensuring the timeliness and accessibility of health care services (i.e., telehealth strategies, mobile clinics).

Validation of Network Adequacy

Network Adequacy Validation Audit Results

HSAG evaluated the NAV audit results for all CCOs, including HSAG’s overall validation rating based on the CCOs’ use of an acceptable methodology during all phases of design, data collection, analysis, and interpretation of the network adequacy indicator. Table 4-12 displays the validation results by CCO.

Table 4-12—CCO NAV Audit Validation Results

CCO	Data Collection Procedures	Network Adequacy Methods	Network Adequacy Results	Overall Validation Rating
AH	Acceptable	Acceptable	Acceptable	<i>High Confidence</i>
AllCare	Acceptable	Acceptable	Acceptable	<i>High Confidence</i>
CHA	Acceptable	Acceptable	Acceptable	<i>High Confidence</i>
CPCCO	Acceptable	Acceptable	Acceptable	<i>High Confidence</i>
EOCCO	Acceptable	Acceptable	Acceptable	<i>High Confidence</i>
HSO	Acceptable	Acceptable	Acceptable	<i>High Confidence</i>
IHN	Acceptable	Acceptable	Acceptable	<i>High Confidence</i>
JCC	Acceptable	Acceptable	Acceptable	<i>High Confidence</i>
PCS-CO	Acceptable	Acceptable	Acceptable	<i>High Confidence</i>
PCS-CG	Acceptable	Acceptable	Acceptable	<i>High Confidence</i>
PCS-LN	Acceptable	Acceptable	Acceptable	<i>High Confidence</i>
PCS-MP	Acceptable	Acceptable	Acceptable	<i>High Confidence</i>
TCHP-SW	Acceptable	Acceptable	Acceptable	<i>High Confidence</i>
TCHP-TC	Acceptable	Acceptable	Acceptable	<i>High Confidence</i>
UHA	Acceptable	Acceptable	Acceptable	<i>High Confidence</i>
YCCO	Acceptable	Acceptable	Acceptable	<i>High Confidence</i>

Delivery System Network Evaluation Results

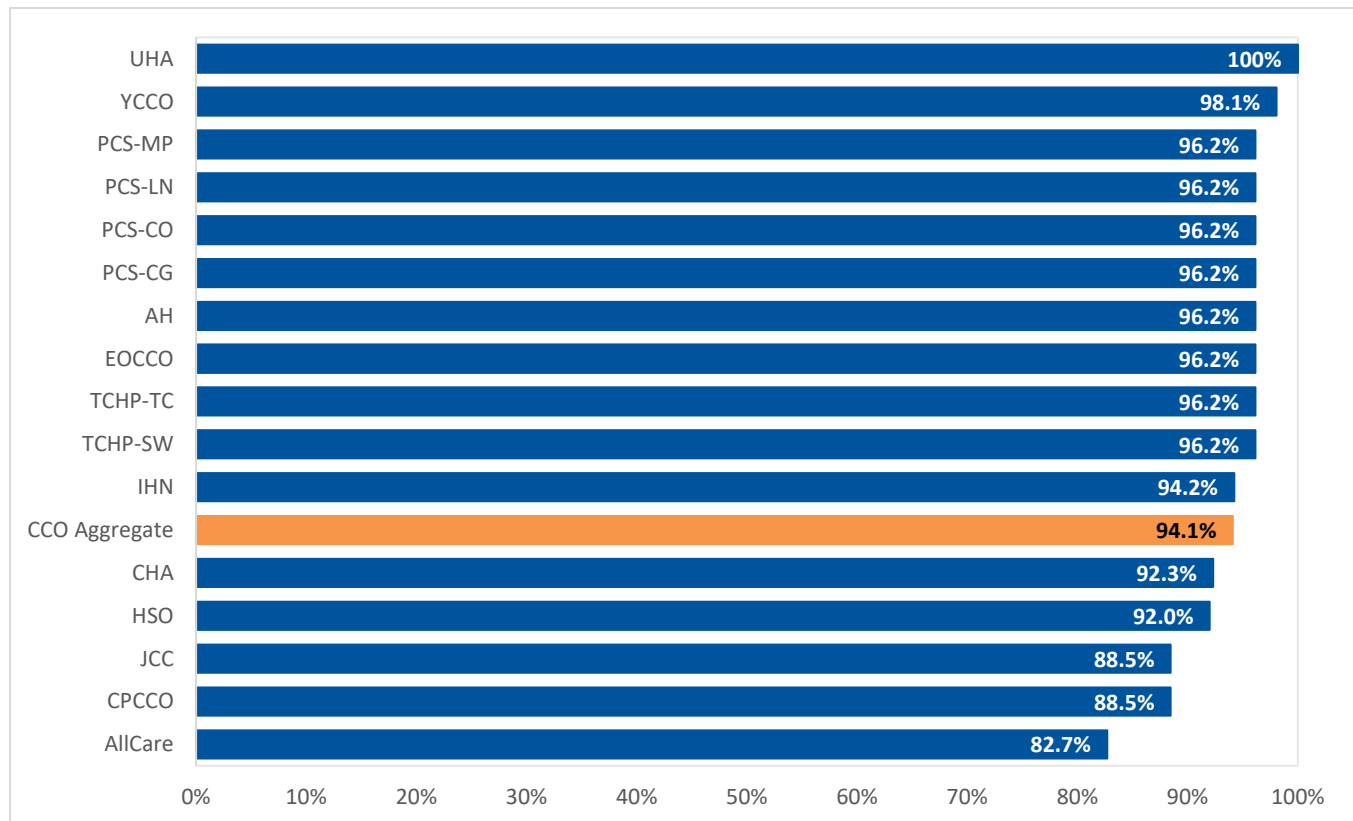
This section contains the results from the CY 2024 DSN Evaluation and includes the qualitative and quantitative findings. Together, these analyses assessed the adequacy of CCO provider networks, their monitoring activities, and overall compliance with State and federal requirements.

DSN Provider Narrative Review

HSAG reviewed CCO submissions across 26 total elements representing four domains—i.e., *DSN Governance Structure, Member Needs and Population Management, DSN Monitoring and Analysis*, and

Network Response Strategy. Figure 4-1 displays each CCO’s overall DSN Provider Narrative compliance score relative to the CCOs’ aggregate score. All CCO compliance scores are ranked from highest to lowest, including the overall CCO aggregate score, within the domain.

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



A summary of CCO compliance results for the individual DSN Provider Narrative domains is presented in Table 4-13.

Table 4-13—Summary of CCO Compliance Results for DSN Provider Narrative Domains

CCO	DSN Governance Structure	Member Needs and Population Management	DSN Monitoring and Analysis	Network Response Strategy
AH	100%	100%	90.0%	100%
AllCare	100%	75.0%	80.0%	91.7%
CHA	100%	100%	90.0%	83.3%
CPCCO	100%	100%	75.0%	91.7%
EOCCO	100%	93.8%	100%	91.7%
HSO	100%	87.5%	90.0%	100%

CCO	DSN Governance Structure	Member Needs and Population Management	DSN Monitoring and Analysis	Network Response Strategy
IHN	100%	87.5%	95.0%	100%
JCC	100%	100%	75.0%	91.7%
PCS-CO	100%	100%	100%	83.3%
PCS-CG	100%	100%	100%	83.3%
PCS-LN	100%	100%	100%	83.3%
PCS-MP	100%	100%	100%	83.3%
TCHP-SW	100%	100%	100%	83.3%
TCHP-TC	100%	100%	100%	83.3%
UHA	100%	100%	100%	100%
YCCO	100%	93.8%	100%	100%
Average CCO Compliance Rate	100%	96.1%	93.4%	90.5%

Network Capacity and Adequacy Assessment

To address provider network capacity, HSAG conducted an independent review of the CCOs' provider network data files and synthesized the results to understand the provider network infrastructure in place to provide health care services to members. Using CCO data provided by OHA, HSAG cleaned and aggregated the data to report three core metrics for PCPs, PCDs, MH providers, and SUD providers—i.e., provider counts, network stability, and provider-to-member ratios.³⁰ These provider types were selected as key measures of network capacity due to their role in providing front-line health services, which serve the widest array of needs and act as intake points. The results are unweighted, and percentages were calculated based on the number of unique, individual practitioners within each category.

Network Capacity

HSAG calculated CCO-specific provider-to-member ratios for all provider types in order to standardize the reporting of provider capacity. The provider-to-member ratio was calculated by dividing the total

³⁰ Provider counts and provider-to-member ratios were generated independently by HSAG based on Q1 2024 DSN Provider Capacity files submitted by the CCOs to OHA, and subsequently to HSAG on May 30, 2024. OHA submitted CCO member enrollment data to HSAG on May 8, 2024, for use in the calculation of provider-to-member ratios and time and distance metrics. Numbers presented in this report may be different than numbers reported by OHA in the CCO Operational Snapshot due to differences in the data cleaning, data aggregation, and calculation methodologies used by HSAG to prepare the network capacity and time and distance analyses. Additionally, subsequent resubmission of provider data following HSAG's evaluation may also lead to differences in reported results.

number of members enrolled in each CCO by the total number of providers within the CCO’s network. The number of members enrolled in each CCO was determined by extracting members from the OHA enrollment and eligibility files who were active with the CCO as of March 31, 2024. This metric serves as a way to standardize estimations of a CCO’s provider network as it accounts for service area and membership size. Since OHA does not currently have specific provider-to-member ratio standards for any provider type, the ratio results below are presented for informational purposes.

Table 4-14 shows the total number of PCPs contracted with each CCO and the ratio of providers to all members. The table also indicates, for each CCO, whether the change from Q1 2023 to Q1 2024 resulted in a substantial increase (i.e., ▲, or 10 percent) or decrease (i.e., ▼, or 10 percent) in the total number of PCPs.

Table 4-14—Counts, Ratios, and Percentages of PCPs by Quarter*

CCO	Q1 2023		Q1 2024		Difference PCP-All	
	PCP-All (N)	Provider-to-Member Ratio	PCP-All (N)	Provider-to-Member Ratio	Number	% Change in Counts
AH	89	1:349	79	1:363	-10	-11.2% ▼
AllCare	352	1:191	355	1:189	3	0.9%
CHA	92	1:329	88	1:314	-4	-4.3%
CPCCO	1,703	1:25	1,661	1:23	-42	-2.5%
EOCCO	1,784	1:45	1,105	1:72	-679	-38.1% ▼
HSO	2,103	1:230	1,990	1:228	-113	-5.4%
IHN	290	1:309	319	1:269	29	10.0% ▲
JCC	1,733	1:43	1,731	1:39	-2	-0.1%
PCS-CO	248	1:333	240	1:326	-8	-3.2%
PCS-CG	90	1:227	90	1:204	0	0%
PCS-LN	402	1:241	353	1:265	-49	-12.2% ▼
PCS-MP	342	1:455	331	1:471	-11	-3.2%
TCHP-SW	500	1:80	645	1:58	145	29.0% ▲
TCHP-TC	618	1:97	710	1:93	92	14.9% ▲
UHA	150	1:273	116	1:345	-34	-22.7% ▼
YCCO	790	1:48	1,314	1:29	524	66.3% ▲

* Numbers presented in this table may be different than numbers reported by OHA in the CCO Operational Snapshot due to differences in the data cleaning, data aggregation, and calculation methodologies used by HSAG to prepare the network capacity and time and distance analyses. Additionally, subsequent resubmission of provider data following HSAG’s evaluation may also lead to differences in reported results.

Table 4-15 shows the total number of PCDs contracted with each CCO and the ratio of providers to all members. The table also indicates, for each CCO, whether the change from Q1 2023 to Q1 2024 resulted in a substantial increase (i.e., ▲, or 10 percent) or decrease (i.e., ▼, or 10 percent) in the total number of PCDs.

Table 4-15—Counts, Ratios, and Percentages of PCDs by Quarter*

CCO	Q1 2023		Q1 2024		Difference PCD-All	
	PCD-All (N)	Provider-to-Member Ratio	PCD-All (N)	Provider-to-Member Ratio	Number	% Change in Counts
AH	23	1:1,115	22	1:1,303	-1	-4.3%
AllCare	36	1:1,460	32	1:2,087	-4	-11.1% ▼
CHA	28	1:910	26	1:1,060	-2	-7.1%
CPCCO	181	1:188	211	1:181	30	16.6% ▲
EOCCO	145	1:465	142	1:559	-3	-2.1%
HSO	504	1:797	478	1:947	-26	-5.2%
IHN	139	1:517	129	1:664	-10	-7.2%
JCC	76	1:760	90	1:745	14	18.4% ▲
PCS-CO	296	1:217	281	1:278	-15	-5.1%
PCS-CG	296	1:49	281	1:66	-15	-5.1%
PCS-LN	296	1:259	281	1:332	-15	-5.1%
PCS-MP	296	1:416	281	1:555	-15	-5.1%
TCHP-SW	116	1:279	108	1:341	-8	-6.9%
TCHP-TC	365	1:139	348	1:188	-17	-4.7%
UHA	29	1:1,113	25	1:1,598	-4	-13.8% ▼
YCCO	54	1:621	55	1:690	1	1.9%

* Numbers presented in this table may be different than numbers reported by OHA in the CCO Operational Snapshot due to differences in the data cleaning, data aggregation, and calculation methodologies used by HSAG to prepare the network capacity and time and distance analyses. Additionally, subsequent resubmission of provider data following HSAG's evaluation may also lead to differences in reported results.

Table 4-16 shows the total number of MH providers contracted with each CCO and the ratio of providers to all members. The table also indicates, for each CCO, whether the change from Q1 2023 to Q1 2024 resulted in a substantial increase (i.e., ▲, or 10 percent) or decrease (i.e., ▼, or 10 percent) in the total number of MH providers.

Table 4-16—Counts, Ratios, and Percentages of MH Providers by Quarter*

CCO	Q1 2023		Q1 2024		Difference MH-All	
	MH-All (N)	Provider-to-Member Ratio	MH-All (N)	Provider-to-Member Ratio	Number	% Change in Counts
AH	182	1:144	250	1:115	68	37.4% ▲
AllCare	488	1:125	501	1:134	13	2.7%
CHA	123	1:194	120	1:230	-3	-2.4%
CPCCO	1,987	1:16	2,467	1:16	480	24.2% ▲
EOCCO	1,100	1:57	1,246	1:64	146	13.3% ▲
HSO	2,012	1:176	2,964	1:153	952	47.3% ▲
IHN	1,217	1:53	1,265	1:68	48	3.9%
JCC	2,108	1:27	2,661	1:26	553	26.2% ▲
PCS-CO	3,682	1:19	4,079	1:20	397	10.8% ▲
PCS-CG	3,681	1:5	4,079	1:5	398	10.8% ▲
PCS-LN	3,681	1:22	4,079	1:23	398	10.8% ▲
PCS-MP	3,684	1:35	4,082	1:39	398	10.8% ▲
TCHP-SW	1,660	1:21	1,933	1:20	273	16.4% ▲
TCHP-TC	1,739	1:28	2,519	1:26	780	44.9% ▲
UHA	139	1:227	209	1:192	70	50.4% ▲
YCCO	2,013	1:16	2,292	1:17	279	13.9% ▲

* Numbers presented in this table may be different than numbers reported by OHA in the CCO Operational Snapshot due to differences in the data cleaning, data aggregation, and calculation methodologies used by HSAG to prepare the network capacity and time and distance analyses. Additionally, subsequent resubmission of provider data following HSAG's evaluation may also lead to differences in reported results.

Table 4-17 shows the total number of SUD providers contracted with each CCO and the ratio of providers to all members. The table also indicates, for each CCO, whether the change from Q1 2023 to Q1 2024 resulted in a substantial increase (i.e., ▲, or 10 percent) or decrease (i.e., ▼, or 10 percent) in the total number of SUD providers. Due to how providers were grouped depending on population served, percentages may not total 100 percent.

Table 4-17—Counts, Ratios, and Percentages of SUD Providers by Quarter*

CCO	Q1 2023		Q1 2024		Difference SUD-All	
	SUD-All (N)	Provider-to-Member Ratio	SUD-All (N)	Provider-to-Member Ratio	Number	% Change in Counts
AH	56	1:518	74	1:388	18	32.1% ▲
AllCare	144	1:457	121	1:552	-23	-16.0% ▼
CHA	69	1:396	49	1:563	-20	-29.0% ▼
CPCCO	528	1:72	511	1:75	-17	-3.2%
EOCCO	292	1:261	409	1:194	117	40.1% ▲
HSO	582	1:755	558	1:811	-24	-4.1%
IHN	411	1:205	464	1:185	53	12.9% ▲
JCC	534	1:124	536	1:126	2	0.4%
PCS-CO	550	1:140	578	1:136	28	5.1%
PCS-CG	550	1:32	578	1:32	28	5.1%
PCS-LN	550	1:167	578	1:162	28	5.1%
PCS-MP	550	1:269	578	1:270	28	5.1%
TCHP-SW	414	1:92	455	1:81	41	9.9%
TCHP-TC	292	1:189	358	1:183	66	22.6% ▲
UHA	100	1:401	150	1:267	50	50.0% ▲
YCCO	417	1:90	352	1:108	-65	-15.6% ▼

* Numbers presented in this table may be different than numbers reported by OHA in the CCO Operational Snapshot due to differences in the data cleaning, data aggregation, and calculation methodologies used by HSAG to prepare the network capacity and time and distance analyses. Additionally, subsequent resubmission of provider data following HSAG's evaluation may also lead to differences in reported results.

Time and Distance Analysis

This section highlights the CCOs' compliance with OHA's network adequacy standards³¹ based on the percentage of members with access to providers within acceptable travel times and distances for select primary and secondary provider types (see Table 3-16). At least 95 percent of CCOs' adult and pediatric members must meet acceptable travel time and distances to individual providers, and at least 95 percent of all CCOs' members must meet acceptable travel times and distance to facilities, to be compliant with OHA's network adequacy standards. Table 4-18 shows the urbanities associated with each CCO's service region based on the Q1 2024 Provider Capacity data files submitted in April 2024. The count of all CCOs by urbanity is given as the total. Eleven CCOs contained more than one type of urbanity within their service regions.

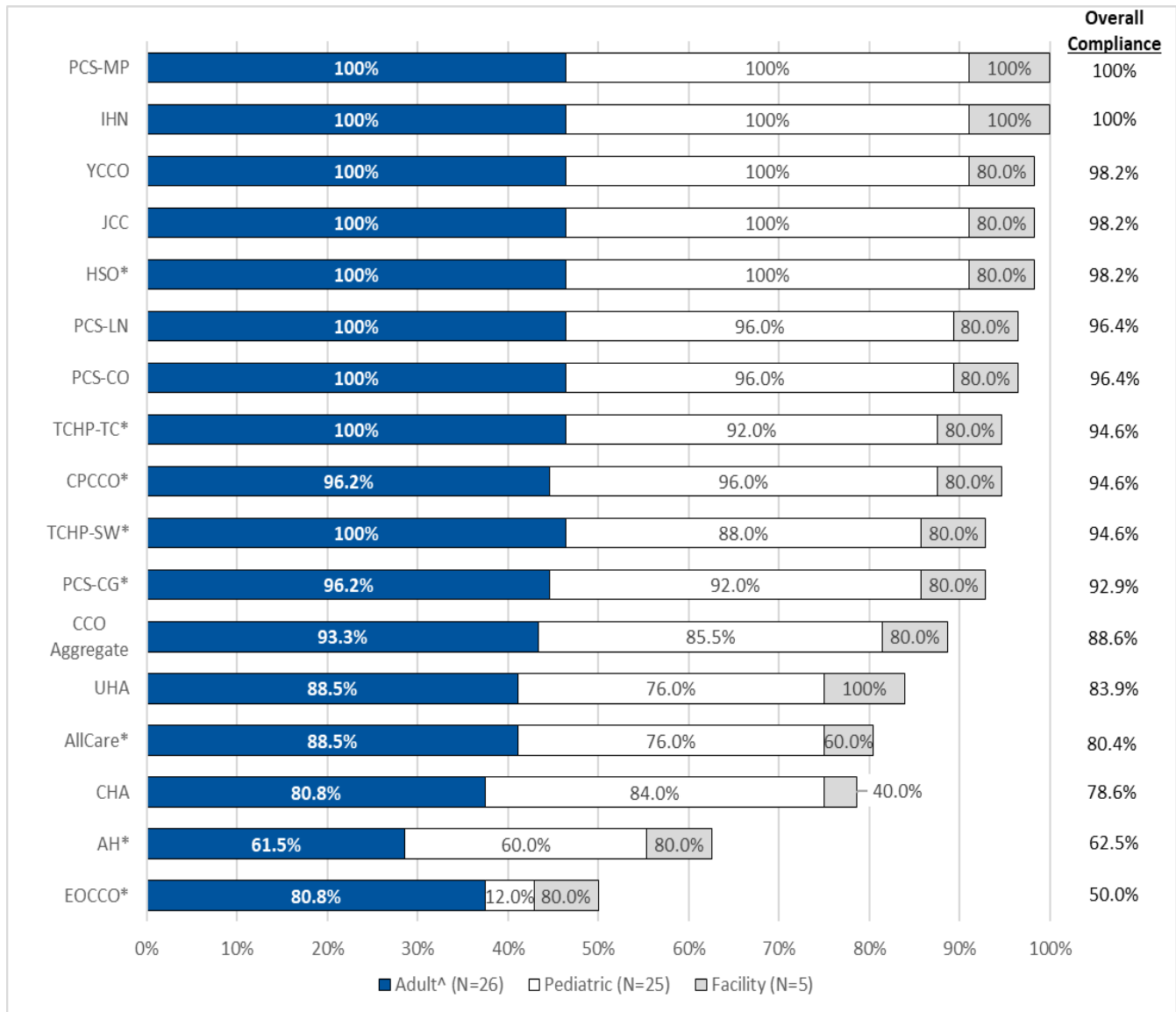
Table 4-18—CCOs by Urbanity

Urbanity	AH	AllCare	CHA	CPCCO	EOCCO	HSO	IHN	JCC	PCS-CO	PCS-CG	PCS-LN	PCS-MP	TCHP-SW	TCHP-TC	UHA	YCCO	Total
Large Urban						X								X		X	3
Urban		X					X	X	X		X	X	X			X	8
Rural	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	16
Extreme Access					X				X								2

Figure 4-2 shows the CCOs' cumulative compliance with network adequacy standards by provider population (i.e., adult, pediatric, and facility) as well as overall compliance score. Percentages are defined by dividing the total number of standards where the CCO met the network adequacy standard divided by the total number of applicable network adequacy standards, overall and by provider population. CCOs are sorted from the highest to lowest overall compliance score.

³¹ Time and distance results were generated independently by HSAG based on Q1 2024 DSN Provider Capacity files submitted by the CCOs to OHA, and subsequently to HSAG on May 30, 2024. OHA submitted CCO member enrollment data to HSAG on May 8, 2024, for use in the calculation of time and distance metrics. Numbers presented in this report may be different than numbers reported by OHA in the CCO Operational Snapshot due to differences in the data cleaning, data aggregation, and calculation methodologies used by HSAG to prepare the network capacity and time and distance analyses. Additionally, subsequent resubmission of provider data following HSAG's evaluation may also lead to differences in reported results.

Figure 4-2—Overall Percentage of Network Adequacy Standards Met by CCO and Population



* indicates that the CCO requested an exception to one or network adequacy standards established by OHA. At the time of this report, OHA had not finalized approval for any CCO.

^ OB/GYN providers were compared to female members ages 13 years and older and not stratified by adult and pediatric populations. This Tier 2 provider specialty was assessed within the adult provider category. Per 42 CFR §438.68, this provider specialty without stratification by adult or pediatric member populations.

Table 4-19 presents the percentage of adult members with acceptable access to a provider rendering adult services regardless of urbanicity. CCO rates are shaded in red “R” where the percentage of adult members with acceptable access is less than the OHA-established compliance threshold (i.e., 95 percent).

Table 4-19—Percentage of Adult Members With Access¹ to Providers Rendering Adult Services[†]

Provider Type	AH*	AllCare*	CHA	CPCCO*	EOCCO*	HSO*	IHN	JCC	PCS-CO	PCS-CG*	PCS-LN	PCS-IMP	TCHP-SW*	TCHP-TC*	UHA	YCCO
Tier 1																
PCP	>99.9	>99.9	95.5	100	97.7	>99.9	>99.9	>99.9	99.8	99.8	>99.9	99.9	>99.9	>99.9	99.6	>99.9
PCD	>99.9	92.9	93.8	99.9	97.5	>99.9	99.8	>99.9	99.3	99.8	98.4	99.9	96.8	>99.9	99.5	99.8
MH Provider	99.9	99.6	95.8	100	97.1	100	>99.9	>99.9	99.8	97.5	100	>99.9	99.8	99.8	99.6	100
SUD Provider	89.5	97.8	96.3	96.2	96.5	99.0	99.1	98.8	99.3	95.5	98.3	99.9	96.6	98.1	96.2	99.3
Tier 2																
CRD	92.5	99.9	100	100	>99.9	100	100	100	100	100	100	100	100	99.8	100	100
M-ONC	92.5	93.0	100	100	96.1	100	100	100	99.9	>99.9	100	100	100	100	100	100
NEUR	92.6	100	100	100	81.8	100	100	100	99.9	100	100	100	100	100	100	100
OB/GYN [^]	100	100	100	100	>99.9	100	100	100	100	100	100	100	100	100	100	100
OPH	100	100	100	100	>99.9	100	100	100	99.9	100	100	100	100	98.3	100	100
OPT	100	100	100	100	>99.9	100	100	100	100	100	100	100	100	>99.9	100	100
OT	100	99.9	0.0	100	97.1	100	100	100	100	100	100	100	100	100	0.0	100
POD	100	100	100	100	96.0	100	100	100	100	73.2	100	100	100	100	100	100
PSYC	100	99.9	100	100	>99.9	100	100	100	100	100	100	100	100	100	100	100
PT	100	100	100	100	93.5	100	100	100	100	100	100	100	100	100	0.0	100
R-ONC	92.5	99.9	100	100	92.6	100	100	100	>99.9	100	100	100	100	95.7	100	100
SLP	92.5	93.0	0.0	80.2	93.3	100	100	100	>99.9	100	100	100	100	100	0.0	100
Tier 3																
ALIM	100	100	100	100	86.5	100	100	100	100	100	100	100	100	99.2	100	100
DERM	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
END	0.0	100	100	100	99.8	100	100	100	100	100	100	100	100	>99.9	100	100
GST	0.0	99.9	0.0	100	97.1	100	100	100	100	100	100	100	100	100	100	100
HEM	100	99.6	100	100	100	100	100	100	100	100	100	100	100	100	100	100
NEPH	100	99.9	0.0	100	99.9	100	100	100	100	100	100	100	100	100	100	100
OTO	100	100	100	100	99.9	100	100	100	100	100	100	100	100	>99.9	100	100
PUL	0.0	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100
RHEU	0.0	99.9	100	100	100	100	100	100	100	100	100	100	100	100	100	100
URO	100	100	100	100	99.9	100	100	100	100	100	100	100	100	100	100	100

¹ See Table 3-17 for a detailed description of the acceptable travel times and distances by urbanicity and provider tier.

[†] Numbers presented in this table may be different than numbers reported by OHA in the CCO Operational Snapshot due to differences in the data cleaning, data aggregation, and calculation methodologies used by HSAG to prepare the network capacity and time and distance analyses. Additionally, subsequent resubmission of provider data following HSAG’s evaluation may also lead to differences in reported results.

* indicates that the CCO requested an exception to one or more network adequacy standards established by OHA. At the time of this report, OHA had not finalized approval for any CCO.

[^] OB/GYN providers were compared to female members ages 13 years and older and not stratified by adult and pediatric populations. This Tier 2 provider specialty was assessed within the adult provider category. Per 42 CFR §438.68, this provider specialty without stratification by adult or pediatric member populations.

Table 4-20 presents the percentage of pediatric members with acceptable access to a provider rendering pediatric services regardless of urbanicity. CCO rates are shaded in red “R” where the percentage of pediatric members with access is less than the OHA-established compliance threshold (i.e., 95 percent).

Table 4-20—Percentage of Pediatric Members With Access¹ to Providers Rendering Pediatric Services[♦]

Provider Type	AH*	AllCare*	CHA	CPCCO*	EOCCO*	HSO*	IHN	JCC	PCS-CO	PCS-CG*	PCS-LN	PCS-MP	TCHP-SW*	TCHP-TC*	UHA	YCCO
Tier 1																
PCP	100	>99.9	96.7	100	97.7	>99.9	98.4	100	99.9	99.9	100	>99.9	>99.9	99.9	99.8	>99.9
PCD	100	92.5	94.9	>99.9	98.0	>99.9	99.9	>99.9	99.4	99.9	98.4	>99.9	96.4	99.9	99.6	99.7
MH Provider	99.9	99.7	96.9	100	60.8	100	>99.9	>99.9	99.8	98.4	100	100	99.8	99.9	99.8	100
SUD Provider	90.4	92.5	97.3	95.7	20.3	99.0	98.9	98.9	99.4	96.1	98.3	>99.9	96.3	98.1	95.7	99.4
Tier 2																
CRD	93.8	>99.9	100	100	97.6	100	100	100	100	100	100	100	100	98.7	0.0	99.5
M-ONC	93.8	92.7	100	100	67.7	100	100	100	>99.9	100	100	100	91.8	92.1	0.0	96.0
NEUR	94.0	92.7	100	100	68.9	100	100	100	99.9	100	100	100	100	100	100	100
OPH	100	100	100	100	19.8	100	100	100	99.9	100	100	100	100	97.7	100	100
OPT	100	100	100	100	0.0	100	100	100	100	100	100	100	100	100	100	100
OT	100	>99.9	0.0	100	0.0	100	100	100	0.0	0.0	0.0	100	100	100	100	100
POD	100	100	100	100	0.0	100	100	100	100	73.6	100	100	100	100	100	100
PSYC	100	>99.9	100	100	66.5	100	100	100	100	100	100	100	100	100	100	100
PT	100	100	100	100	0.0	100	100	100	100	100	100	100	100	100	28.5	100
R-ONC	93.8	>99.9	100	100	0.0	100	100	100	100	100	100	100	100	94.5	100	100
SLP	93.8	0.0	100	82.3	0.0	100	100	100	>99.9	100	100	100	100	100	100	100
Tier 3																
ALIM	100	100	100	100	9.1	100	100	100	100	100	100	100	100	98.7	100	100
DERM	100	100	100	100	1.2	100	100	100	100	100	100	100	100	100	100	100
END	0.0	>99.9	100	100	85.2	100	100	100	100	100	100	100	100	99.9	100	100
GST	0.0	99.8	0.0	100	81.8	100	100	100	100	100	100	100	100	98.6	0.0	99.9
HEM	100	99.8	100	100	84.8	100	100	100	100	100	100	100	100	99.9	0.0	>99.9
NEPH	100	>99.9	0.0	100	81.8	100	100	100	100	100	100	100	100	99.8	100	99.7
OTO	100	100	100	100	27.3	100	100	100	100	100	100	100	100	>99.9	100	100
PUL	0.0	100	100	100	81.8	100	100	100	100	100	100	100	23.3	98.6	0.0	100
RHEU	0.0	0.0	100	100	27.7	100	100	100	100	100	100	100	0.0	95.1	100	100
URO	100	>99.9	100	100	72.2	100	100	100	100	100	100	100	100	100	100	100

¹ See Table 3-17 for a detailed description of the acceptable travel times and distances by urbanicity and provider tier.

[♦] Numbers presented in this table may be different than numbers reported by OHA in the CCO Operational Snapshot due to differences in the data cleaning, data aggregation, and calculation methodologies used by HSAG to prepare the network capacity and time and distance analyses. Additionally, subsequent resubmission of provider data following HSAG’s evaluation may also lead to differences in reported results.

* indicates that the CCO requested an exception to one or more network adequacy standards established by OHA. At the time of this report, OHA had not finalized approval for any CCO.

Table 4-21 presents the percentage of all members with acceptable access to a facility regardless of urbanicity. CCO rates are shaded in red “R” where the percentage of members with access is less than the OHA-established compliance threshold (i.e., 95 percent).

Table 4-21—Percentage of Members With Access¹ to Facilities[♦]

Facility Type	AH [*]	AllCare [*]	CHA	CPCCO [*]	EOCCO [*]	HSO [*]	IHN	JCC	PCS-CO	PCS-CG [*]	PCS-LN	PCS-MIP	TCHP-SW [*]	TCHP-TC [*]	UHA	YCCO
Tier 1																
Rx	>99.9	87.7	93.7	100	96.1	>99.9	>99.9	99.9	99.4	97.7	99.8	99.9	99.4	>99.9	99.6	>99.9
Tier 2																
DME	100	100	0.0	100	96.4	100	100	100	100	100	100	100	100	100	100	99.9
HOSP	100	100	100	100	>99.9	100	100	100	99.9	100	100	100	100	100	100	100
MTD	0.0	92.9	0.0	50.4	0.0	66.2	100	0.0	<0.1	0.0R	17.5	100	17.2	92.7	100	0.0
Tier 3																
SNF	100	100	100	100	99.6	100	100	100	100	100	100	100	100	100	100	100

¹ See Table 3-17 for a detailed description of the acceptable travel times and distances by urbanicity and provider tier.

[♦] Numbers presented in this table may be different than numbers reported by OHA in the CCO Operational Snapshot due to differences in the data cleaning, data aggregation, and calculation methodologies used by HSAG to prepare the network capacity and time and distance analyses. Additionally, subsequent resubmission of provider data following HSAG’s evaluation may also lead to differences in reported results.

* indicates that the CCO requested an exception to one or more network adequacy standards established by OHA. At the time of this report, OHA had not finalized approval for any CCO.

Network Availability and Accessibility Analysis

Network Availability and Accessibility results are based on the Q1 2024 Quarterly *DSN Provider Capacity Report* data supplied by CCOs to OHA. This section provides key aggregate findings from the data.

OHA assessed the availability of the CCOs’ network providers by assessing the percentage of PCPs, PCDs, MH providers, and SUD providers who were active, accepting new Medicaid patients, and located within a CCO’s service areas. These service categories were selected as key measures of the adequacy of accessibility to front-line health services, which serve the widest array of needs and act as intake points and facilitators to more specialized care. They also constitute the non-facility provider types within OHA’s Tier 1 provider grouping.

The results provided below also display the overall percentage of providers who speak a non-English language. While the CCOs are required to provide QHCI services (typically via a vendor service), assessing the number of providers within a network who speak a non-English language contributes to an understanding of how each CCO evaluates and adjusts its ability to provide services in a linguistically accessible and culturally responsive manner. It should be noted that language data for all providers are self-reported and may not fully represent a provider’s fluency or health literacy with a non-English language.

For PCPs, HSAG also evaluated the percentage of a PCP’s total capacity available for assignment as of Q1 2024. The measure of “PCP capacity” indicates the difference between a PCP’s maximum patient panel assignment and its actual number of assigned patients. For example, if a PCP can accept 100 patients and has 40 assigned to them, their PCP capacity is 60 percent. In the table below, PCP capacity represents this overall measure averaged across all contracted PCPs.

Table 4-22 shows the unweighted results for PCPs stratified by CCO.

Table 4-22—Availability and Accessibility of PCPs by CCO*

CCO	Count	Availability				Accessibility
		Active	Within Service Region	Accepting New Patients	PCP Capacity	Non-English Speaking
AH	78	96.2%	100%	100%	60.3%	34.6%
AllCare	363	95.3%	98.6%	38.3%	88.7%	33.9%
CHA	88	98.9%	100%	70.5%	93.2%	18.2%
CPCCO	1,661	98.4%	8.1%	58.3%	97.2%	17.5%
EOCCO	823	94.7%	29.5%	94.3%	100%	1.6%
HSO	2,095	98.3%	82.4%	68.6%	80.8%	14.0%
IHN	319	98.8%	76.8%	98.1%	0%	9.7%
JCC	1,731	98.0%	10.6%	59.3%	92.7%	17.6%
PCS-CO	240	99.2%	99.2%	75.0%	88.3%	16.7%
PCS-CG	90	98.9%	97.8%	85.6%	90.0%	27.8%
PCS-LN	352	99.2%	99.4%	53.4%	68.8%	18.2%
PCS-MP	330	99.4%	99.4%	27.6%	84.9%	16.4%
TCHP-SW	646	94.7%	59.7%	98.6%	98.0%	17.2%
TCHP-TC	711	92.0%	90.4%	93.3%	92.0%	15.3%
UHA	115	99.1%	75.7%	58.3%	88.7%	16.5%
YCCO	1,307	98.9%	98.2%	75.7%	49.1%	8.4%

* Numbers presented in this table may be different than numbers reported by OHA in the CCO Operational Snapshot due to the subsequent resubmission of provider data following HSAG’s evaluation.

Table 4-23 shows the results for PCDs stratified by CCO.

Table 4-23—Availability and Acceptability of PCDs by CCO*

CCO	Count	Availability			Accessibility
		Active	Within Service Region	Accepting New Patients	Non-English Speaking
AH	22	100%	72.7%	100%	18.2%
AllCare	34	97.1%	100%	88.2%	32.4%
CHA	26	100%	53.9%	84.6%	3.9%
CPCCO	211	99.5%	14.2%	97.6%	18.0%
EOCCO	142	96.5%	76.8%	78.9%	12.7%
HSO	482	96.2%	95.4%	76.6%	26.3%
IHN	129	85.3%	76.7%	93.0%	20.9%
JCC	90	97.8%	63.3%	81.1%	32.2%
PCS-CO	281	98.9%	23.5%	74.4%	21.4%
PCS-CG	281	98.9%	6.8%	74.4%	21.4%
PCS-LN	281	98.9%	26.0%	74.4%	21.4%
PCS-MP	281	98.9%	39.2%	74.4%	21.4%
TCHP-SW	108	97.2%	64.8%	85.2%	23.2%
TCHP-TC	348	94.8%	97.7%	68.4%	35.3%
UHA	25	100%	96.0%	100%	4.0%
YCCO	55	98.2%	40.0%	94.6%	32.7%

* Numbers presented in this table may be different than numbers reported by OHA in the CCO Operational Snapshot due to the subsequent resubmission of provider data following HSAG's evaluation.

Table 4-24 shows the results for MH providers stratified by CCO.

Table 4-24—Availability and Accessibility of MH Providers by CCO*

CCO	Count	Availability			Accessibility
		Active	Within Service Region	Accepting New Patients	Non-English Speaking
AH	248	94.4%	60.1%	100%	11.3%
AllCare	471	90.2%	96.2%	89.4%	8.9%
CHA	118	94.1%	87.3%	100%	8.5%
CPCCO	2,224	86.5%	7.6%	0.2%	3.8%

CCO	Count	Availability			Accessibility
		Active	Within Service Region	Accepting New Patients	Non-English Speaking
EOCCO	1,177	74.9%	33.0%	0.1%	0.1%
HSO	2,646	88.2%	80.4%	7.0%	4.4%
IHN	1,093	84.3%	37.9%	98.2%	4.3%
JCC	2,456	86.1%	22.4%	0.1%	2.9%
PCS-CO	3,796	92.9%	19.8%	85.7%	6.5%
PCS-CG	3,796	92.9%	2.7%	85.7%	6.5%
PCS-LN	3,796	92.9%	32.9%	85.8%	6.5%
PCS-MP	3,799	92.9%	16.5%	85.7%	6.5%
TCHP-SW	1,835	77.8%	69.5%	100%	3.3%
TCHP-TC	2,279	83.3%	94.0%	99.0%	3.6%
UHA	197	92.4%	71.1%	93.4%	1.0%
YCCO	2,053	80.4%	74.8%	98.3%	1.6%

* Numbers presented in this table may be different than numbers reported by OHA in the CCO Operational Snapshot due to the subsequent resubmission of provider data following HSAG's evaluation.

Table 4-25 shows the results for SUD providers stratified by CCO.

Table 4-25—Availability and Accessibility of SUD Providers by CCO*

CCO	Count	Availability			Accessibility
		Active	Within Service Region	Accepting New Patients	Non-English Speaking ¹
AH	74	91.9%	48.7%	100%	1.4%
AllCare	126	92.9%	87.3%	93.7%	17.5%
CHA	49	93.9%	67.4%	100%	6.1%
CPCCO	511	90.2%	6.5%	0.6%	2.5%
EOCCO	412	73.5%	30.6%	0%	NR
HSO	559	90.7%	65.4%	3.6%	3.9%
IHN	464	78.2%	38.2%	99.4%	NR
JCC	536	91.4%	17.7%	0.6%	2.8%
PCS-CO	579	88.3%	17.8%	96.9%	3.6%
PCS-CG	579	88.3%	1.2%	96.9%	3.6%
PCS-LN	579	88.3%	33.7%	96.9%	3.6%

CCO	Count	Availability			Accessibility
		Active	Within Service Region	Accepting New Patients	Non-English Speaking ¹
PCS-MP	579	88.3%	25.9%	96.9%	3.6%
TCHP-SW	455	71.2%	51.0%	100%	0.4%
TCHP-TC	360	74.4%	93.1%	100%	2.2%
UHA	148	74.3%	33.1%	100%	NR
YCCO	349	79.7%	86.5%	99.4%	0.3%

Note: Results given as “NR” indicate data elements that were not reported by OHA.

* Numbers presented in this table may be different than numbers reported by OHA in the CCO Operational Snapshot due to the subsequent resubmission of provider data following HSAG’s evaluation.

Revealed Telephone Survey Results

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

PCP Providers

Response Rates

Table 4-26 displays the detailed survey dispositions and response rates. Overall, 74.8 percent of PCP locations were reached. HSO achieved the highest response rate at 91.5 percent. Additionally, nine CCOs had response rates below 80.0 percent, ranging from 53.1 percent (YCCO) to 75.8 percent (EOCCO).

Table 4-26—Survey Dispositions and Response Rates: Total PCP Outreach Calls

CCO	Sampled Cases	Cases Reached ¹	Bad Phone Number ²	Unable to Reach ³	Response Rate ⁴
Overall	1,856	1,389	162	305	74.8%
AH	17	14	0	3	82.4%
AllCare	107	90	5	12	84.1%
CHA	12	9	2	1	75.0%
CPCCO	192	167	7	18	87.0%
EOCCO	194	147	16	31	75.8%
HSO	213	195	10	8	91.5%
IHN	98	86	7	5	87.8%

CCO	Sampled Cases	Cases Reached ¹	Bad Phone Number ²	Unable to Reach ³	Response Rate ⁴
JCC	193	117	7	69	60.6%
PCS-CO	87	58	26	3	66.7%
PCS-CG	28	21	5	2	75.0%
PCS-LN	122	79	24	19	64.8%
PCS-MP	87	60	8	19	69.0%
TCHP-SW	124	107	7	10	86.3%
TCHP-TC	132	99	11	22	75.0%
UHA	26	21	3	2	80.8%
YCCO	224	119	24	81	53.1%

¹ Cases Reached represents cases where a survey respondent was reached.

² Bad Phone Number includes reaching a disconnected number, fax number, nonmedical facility, or billing office (corrected number unavailable).

³ Unable to Reach includes reaching a voicemail, busy signal, continuous ringing, an extended hold time after three attempts, or refusals.

⁴ The denominator includes the number of sampled cases.

Interviewers attempted to contact each survey case up to three times during standard business hours at different times on different days; a case that could not be contacted was considered to be nonresponsive. Interviewers who were put on hold at any point during the call remained on hold for five minutes before ending the call, resulting in an extended hold time nonresponse reason.

Overall, the most prevalent nonresponse reasons included:

- Incorrect phone numbers accounted for 8.7 percent of survey calls (162 cases).
- Voicemail after three call attempts accounted for 7.2 percent of survey calls (134 cases).
- Extended hold time accounted for 5.8 percent of survey calls (108 cases).

Provider Data Accuracy

Table 4-27 reflects the accuracy of key data elements as reported by survey respondents and displays the number and percentage of PCP cases for which provider data were validated. Among the cases reached, 88.7 percent confirmed the correct location, 76.2 percent offered the requested service, 66.4 percent accepted OHP Medicaid, and 41.3 percent accepted the requested CCO. Further, this indicates that 58.7 percent of PCP cases overall had provider data inaccuracies (i.e., incorrect location, not offering the requested services, and not accepting OHP Medicaid or CCO).

Table 4-27—PCP Data Accuracy Results

CCO	Correct Location		Offering Requested Services ¹		OHP Medicaid Acceptance ²		CCO Acceptance ³	
	Count	Rate ⁴	Count	Rate ⁴	Count	Rate ⁴	Count	Rate ⁴
Overall	1,232	88.7%	1,058	76.2%	922	66.4%	574	41.3%
AH	14	100%	13	92.9%	13	92.9%	12	85.7%

CCO	Correct Location		Offering Requested Services ¹		OHP Medicaid Acceptance ²		CCO Acceptance ³	
	Count	Rate ⁴	Count	Rate ⁴	Count	Rate ⁴	Count	Rate ⁴
AllCare	80	88.9%	63	70.0%	59	65.6%	36	40.0%
CHA	8	88.9%	8	88.9%	7	77.8%	7	77.8%
CPCCO	158	94.6%	152	91.0%	145	86.8%	46	27.5%
EOCCO	126	85.7%	98	66.7%	88	59.9%	64	43.5%
HSO	181	92.8%	161	82.6%	149	76.4%	108	55.4%
IHN	83	96.5%	77	89.5%	36	41.9%	32	37.2%
JCC	106	90.6%	103	88.0%	96	82.1%	27	23.1%
PCS-CO	45	77.6%	31	53.4%	26	44.8%	24	41.4%
PCS-CG	21	100%	15	71.4%	13	61.9%	13	61.9%
PCS-LN	67	84.8%	49	62.0%	34	43.0%	30	38.0%
PCS-MP	52	86.7%	45	75.0%	40	66.7%	38	63.3%
TCHP-SW	89	83.2%	68	63.6%	65	60.7%	46	43.0%
TCHP-TC	86	86.9%	73	73.7%	68	68.7%	54	54.5%
UHA	17	81.0%	16	76.2%	13	61.9%	13	61.9%
YCCO	99	83.2%	86	72.3%	70	58.8%	24	20.2%

¹ Data element was assessed from survey respondents with verified locations.

² Data element was assessed from survey respondents with verified locations that offered the requested services.

³ Data element was assessed from survey respondents with verified locations, offering the requested services, and accepting OHP Medicaid.

⁴ The denominator includes cases reached.

Access and Availability

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

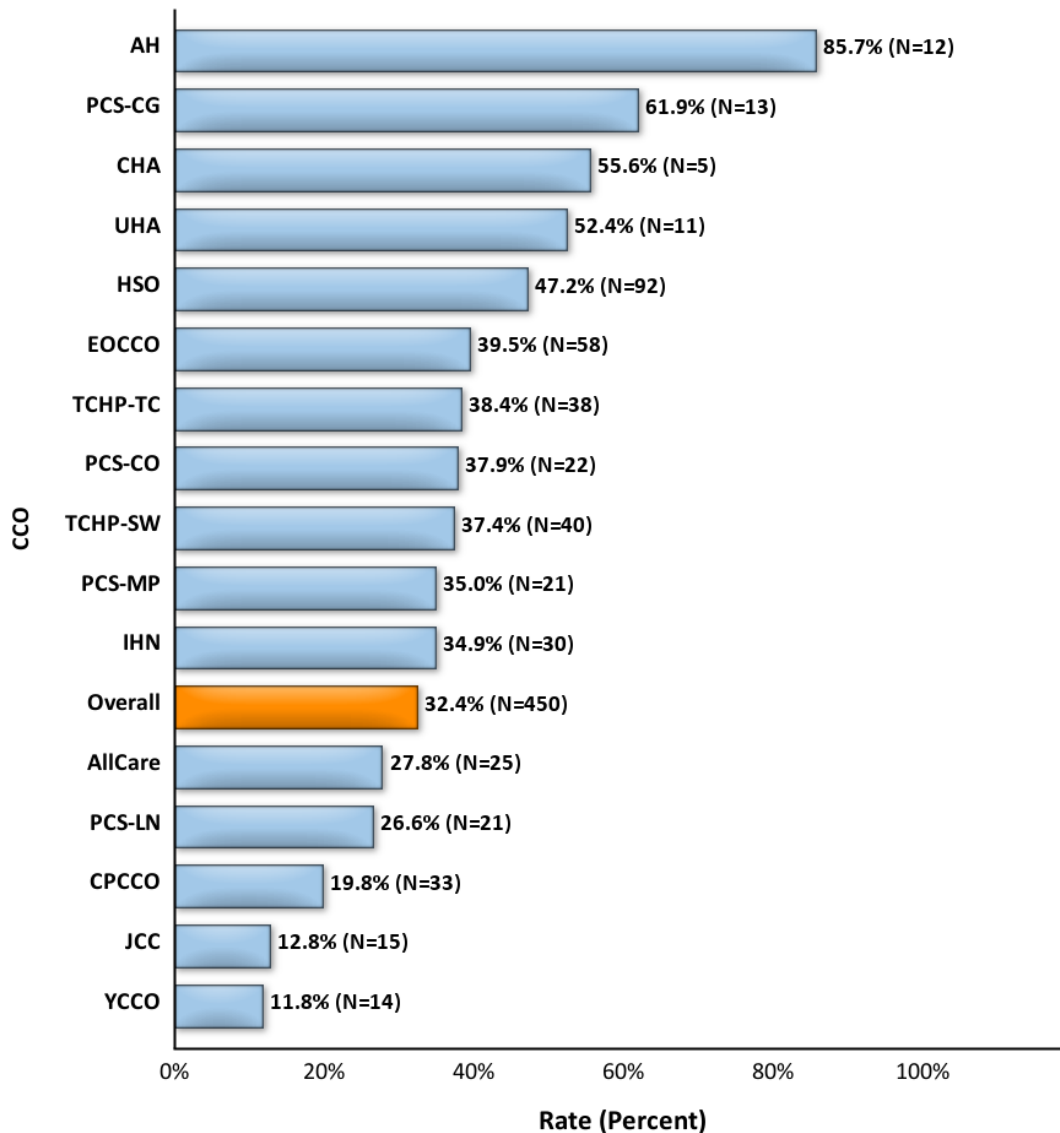
New Patient Acceptance

Figure 4-3 displays the number and percentage of survey respondents that accepted new patients out of all cases reached.³² Please note, the new patient acceptance question was asked only for verified locations that offered the requested services and accepted OHP Medicaid for the specified CCO. Overall, 32.4 percent of cases reached confirmed new patient acceptance. Additionally, 15 of the 16

³² New patient rates should be reviewed in context of the limited number of cases that confirmed accurate provider data (i.e., correct phone number, location, specialty, and OHP Medicaid and CCO acceptance). Cases confirming accurate provider data ranged from seven cases (CHA) to 108 cases (HSO), which may have impacted appointment availability rates and wait time results. Caution should be exercised when interpreting access and availability results.

CCOs had new patient acceptance rates below 80.0 percent, ranging from 11.8 percent (YCCO) to 61.9 percent (PCS-CG).

Figure 4-3—PCP Locations Accepting New Patients



The denominator includes cases reached.

Note: “N” represents the numerator for the measure.

Appointment Availability

Table 4-28 and Table 4-29 display the number and percentage of survey respondents that offered a PCP appointment for new and existing patients, respectively, for routine and urgent visits. Please note, new patient appointments were requested from verified service locations that offered the requested services and accepted new patients with OHP Medicaid for the specified CCO. Additionally, existing patient

appointments were requested from verified service locations that offered the requested services and accepted OHP Medicaid for the specified CCO.

Among the cases reached, 23.8 percent and 18.3 percent offered appointments for routine and urgent new patient visits, respectively. Additionally, 31.9 percent and 30.2 percent offered appointments for routine and urgent existing patient visits, respectively.

Table 4-28—PCP New Patient Appointment Availability Rates

CCO	Routine New Patient Visits		Urgent New Patient Visits	
	Count	Rate ¹	Count	Rate ¹
Overall	330	23.8%	254	18.3%
AH	9	64.3%	4	28.6%
AllCare	21	23.3%	8	8.9%
CHA	4	44.4%	3	33.3%
CPCCO	30	18.0%	18	10.8%
EOCCO	41	27.9%	27	18.4%
HSO	78	40.0%	67	34.4%
IHN	11	12.8%	11	12.8%
JCC	11	9.4%	7	6.0%
PCS-CO	18	31.0%	15	25.9%
PCS-CG	11	52.4%	11	52.4%
PCS-LN	13	16.5%	12	15.2%
PCS-MP	16	26.7%	12	20.0%
TCHP-SW	24	22.4%	20	18.7%
TCHP-TC	28	28.3%	25	25.3%
UHA	7	33.3%	7	33.3%
YCCO	8	6.7%	7	5.9%

¹ The denominator includes cases reached.

Table 4-29—PCP Existing Patient Appointment Availability Rates

CCO	Routine Existing Patient Visits		Urgent Existing Patient Visits	
	Count	Rate ¹	Count	Rate ¹
Overall	443	31.9%	420	30.2%
AH	9	64.3%	7	50.0%
AllCare	31	34.4%	29	32.2%
CHA	6	66.7%	6	66.7%
CPCCO	42	25.1%	37	22.2%

CCO	Routine Existing Patient Visits		Urgent Existing Patient Visits	
	Count	Rate ¹	Count	Rate ¹
EOCCO	47	32.0%	46	31.3%
HSO	94	48.2%	88	45.1%
IHN	14	16.3%	15	17.4%
JCC	17	14.5%	16	13.7%
PCS-CO	22	37.9%	21	36.2%
PCS-CG	11	52.4%	11	52.4%
PCS-LN	24	30.4%	24	30.4%
PCS-MP	25	41.7%	25	41.7%
TCHP-SW	32	29.9%	30	28.0%
TCHP-TC	43	43.4%	40	40.4%
UHA	12	57.1%	12	57.1%
YCCO	14	11.8%	13	10.9%

¹ The denominator includes cases reached.

While interviewers did not specifically ask survey respondents about factors limiting the ability to schedule appointments, any additional information captured by the interviewers was categorized and presented below. In some cases, these limitations or conditions must be met to schedule an appointment but did not prevent the interviewer from documenting the first available appointment.

Conditional factors limiting the scheduling of appointments are listed below:

- Requiring preregistration, initial evaluation, medical record review, or Medicaid eligibility verification (142 cases).
- Unavailability of office location schedule or calendar (92 cases).
- Limiting appointments to specific age groups or clinical conditions (44 cases).

Office locations may have multiple requirements and limitations that affect members' access to care, including the ability to obtain appointment availability.

Appointment Wait Times

The CCOs must have policies and procedures in place to ensure the scheduling of appointments is reasonable. PCP appointments must comply with the following wait time standards: four weeks (or 28 calendar days) for routine visits and 72 hours (or three calendar days) for urgent visits.

Table 4-30 displays the average wait times, in calendar days, for new and existing patients for routine and urgent PCP visits. Please note, new patient appointments were requested from verified service locations that offered the requested services and accepted new patients with OHP Medicaid for the

specified CCO. Additionally, existing patient appointments were requested from verified service locations that offered the requested services and accepted OHP Medicaid for the specified CCO.

Overall, the average wait times for new patients were 35 and 12 calendar days for routine and urgent visits, respectively. Furthermore, the average wait times for existing patients were 17 and three calendar days for routine and urgent visits, respectively.

Table 4-30—Average Wait Times, in Calendar Days, to First Available PCP Appointments

CCO	Routine PCP New Patient Visits	Urgent PCP New Patient Visits	Routine PCP Existing Patient Visits	Urgent PCP Existing Patient Visits
Overall	35	12	17	3
AH	41	4	21	1
AllCare	52	8	16	1
CHA	18	0	21	2
CPCCO	30	4	14	0
EOCCO	45	23	20	1
HSO	25	2	16	1
IHN	43	43	39	34
JCC	40	34	13	3
PCS-CO	27	2	20	1
PCS-CG	9	9	9	9
PCS-LN	62	36	15	4
PCS-MP	35	20	16	1
TCHP-SW	42	4	17	3
TCHP-TC	27	3	13	1
UHA	41	41	19	17
YCCO	45	30	30	7

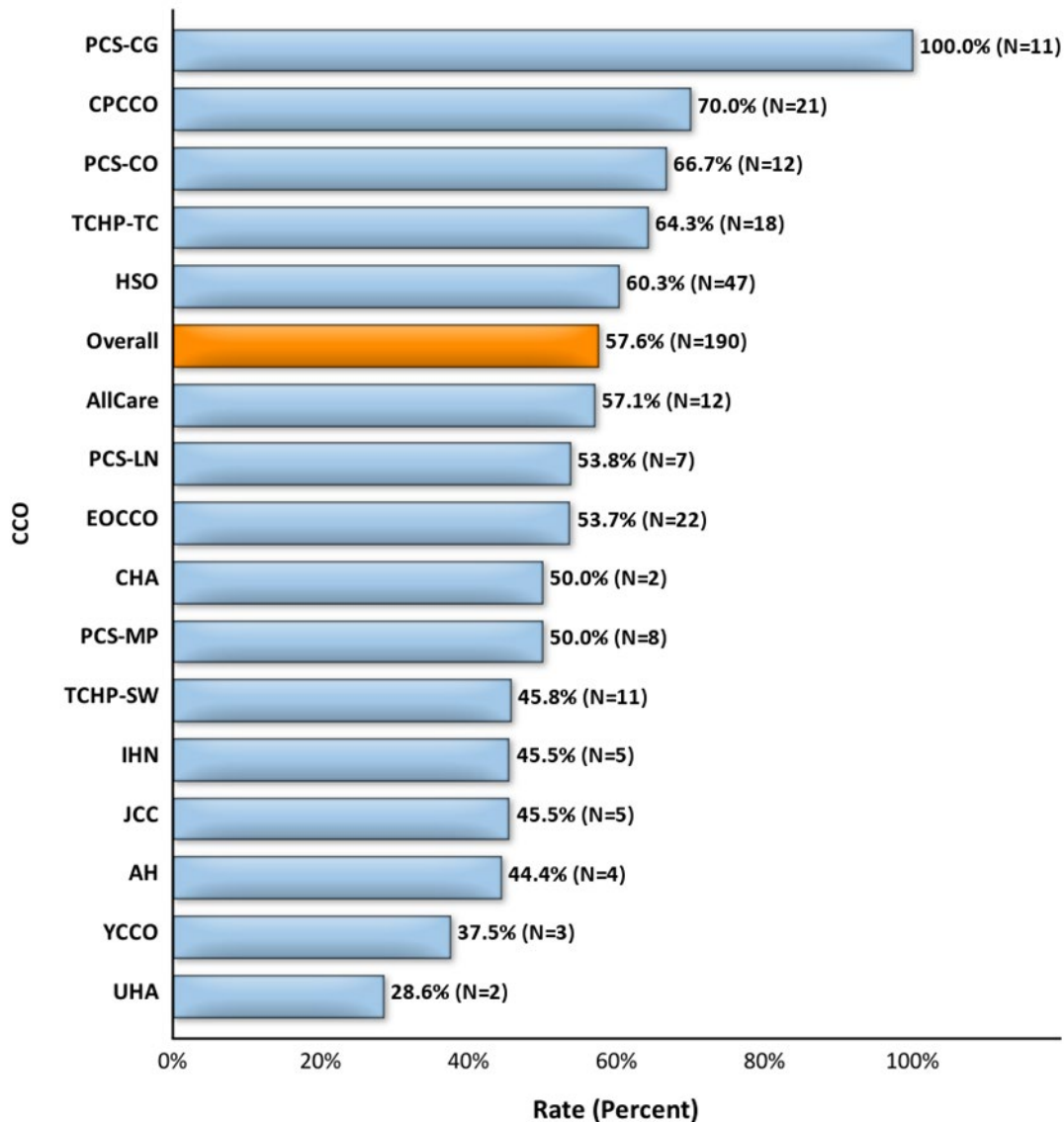
Appointment Availability Compliance

Figure 4-4 through Figure 4-7 display the percentage of PCP appointments that complied with the appointment availability compliance standards for routine visits (i.e., four weeks or 28 calendar days) and for urgent visits (i.e., 72 hours or three calendar days). The denominator includes cases that were offered an appointment date for the applicable visit type. Please note, new patient appointments were requested from verified service locations that offered the requested services and accepted new patients with OHP Medicaid for the specified CCO. Additionally, existing patient appointments were requested from verified service locations that offered the requested services and accepted OHP Medicaid for the specified CCO.

Routine Visits

Of the total cases that offered a routine PCP appointment, 57.6 percent of new patient appointments and 82.4 percent of existing patient appointments were within the compliance standards.

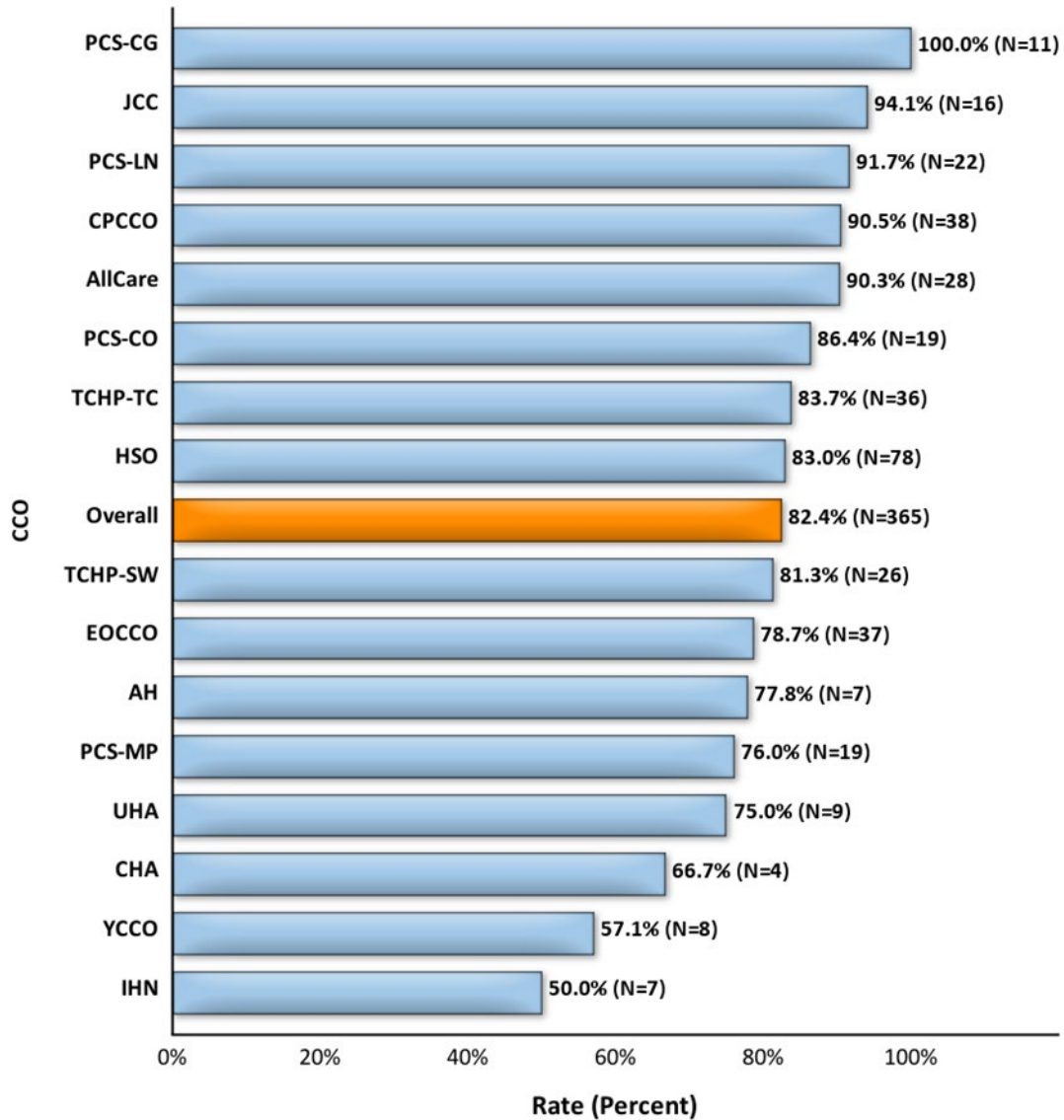
Figure 4-4—Percentage of Compliant New Patient Appointments—Routine PCP Visits



The denominator includes cases that offered an appointment for the applicable visit type.

Note: “N” represents the numerator for the measure.

Figure 4-5—Percentage of Compliant Existing Patient Appointments—Routine PCP Visits

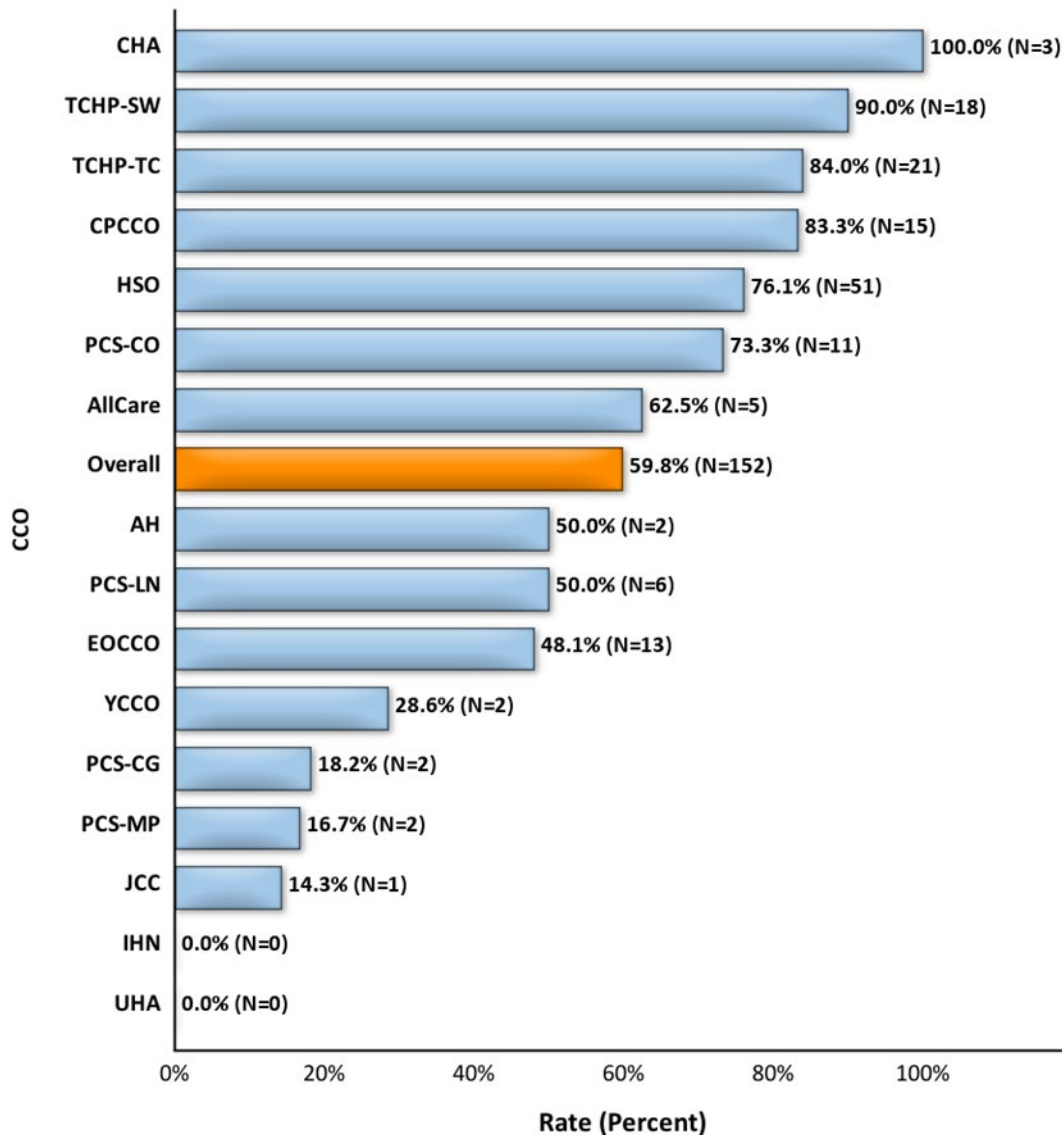


The denominator includes cases that offered an appointment for the applicable visit type.
Note: “N” represents the numerator for the measure.

Urgent Visits

Of the total cases that offered an urgent PCP appointment, 59.8 percent of new patient appointments and 85.5 percent of existing patient appointments were within compliance standards.

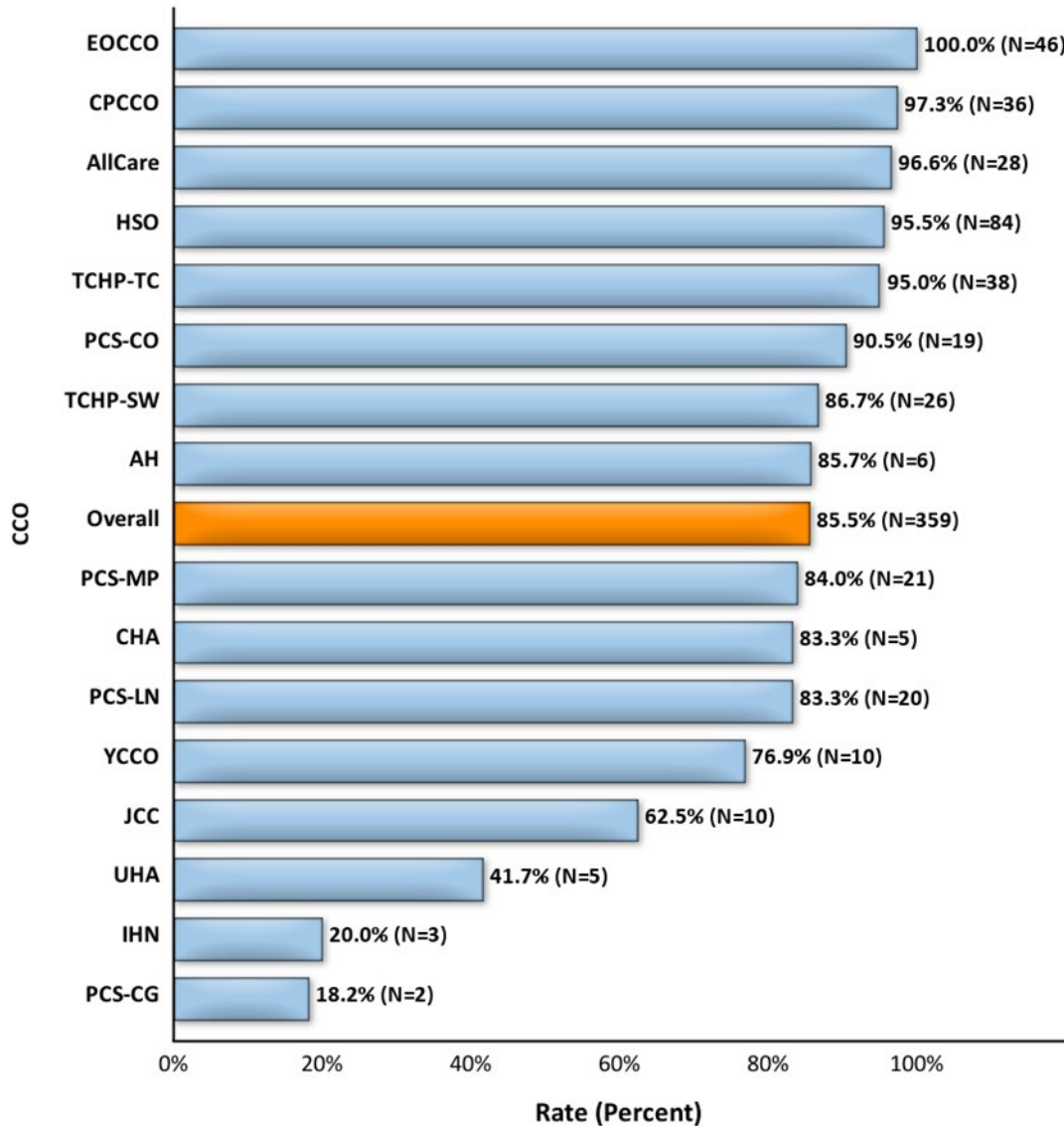
Figure 4-6—Percentage of Compliant New Patient Appointments—Urgent PCP Visits



The denominator includes cases that offered an appointment for the applicable visit type.

Note: “N” represents the numerator for the measure.

Figure 4-7—Percentage of Compliant Existing Patient Appointments—Urgent PCP Visits



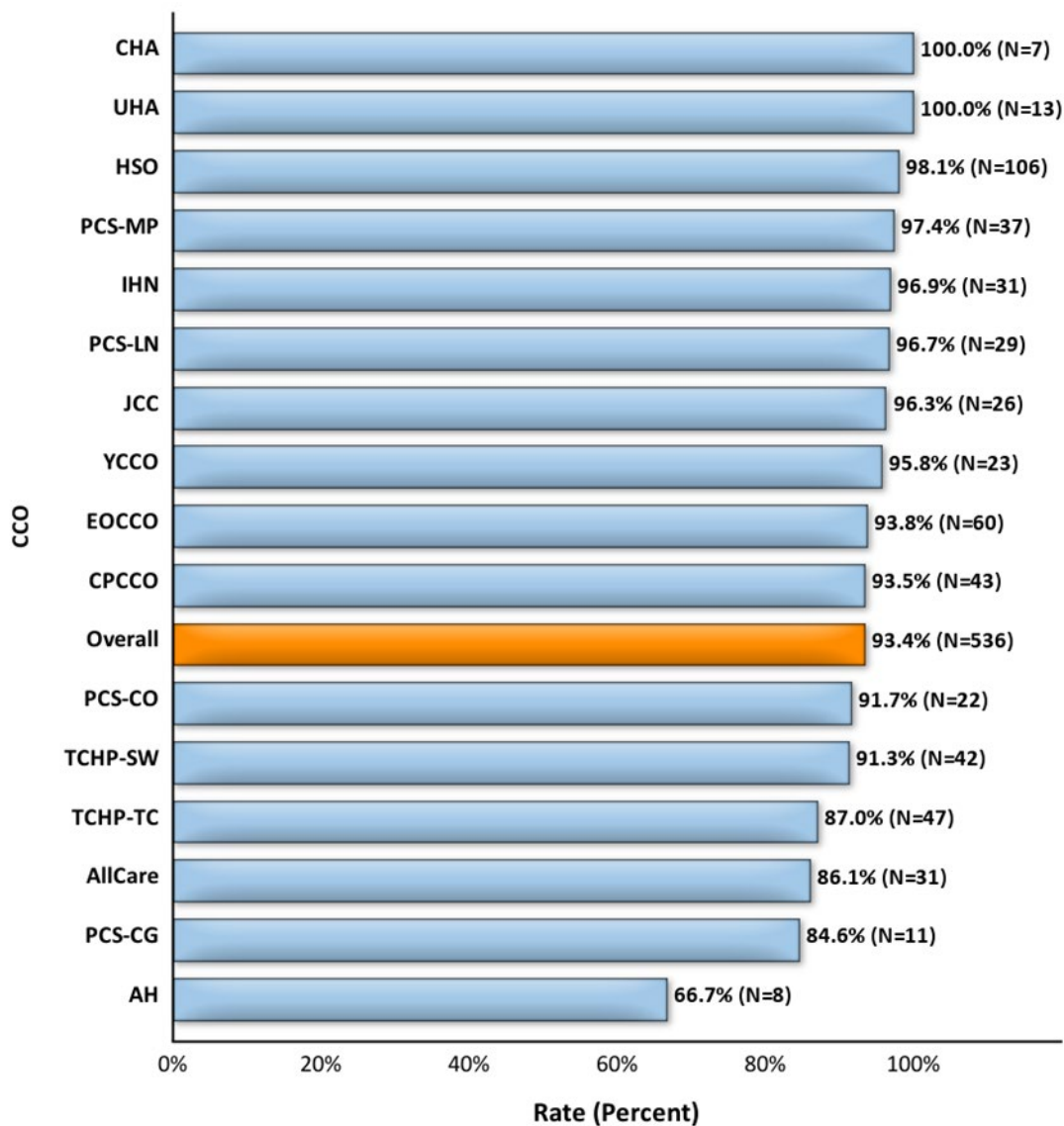
The denominator includes cases that offered an appointment for the applicable visit type.

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

Translation or Interpreter Services

Figure 4-8 displays the number and percentage of survey respondents that offered translation or interpreter services out of the cases accepting the CCO. Please note, the translation or interpreter services question was asked only for verified locations that offered the requested services and accepted OHP Medicaid for the specified CCO. Overall, 93.4 percent of PCP cases were offered translation or interpreter services among cases that accepted the requested CCO.

Figure 4-8—PCP Locations Offering Translation or Interpreter Services



The denominator includes cases accepting the CCO.

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

Table 4-31 displays the documented translation or interpreter service methods identified by survey respondents. The denominator includes cases offering translation or interpreter services. The most common reported service method for translation or interpreter service was verbal via electronic device (91.8 percent).

Table 4-31—Reported Translation or Interpreter Service Methods for PCP Locations

CCO ¹	Verbal (In Person)	Verbal (Electronic)	Sign Language (In Person)	Sign Language (Electronic)	Cued Language Transliterating/ Visual Interpretation (In Person)	Cued Language Transliterating/ Visual Interpretation (Electronic)
Overall (D=536)	61.2%	91.8%	41.2%	66.6%	19.4%	32.3%
AH (D=8)	25.0%	87.5%	25.0%	87.5%	0.0%	0.0%
AllCare (D=31)	48.4%	83.9%	32.3%	77.4%	0.0%	0.0%
CHA (D=7)	57.1%	71.4%	14.3%	57.1%	0.0%	0.0%
CPCCO (D=43)	79.1%	95.3%	74.4%	90.7%	0.0%	0.0%
EOCCO (D=60)	78.3%	90.0%	61.7%	88.3%	45.0%	45.0%
HSO (D=106)	34.9%	95.3%	29.2%	92.5%	1.9%	54.7%
IHN (D=31)	29.0%	83.9%	3.2%	6.5%	0.0%	0.0%
JCC (D=26)	92.3%	100%	88.5%	96.2%	76.9%	76.9%
PCS-CO (D=22)	50.0%	86.4%	22.7%	81.8%	0.0%	59.1%
PCS-CG (D=11)	90.9%	81.8%	0.0%	0.0%	0.0%	0.0%
PCS-LN (D=29)	72.4%	93.1%	51.7%	65.5%	31.0%	31.0%
PCS-MP (D=37)	91.9%	97.3%	91.9%	97.3%	78.4%	78.4%
TCHP-SW (D=42)	45.2%	92.9%	2.4%	9.5%	0.0%	0.0%
TCHP-TC (D=47)	68.1%	93.6%	14.9%	17.0%	0.0%	0.0%
UHA (D=13)	53.8%	84.6%	0.0%	0.0%	0.0%	0.0%
YCCO (D=23)	95.7%	91.3%	95.7%	87.0%	73.9%	73.9%

¹ “D” represents the denominator for the rate of translation or interpreter service methods.

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

OP SUD Providers

Response Rates

Table 4-32 displays the detailed survey dispositions and response rates. Overall, 73.8 percent of OP SUD locations were reached. AH achieved the highest response rate at 100 percent, while PCS-MP experienced the lowest response rate at 56.4 percent. Additionally, 10 CCOs had response rates below 80.0 percent. Please note that AH, AllCare, CHA, and UHA had less than 20 cases reached due to the limited number of providers sampled, which may have affected results related to data accuracy and appointment availability.

Table 4-32—Survey Dispositions and Response Rates: Total OP SUD Provider Outreach Calls

CCO	Sampled Cases	Cases Reached ^{1,2}	Bad Phone Number ³	Unable to Reach ⁴	Response Rate ⁵
Overall	1,040	767	178	95	73.8%
AH	10	10	0	0	100%
AllCare	20	19	1	0	95.0%
CHA	6	5	1	0	83.3%
CPCCO	65	63	1	1	96.9%
EOCCO	69	46	19	4	66.7%
HSO	85	60	19	6	70.6%
IHN	72	49	16	7	68.1%
JCC	64	57	3	4	89.1%
PCS-CO	101	64	34	3	63.4%
PCS-CG	101	79	19	3	78.2%
PCS-LN	101	70	27	4	69.3%
PCS-MP	101	57	20	24	56.4%
TCHP-SW	62	51	5	6	82.3%
TCHP-TC	69	52	5	12	75.4%
UHA	21	16	2	3	76.2%
YCCO	93	69	6	18	74.2%

¹ *Cases Reached* represents cases where a survey respondent was reached.

² Due to the limited number of sampled cases and cases reached for specific CCOs, caution should be exercised when interpreting provider data accuracy and access and availability results.

³ This data element includes reaching a disconnected number, fax number, nonmedical facility, or billing office (corrected number unavailable).

⁴ This data element includes reaching a voicemail, busy signal, continuous ringing, an extended hold time after three attempts, or refusals.

⁵ The denominator includes the number of sampled cases.

Interviewers attempted to contact each survey case up to three times during standard business hours at different times on different days; a case that could not be contacted was considered to be nonresponsive.

Interviewers who were put on hold at any point during the call remained on hold for five minutes before ending the call, resulting in an extended hold time nonresponse reason.

Overall, the most prevalent nonresponse reasons included:

- Incorrect phone numbers accounted for 17.1 percent of survey calls (178 cases).
- Voicemail after three call attempts accounted for 5.8 percent of survey calls (60 cases).
- Refusals accounted for 2.2 percent of calls (23 cases).

Provider Data Accuracy

Table 4-33 reflects the accuracy of key data elements as reported by survey respondents and displays the number and percentage of OP SUD cases for which provider data were validated. Among the cases reached, 83.3 percent confirmed the correct location, 57.8 percent offered the requested service, 52.5 percent accepted OHP Medicaid, and 39.9 percent accepted the requested CCO. Further, this indicates that 60.1 percent of OP SUD cases overall had provider data inaccuracies (i.e., incorrect location, not offering the requested services, and not accepting OHP Medicaid or CCO). Of note, since CHA had no cases that offered the requested services, OHP Medicaid and CCO acceptance was not confirmed.

Table 4-33—OP SUD Provider Data Accuracy Results

CCO	Correct Location		Offering Requested Services ¹		OHP Medicaid Acceptance ²		CCO Acceptance ³	
	Count	Rate ⁴	Count	Rate ⁴	Count	Rate ⁴	Count	Rate ⁴
Overall	639	83.3%	443	57.8%	403	52.5%	306	39.9%
AH	10	100%	8	80.0%	7	70.0%	7	70.0%
AllCare	15	78.9%	14	73.7%	13	68.4%	13	68.4%
CHA	3	60.0%	0	0.0%	NA	NA	NA	NA
CPCCO	54	85.7%	34	54.0%	31	49.2%	31	49.2%
EOCCO	41	89.1%	35	76.1%	31	67.4%	19	41.3%
HSO	53	88.3%	30	50.0%	20	33.3%	18	30.0%
IHN	42	85.7%	25	51.0%	22	44.9%	19	38.8%
JCC	51	89.5%	29	50.9%	28	49.1%	17	29.8%
PCS-CO	53	82.8%	39	60.9%	31	48.4%	26	40.6%
PCS-CG	62	78.5%	45	57.0%	40	50.6%	30	38.0%
PCS-LN	59	84.3%	41	58.6%	37	52.9%	33	47.1%
PCS-MP	42	73.7%	31	54.4%	31	54.4%	21	36.8%
TCHP-SW	43	84.3%	37	72.5%	37	72.5%	23	45.1%
TCHP-TC	41	78.8%	30	57.7%	30	57.7%	26	50.0%

CCO	Correct Location		Offering Requested Services ¹		OHP Medicaid Acceptance ²		CCO Acceptance ³	
	Count	Rate ⁴	Count	Rate ⁴	Count	Rate ⁴	Count	Rate ⁴
UHA	16	100%	13	81.3%	13	81.3%	8	50.0%
YCCO	54	78.3%	32	46.4%	32	46.4%	15	21.7%

¹ Data element was assessed from survey respondents with verified locations.

² Data element was assessed from survey respondents with verified locations that offered the requested services.

³ Data element was assessed from survey respondents with verified locations, offering the requested services, and accepting OHP Medicaid.

⁴ The denominator includes cases reached.

NA indicates “not applicable” since no cases provided OP SUD services for the specific CCO.

Access and Availability

The following charts reflect members’ access to services and display the percentage of cases that resulted in obtaining new patient appointment availability among cases reached, as well as the prevalence and type of translation or interpreter services available at provider offices.³³

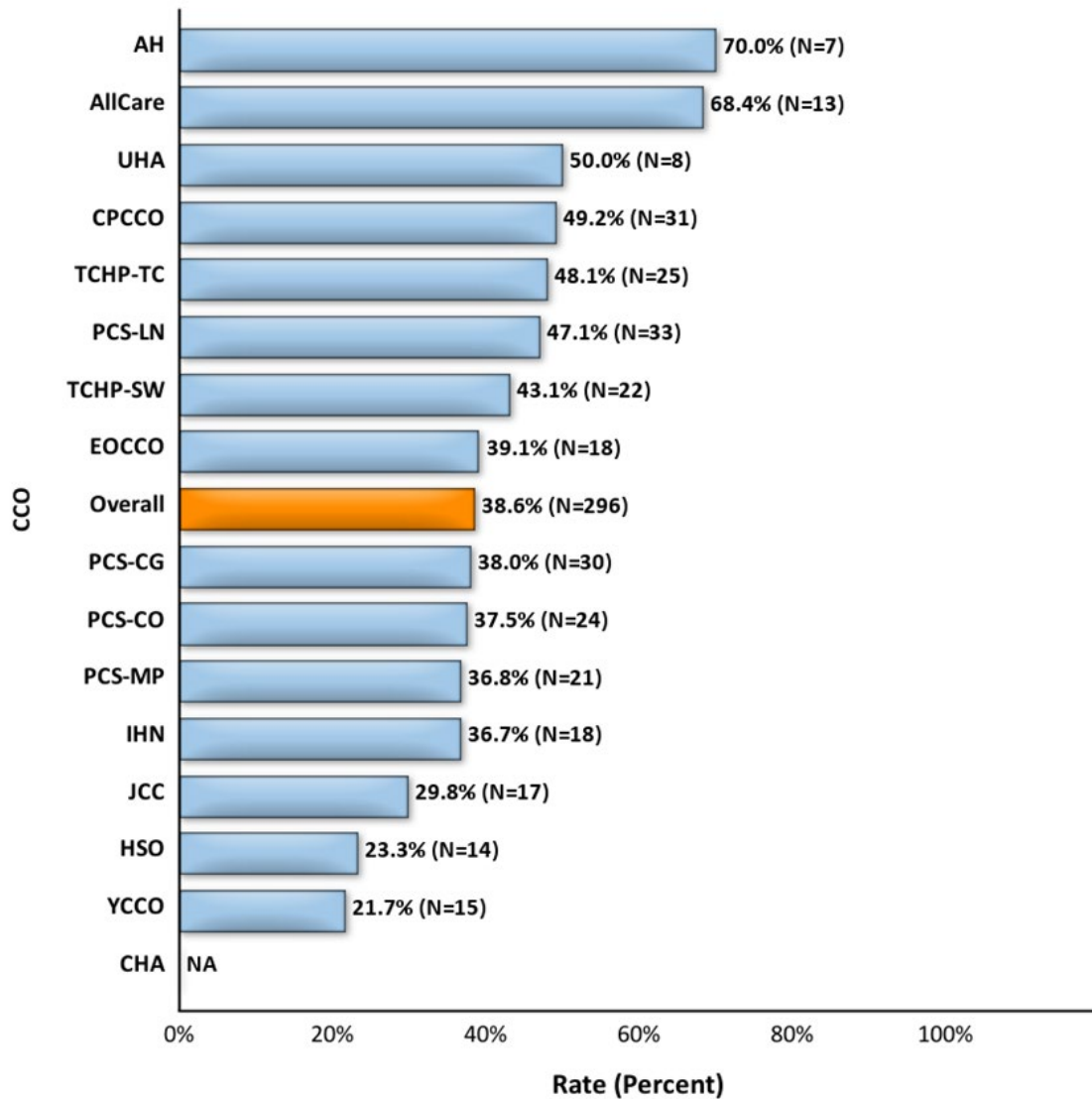
New Patient Acceptance

Figure 4-9 displays the number and percentage of survey respondents that accepted new patients out of all cases reached.³⁴ Please note, the new patient acceptance question was asked only for verified locations that offered the requested services and accepted OHP Medicaid for the specified CCO. Overall, 38.6 percent of cases reached confirmed new patient acceptance. Additionally, all CCOs had new patient acceptance rates below 80.0 percent, ranging from 21.7 percent (YCCO) to 70.0 percent (AH).

³³ Since none of CHA’s sample provider locations offered the requested services, the CCO was excluded from the access and appointment availability analyses.

³⁴ New patient rates should be reviewed in context of the limited number of cases that confirmed accurate provider data (i.e., phone number, location, specialty, and OHP Medicaid and CCO acceptance). Cases confirming accurate provider data ranged from seven cases (AH) to 33 cases (PCS-LN), which may have impacted appointment availability rates and wait time results. Caution should be exercised when interpreting access and availability results.

Figure 4-9—OP SUD Locations Accepting New Patients



The denominator includes cases reached.

Note:

- “N” represents the numerator for the measure.
- NA indicates “not applicable” since no cases provided OP SUD services for the specific CCO.

Appointment Availability

Table 4-34 displays the number and percentage of survey respondents that offered an OP SUD appointment for routine care, urgent care, opioid use disorder, and pregnant members out of all cases reached. Please note, appointments were requested from verified service locations that offered the requested services and accepted OHP Medicaid for the specified CCO. Overall, among the cases reached, 28.9 percent and 27.2 percent offered routine and urgent OP SUD visits, respectively. In addition, 28.3 percent and 32.9 percent of cases reached offered an appointment for opioid use disorder treatment and an OP SUD visit for pregnant members, respectively.

Table 4-34—OP SUD Appointment Availability Rates

CCO	Routine OP SUD Visits		Urgent OP SUD Visits		OP Opioid Use Disorder Visits		OP SUD Visits for Pregnant Members	
	Count	Rate ¹	Count	Rate ¹	Count	Rate ¹	Count	Rate ¹
Overall	222	28.9%	209	27.2%	217	28.3%	252	32.9%
AH	6	60.0%	6	60.0%	6	60.0%	7	70.0%
AllCare	13	68.4%	5	26.3%	6	31.6%	13	68.4%
CHA	NA	NA	NA	NA	NA	NA	NA	NA
CPCCO	28	44.4%	24	38.1%	25	39.7%	29	46.0%
EOCCO	13	28.3%	13	28.3%	13	28.3%	13	28.3%
HSO	10	16.7%	9	15.0%	10	16.7%	11	18.3%
IHN	7	14.3%	6	12.2%	6	12.2%	7	14.3%
JCC	17	29.8%	15	26.3%	16	28.1%	17	29.8%
PCS-CO	16	25.0%	16	25.0%	19	29.7%	22	34.4%
PCS-CG	22	27.8%	21	26.6%	21	26.6%	29	36.7%
PCS-LN	25	35.7%	25	35.7%	25	35.7%	33	47.1%
PCS-MP	15	26.3%	15	26.3%	18	31.6%	15	26.3%
TCHP-SW	18	35.3%	19	37.3%	16	31.4%	19	37.3%
TCHP-TC	18	34.6%	20	38.5%	21	40.4%	21	40.4%
UHA	6	37.5%	7	43.8%	7	43.8%	7	43.8%
YCCO	8	11.6%	8	11.6%	8	11.6%	9	13.0%

¹ The denominator includes cases reached.

NA indicates “not applicable” since no cases provided OP SUD services for the specified CCO.

While interviewers did not specifically ask survey respondents about factors limiting the ability to schedule appointments, any additional information captured by the interviewers was categorized and presented below. In some cases, these limitations or conditions must be met to schedule an appointment but did not prevent the interviewer from documenting the first available appointment.

Conditional factors limiting the scheduling of appointments are listed below:

- Requiring preregistration or initial evaluation (106 cases).
- Unavailability of office location schedule or calendar (30 cases).

Office locations may have multiple requirements and limitations that affect members' access to care, including the ability to obtain appointment availability.

Appointment Wait Times

The CCOs must have policies and procedures in place to ensure the scheduling of appointments is reasonable. OP SUD appointments must comply with the following wait time standards: seven calendar days for routine visits, one calendar day for urgent visits, three calendar days for opioid use disorder visits, and same day for pregnant members.

Table 4-35 displays the average wait times, in calendar days, for routine and urgent OP SUD visits, and OP visits for opioid use disorder and pregnant members. Please note, appointments were requested from verified service locations that offered the requested services and accepted OHP Medicaid for the specified CCO.

Overall, the average wait times for routine and urgent OP SUD visits were seven and four calendar days, respectively. The average wait times for OP opioid use disorder treatments and OP SUD visits for pregnant members were six and four calendar days, respectively.

Table 4-35—Average Wait Times, in Calendar Days, to First Available OP SUD Appointments

CCO	Routine OP SUD Visits	Urgent OP SUD Visits	OP Opioid Use Disorder Visits	OP SUD Visits for Pregnant Members
Overall	7	4	6	4
AH	10	8	8	0
AllCare	20	0	11	0
CHA	NA	NA	NA	NA
CPCCO	9	7	11	11
EOCCO	16	24	15	24
HSO	6	3	6	4
IHN	6	7	8	5
JCC	4	1	1	1
PCS-CO	5	5	3	2
PCS-CG	2	1	1	0
PCS-LN	2	1	1	0
PCS-MP	4	0	9	2

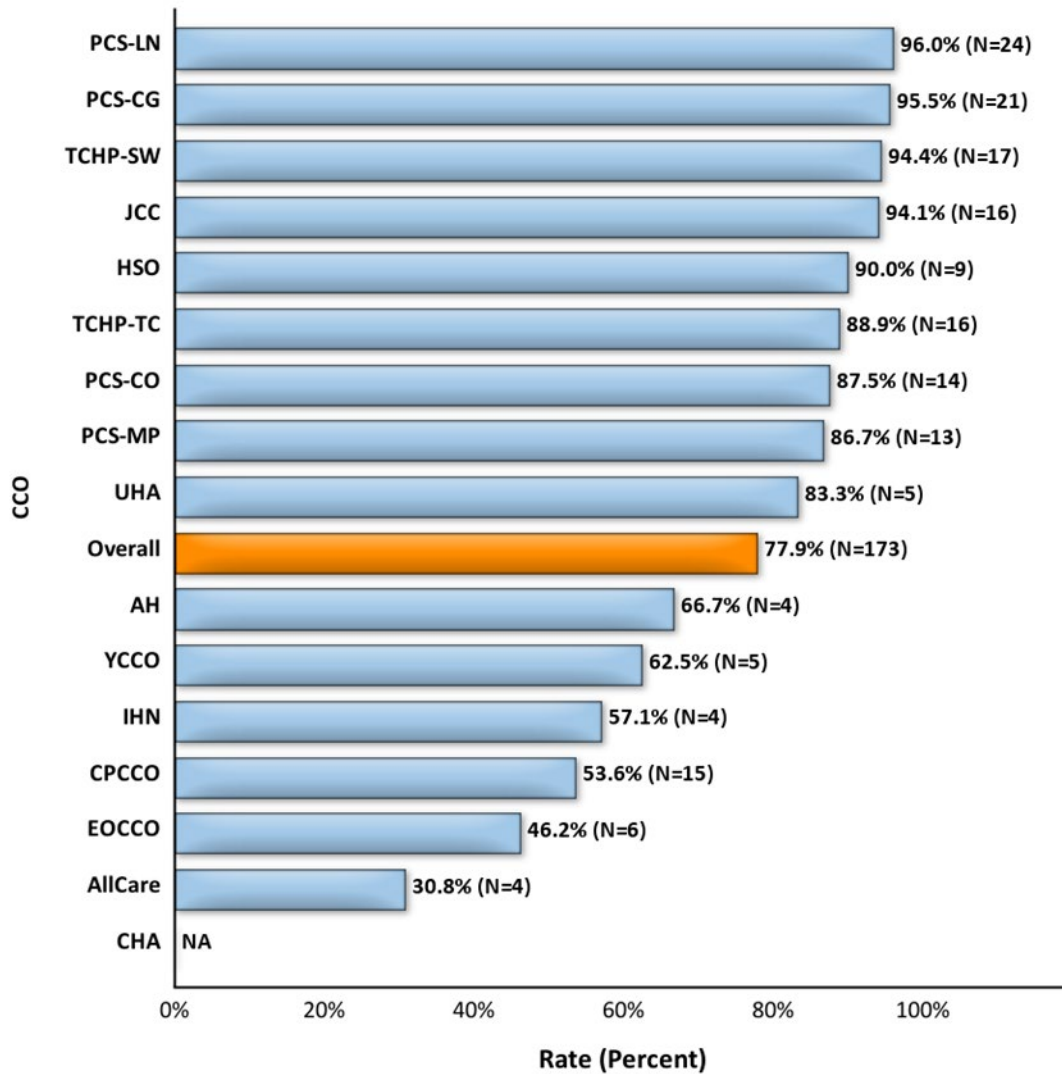
CCO	Routine OP SUD Visits	Urgent OP SUD Visits	OP Opioid Use Disorder Visits	OP SUD Visits for Pregnant Members
TCHP-SW	8	1	12	3
TCHP-TC	4	0	4	1
UHA	5	1	13	0
YCCO	8	2	6	5

NA indicates “not applicable” since no cases offered an appointment for the specified CCO.

Appointment Availability Compliance

Figure 4-10 through Figure 4-13 display the percentage of OP SUD appointments that complied with the appointment availability compliance standards for routine visits (i.e., seven calendar days), urgent visits (i.e., one calendar day), opioid use disorder visits (i.e., three calendar days), and OP SUD visits for pregnant members (i.e., same day). The denominator includes cases that offered an appointment for the applicable visit type. Please note, appointments were requested from verified service locations that offered the requested services and accepted OHP Medicaid for the specified CCO. Of the appointments that were offered, 77.9 percent of routine visits and 67.9 percent of urgent visits met the appointment compliance standards. In addition, 60.8 percent of opioid use disorder treatment appointments and 65.9 percent of OP SUD visits for pregnant members met the appointment compliance standards.

Figure 4-10—Percentage of Compliant Appointments—Routine OP SUD Visits

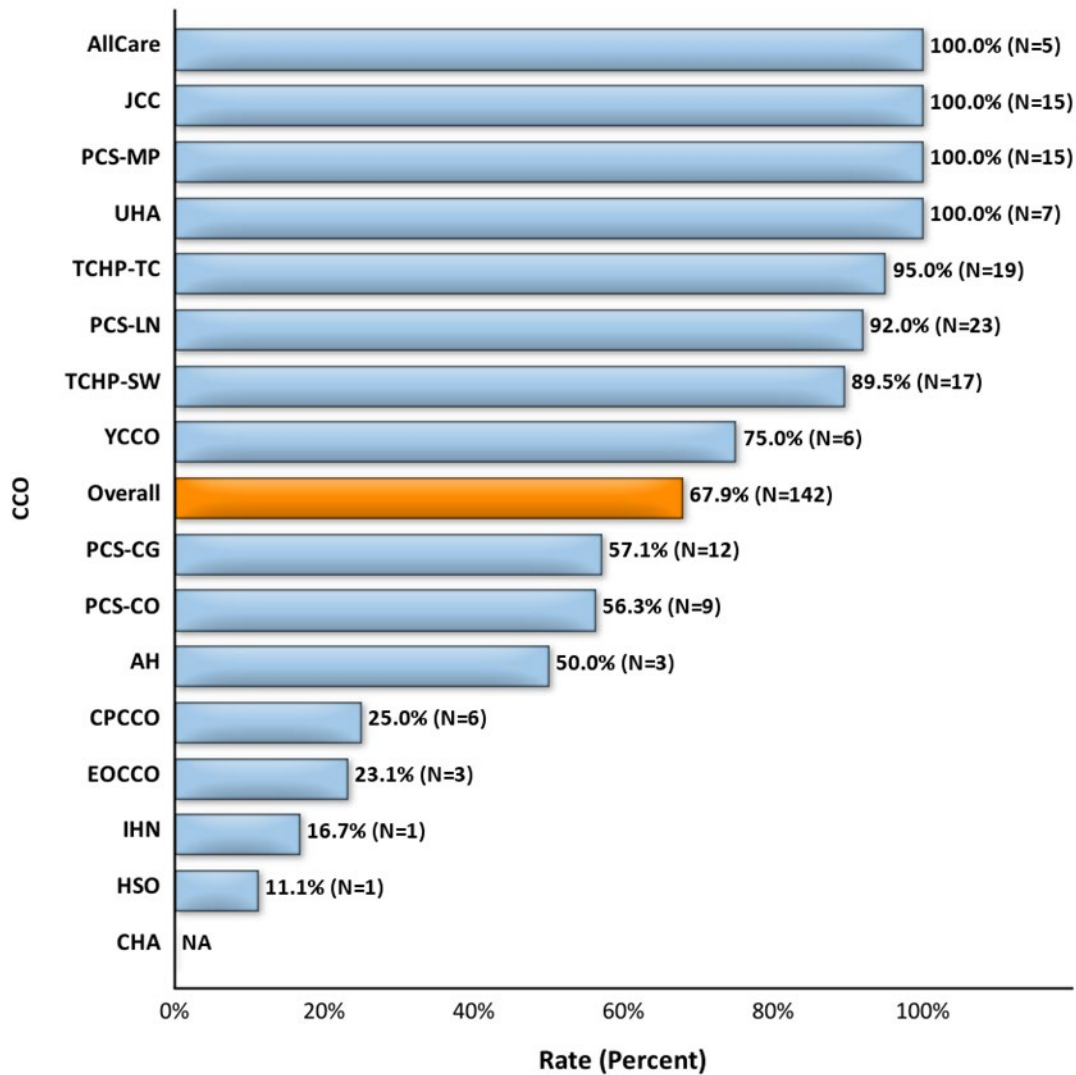


The denominator includes cases that offered an appointment for the applicable visit type.

Note:

- “N” represents the numerator for the measure.
- NA indicates “not applicable” since no cases provided OP SUD services for the specific CCO.

Figure 4-11—Percentage of Compliant Appointments—Urgent SUD Visits

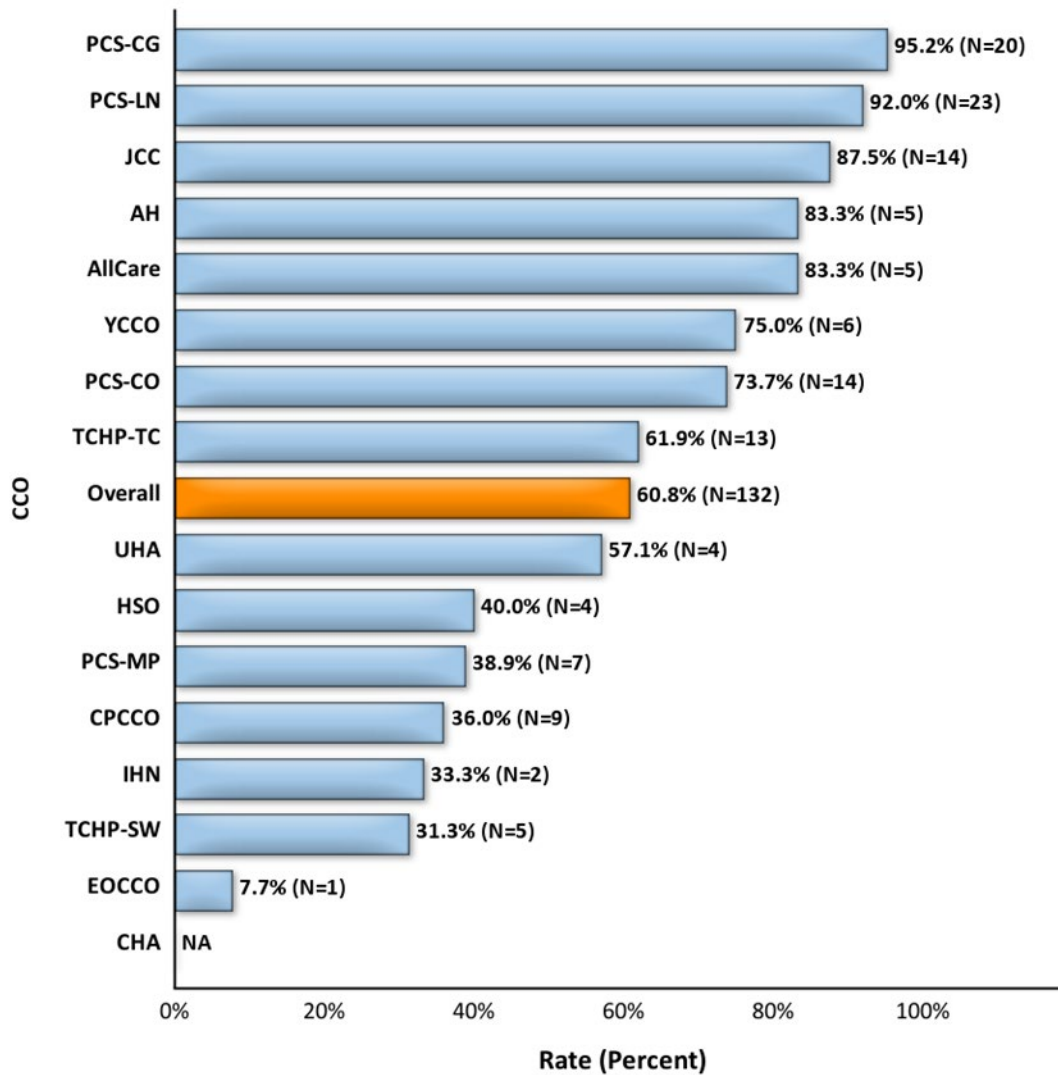


The denominator includes cases that offered an appointment for the applicable visit type.

Note:

- “N” represents the numerator for the measure.
- NA indicates “not applicable” since no cases provided OP SUD services for the specific CCO.

Figure 4-12—Percentage of Compliant Appointments—Opioid Use Disorder Visits

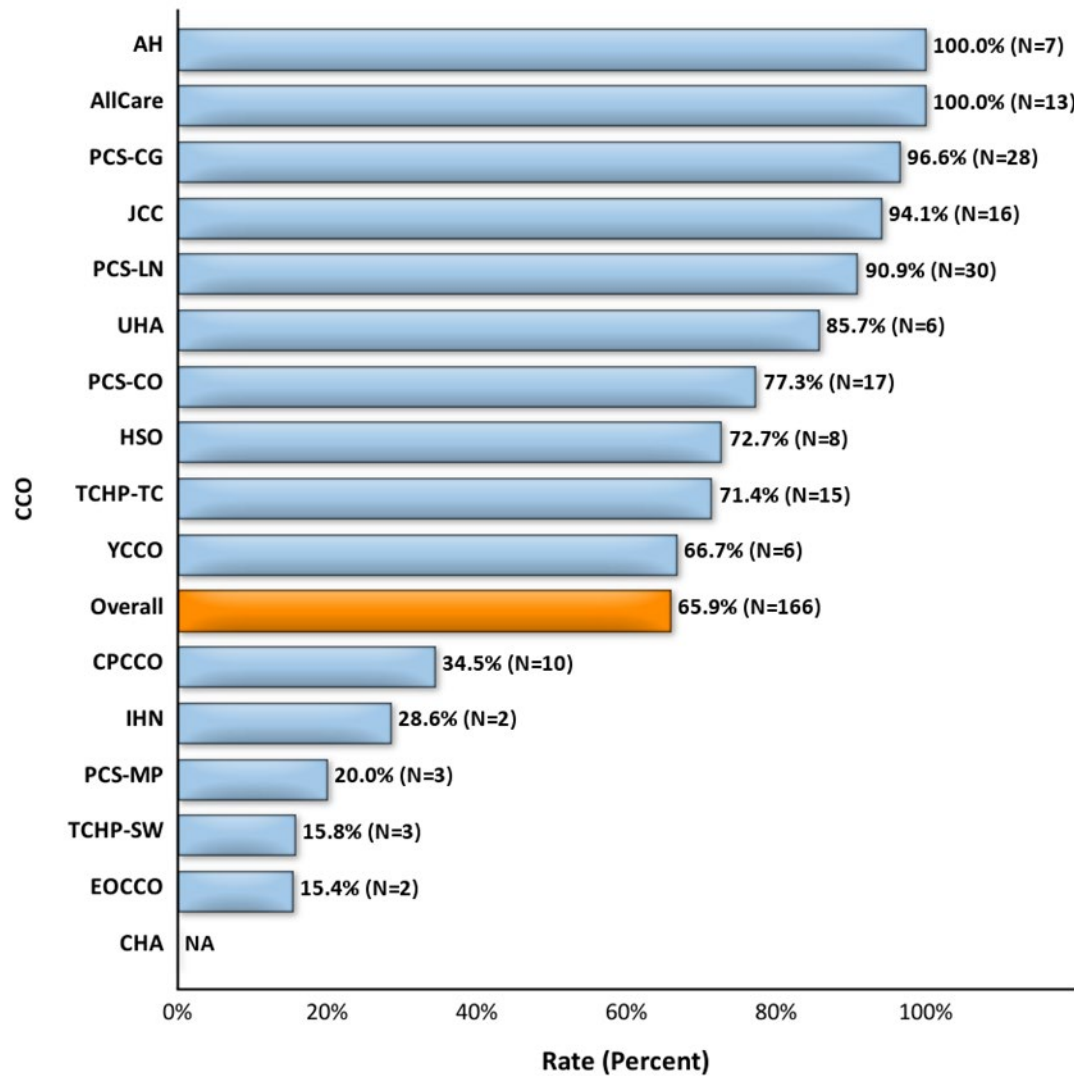


The denominator includes cases that offered an appointment for the applicable visit type.

Note:

- “N” represents the numerator for the measure.
- NA indicates “not applicable” since no cases provided OP SUD services for the specific CCO.

Figure 4-13—Percentage of Compliant Appointments—SUD Visits for Pregnant Members



The denominator includes cases that offered an appointment for the applicable visit type.

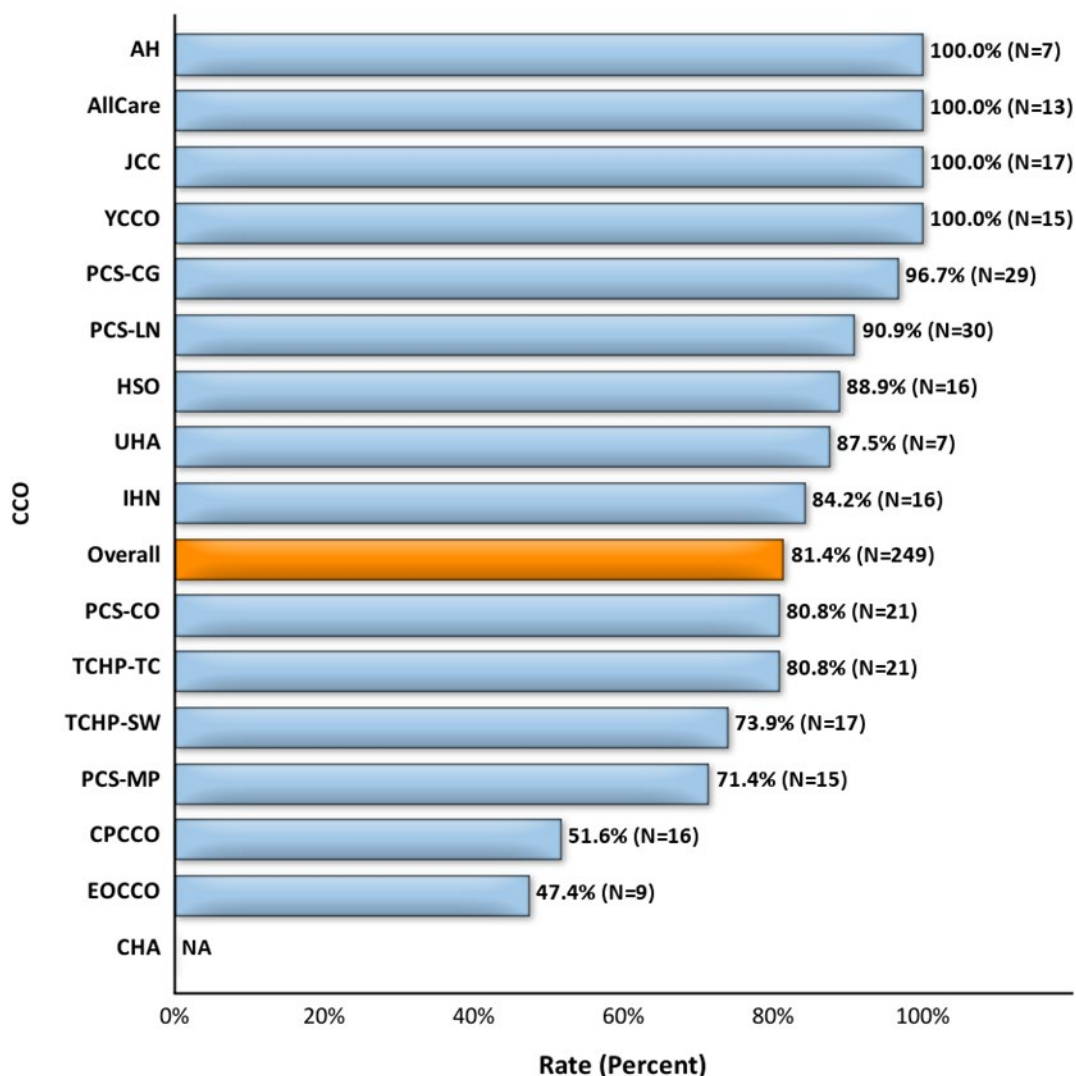
Note:

- “N” represents the numerator for the measure.
- NA indicates “not applicable” since no cases provided OP SUD services for the specific CCO.

Translation or Interpreter Services

Figure 4-14 displays the number and percentage of survey respondents that offered translation or interpreter services out of the cases accepting the CCO. Please note, the translation or interpreter services question was asked only for verified locations that offered the requested services and accepted OHP Medicaid for the specified CCO. Overall, 81.4 percent of OP SUD cases offered translation or interpreter services. Of note, since CHA had no cases that offered the requested services, translation or interpreter services were not confirmed.

Figure 4-14—SUD Locations Offering Translation or Interpreter Services



The denominator includes cases accepting the CCO.

Note:

- “N” represents the numerator for the measure.
- NA indicates “not applicable” since no cases provided OP SUD services for the specific CCO.

Table 4-36 displays the documented translation or interpreter service methods identified by survey respondents. The denominator includes cases that offered translation or interpreter services. The most common reported service method for translation or interpreter service was verbal via electronic device (68.7 percent).

Table 4-36—Reported Translation or Interpreter Service Methods for SUD Locations

CCO ¹	Verbal (In Person)	Verbal (Electronic)	Sign Language (In Person)	Sign Language (Electronic)	Cued Language Transliterating/ Visual Interpretation (In Person)	Cued Language Transliterating/ Visual Interpretation (Electronic)	Other
Overall (D=249)	58.2%	68.7%	18.5%	52.6%	16.5%	40.6%	2.0%
AH (D=7)	100%	100%	100%	100%	100%	100%	0.0%
AllCare (D=13)	84.6%	100%	84.6%	100%	84.6%	100%	0.0%
CHA	NA	NA	NA	NA	NA	NA	NA
CPCCO (D=16)	75.0%	100%	75.0%	93.8%	75.0%	93.8%	0.0%
EOCCO (D=9)	100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
HSO (D=16)	100%	6.3%	6.3%	6.3%	6.3%	6.3%	0.0%
IHN (D=16)	87.5%	12.5%	0.0%	0.0%	0.0%	0.0%	0.0%
JCC (D=17)	35.3%	94.1%	17.6%	94.1%	17.6%	76.5%	0.0%
PCS-CO (D=21)	61.9%	42.9%	0.0%	33.3%	0.0%	33.3%	0.0%
PCS-CG (D=29)	44.8%	82.8%	20.7%	96.6%	20.7%	86.2%	0.0%
PCS-LN (D=30)	40.0%	76.7%	0.0%	73.3%	0.0%	60.0%	0.0%
PCS-MP (D=15)	46.7%	73.3%	0.0%	6.7%	0.0%	0.0%	6.7%
TCHP-SW (D=17)	41.2%	82.4%	5.9%	11.8%	5.9%	5.9%	0.0%
TCHP-TC (D=21)	47.6%	81.0%	9.5%	38.1%	0.0%	0.0%	9.5%
UHA (D=7)	28.6%	57.1%	0.0%	42.9%	0.0%	0.0%	14.3%
YCCO (D=15)	40.0%	93.3%	20.0%	53.3%	0.0%	6.7%	6.7%

¹ “D” represents the denominator for the rate of translation or interpreter service methods.

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

NA indicates “not applicable” since no cases provided OP SUD services for the specific CCO.

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

For the CCOs statewide, the following conclusions were made:

Network Adequacy Validation Audit

- All CCOs achieved a *High Confidence* validation rating, demonstrating the acceptable use of data collection procedures, network adequacy methods, and the calculation and interpretation of network adequacy time and distance results.
- HSAG observed the following best practices used by CCOs:
 - Implementation of processes for members to self-report demographic changes.
 - Offering multiple options for providers to update demographic and practice data through self-service tools available through the CCO website, ongoing provider attestations of quarterly data, and monthly audits of provider data to identify changes, additions, or terminations.
 - Implementation and monthly monitoring of time and distance dashboards.
 - Development of detailed work instructions outlining the time and distance calculation process.

Delivery System Network Evaluation

- Based on improvements in DSN Provider Narrative submissions, the CCOs' overall level of compliance with State requirements for monitoring network adequacy as well as subject matter expertise improved, with some CCOs showing marked improvement (AllCare, CHA, IHN, and YCCO).
- The CCOs generally improved their ability to use new and previously available data to support network adequacy monitoring and decision making.
- Provider networks remained stable or were expanded for primary care practitioners (i.e., PCPs, PCDs, MH providers, and SUD providers). Instances where there were substantial provider reductions for PCPs (i.e., greater than 10 percent) were either explained by data corrections since 2023 or were reflective of small provider pools where small changes lead to big differences. Additionally, most CCOs either improved or maintained consistent provider-to-member ratios for primary care practitioners, or came into approximate alignment with other CCOs of similar membership size and service region urbanicity.
- While the results for PCD counts and ratios among the CCOs with service regions in southern Oregon suggest a regional access concern for oral health care, all CCOs exhibited a high degree of compliance with adult and pediatric time and distance standards.
- All CCOs showed full implementation of OHA's 2024 time and distance standards, which represented an operational improvement in CCO compliance with monitoring standards over previous years.
- Overall, most CCOs (i.e., 11 of 16) demonstrated a high level of compliance with Oregon network adequacy standards across adult, pediatric, and facility providers. Two CCOs (IHN and PCS-MP) achieved 100 percent compliance across all network adequacy standards with nine additional CCOs

achieving compliance with 90.0 percent or more of the network adequacy standards. Although compliance with network adequacy standards was generally high, time and distance results varied by adult and pediatric populations and provider tiers.

- In general, compliance with network adequacy standards among pediatric members was lower than compliance among adult providers for all provider tiers, particularly for CCOs with service regions in rural areas and in counties with extreme access issues. Compliance with network adequacy standards was also generally lower among Tier 2 providers, especially among pediatric members. In general, the results suggest non-compliance was driven by a high number of pediatric members living outside of acceptable travel times and distances relative to pediatric providers as well as the limited number of MTD providers available within the State.
- Among the provider types and facilities evaluated, compliance rates among MTD providers were an outlier across the CCOs.

Revealed Telephone Survey

- Individual provider and practice data (i.e., phone number, address, specialty, OHP and CCO affiliation, and panel status) contained in the provider capacity data files were incorrect.
- Members seeking PCP and OP SUD appointments were experiencing limited appointment availability.
- New patients seeking primary care services, and any patient seeking OP SUD services, were experiencing wait times beyond the appointment compliance standards.

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

Network Adequacy Validation Audit

- HSAG identified variation across the CCOs in the methodology used to define distance for network adequacy indicator calculations, including the use of straight line and driving distance.
- Although OHA provided official guidance on geographic designations, several options for applying geographic designations were suggested. HSAG observed variation in CCO application of the OHA guidance provided.
- HSAG identified CCOs that relied on manual processes for entering provider network data information, including specialty and taxonomy codes.

Delivery System Network Evaluation

- Results from the DSN Evaluation highlighted ongoing challenges in the assessment of CCO network monitoring due to the lack of consistency in the application of technical definitions and ensuring the data collected and reported aligned with OHA's intent for network monitoring.
- The results associated with all availability and accessibility data elements suggest ongoing data quality issues across the CCOs, potentially including but not limited to data definitions and methodological alignment.
- Although compliance with network adequacy standards was generally high, time and distance results varied by adult and pediatric populations and provider tiers. Compliance with network adequacy

standards among pediatric members was lower than compliance among adult providers for all provider tiers, particularly for CCOs with service regions in rural areas and in counties with extreme access issues.

- HSAG identified CCOs that did not have at least one provider within its network for each type of medical service that is covered under the health plan.
- The raw counts of MH providers and SUD providers added in just one year across the CCOs, combined with the low percentage of in-region providers, suggest access concerns that should be monitored to ensure adequate availability of providers for all member populations.
- Among the provider types and facilities evaluated, compliance rates among MTD providers were an outlier across the CCOs. Of the 13 CCOs contracted with MTD providers, only three CCOs met the time and distance standards across all urbanities.
- A supplemental review of the MTD provider locations suggest that MTD providers may be restricted to specific regions within the State (i.e., within the Interstate-5 corridor), and not all contracted facilities reported by the CCOs as MTD providers offered MTD services. These findings suggest there may be broad data quality issues associated with the classification, monitoring, and reporting of this provider type and indicate the need for increased collaboration between OHA and the CCOs to ensure accurate assessment of member access to MTD services.

Revealed Telephone Survey

- Overall, HSAG was unable to contact 25.2 percent of PCP cases and 26.2 percent of OP SUD cases. Of the total cases reached, 8.7 percent of PCP cases and 17.1 percent of OP SUD cases reported incorrect phone numbers (i.e., disconnected numbers, fax numbers, nonmedical facility, or billing office). Additionally, survey results indicated 58.7 percent of PCP cases and 60.1 percent of OP SUD cases had inaccuracies in the office information (i.e., incorrect location, not offering the requested services, and not accepting OHP Medicaid or CCO).
- HSAG was only able to obtain routine and urgent new patient appointments for 23.8 percent and 18.3 percent of PCP cases reached, respectively. Additionally, less than one-third of the PCP cases reached resulted in an existing patient routine and urgent visit (i.e., 31.9 percent and 30.2 percent, respectively). Similarly, HSAG was only able to obtain routine and urgent OP SUD appointments in 28.9 percent and 27.2 percent of the OP SUD cases reached, respectively, with comparable percentage of appointments being offered for opioid use disorder treatment and OP SUD appointments for pregnant members (i.e., 28.3 percent and 32.9 percent, respectively).
- The survey identified several barriers for members obtaining appointment dates, including requiring pre-registration, an initial evaluation before scheduling, or the schedule/calendar being unavailable. While some barriers pose unique limitations since the interviewer cannot provide the office personal information, other limitations may pose barriers to all OHP Medicaid members trying to schedule appointments.
- New patient PCP appointment compliance rates were low with 57.6 percent and 59.8 percent of routine and urgent appointments meeting the appointment compliance standards, respectively. Similarly, SUD appointment compliance rates were also low with 77.9 percent of routine visits, 67.9 percent of urgent visits, 60.8 percent of opioid use disorder treatment appointments, and 65.9 percent of SUD visits for pregnant members meeting the appointment compliance standards.

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

Network Adequacy Validation Audit

- HSAG recommends that OHA develop comprehensive technical specifications to ensure consistent and accurate calculation of time and distance metrics to ensure consistency across all CCOs. The technical specifications should address data cleaning, population definitions, calculation parameters, and reporting guidelines.
- To reduce CCO variation in how geographic designations are applied, HSAG recommends that the CCOs obtain guidance from OHA regarding calculation of time and distance when two or more urbanities are attributed to a single county.
- The CCOs should explore options to automate data transfers and implement robust validation and data quality control mechanisms to reduce the potential for data errors and ensure the accuracy and completeness of network provider data.

Delivery System Network Evaluation

- The CCOs and OHA should collaborate to establish clear technical specifications to support network adequacy monitoring and assessment.
- The CCOs should engage in technical assistance sessions provided by OHA and seek guidance on expectations around monitoring network adequacy, especially in evaluating member needs and population monitoring.
- Any CCO demonstrating noncompliance with one or more network adequacy standards should engage with OHA in its network adequacy exception request process.
- All CCOs should ensure they contract with at least one provider for each type of medical service that is covered under the health plan, ensuring that members can access necessary care, regardless of the specialty within the CCO's provider network, even if the provider is not within the CCO's service region. Such providers should still be meaningfully accessible through regional transportation (e.g., driving to a nearby population center).
- The CCOs should ensure member monitoring programs, including but limited to wait time to appointment availability and physical accessibility accommodations, are both methodologically robust and in alignment with State requirements and expectations.

Revealed Telephone Survey

- OHA should supply each CCO with the case-level survey results files and establish a defined timeline for addressing provider data errors identified during the survey calls (e.g., disconnected telephone numbers, telephone numbers and addresses that did not correspond to the sampled provider location, and inaccurate provider specialty and services).
- To further evaluate data inconsistencies, OHA could consider conducting a network validation survey (NVS) to evaluate the CCOs' provider directory information in addition to appointment wait times. An NVS would evaluate the accuracy of the CCOs' provider directory and whether key

indicators (i.e., provider name, address, telephone number, specialty, and new patient acceptance) in CCO-submitted provider data matches the CCOs' online provider directories.

- CCOs should consider conducting a review of the provider offices' appointment scheduling requirements to ensure the barriers are not unduly burdening members' ability to schedule appointments.
- The CCOs should investigate the results of the study to identify whether deficiencies appear to be systematic or associated with the specialty category. Then, the CCOs should conduct a root cause analysis to identify potential factors affecting compliance with appointment availability standards.
- In coordination with ongoing outreach and network management activities, the CCOs should review provider office procedures for ensuring appointment availability standards are being met, address questions, or reeducate providers and office staff on OHA standards.

Encounter Data Validation

Results

The CY 2024 EDV activity progressed as planned until challenges with data submissions necessitated additional reviews and adjustments to the project timeline.

In June 2024, OHA submitted its initial data. During HSAG's review, an issue related to the application of the date of service requirement was identified, necessitating a data resubmission from OHA in August 2024. That same month, HSAG also received the initial data submissions from the CCOs.

HSAG conducted an initial file review in September 2024, sharing findings with both OHA and the CCOs. A common result across the CCOs was a significantly higher count of encounters in OHA's submission compared to the CCOs' submissions. After discussions with OHA regarding the inclusion of reversed encounters, it was determined that updates to the OHA data extract were needed to align with the study's inclusion criteria.

HSAG's data request for the EDV study specified that only final paid encounters should be included, while interim history (e.g., reversed encounters) should be excluded from the data extracts. In September 2024, OHA submitted a supplemental data file to clarify which encounters should be excluded from the analysis.

During the same period, several CCOs resubmitted their data in response to findings from the first file review. HSAG conducted a secondary file review in October 2024, comparing the CCO data against the finalized OHA data set. This process provided the CCOs an additional opportunity to refine their submissions based on updated findings.

A few CCOs determined that further resubmissions were appropriate, and HSAG incorporated the updated data into a final data set for the comparative analysis.

The timeline adjustments required to obtain a finalized data set delayed the availability of EDV study results. Consequently, the EDV findings could not be included in the 2024 EQR technical report. However, the final study results are expected by March 2025 and will be included in the 2025 EQR technical report.

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

Statewide conclusions, opportunities for improvement, and recommendations related to the CY 2024 EDV activity will be included in the 2025 EQR technical report.

Mental Health Parity

Results for Mental Health Parity

Treatment Limitation Reviews

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

- FRs—payments by members for services received that are in addition to payments made by the CCO (e.g., copayments and deductibles).
- AL/ADLs—dollar limits on the total amount of a specified benefit over a lifetime or on an annual basis.
- QTLs—limits³⁵ on the scope or duration of a benefit that are expressed numerically (e.g., days or visit limits).
- NQTLs—limits on the scope or duration of benefits, such as PA or network admission standards. NQTLs were separated into three main categories—i.e., Medical Management, Provider Network, and Pharmacy Management.

HSAG's evaluation of the CCOs' responses to the *MHP Treatment Limitation Attestation Tool*, along with supplemental documentation (e.g., policies, procedures, processes, and workflows), indicated whether changes to existing processes, policies, or procedures for managing MH/SUD and M/S benefits were compliant with MHP requirements. If a CCO was compliant with MHP requirements previously, the organization either attested that no changes were implemented within the organization, or reported on any changes to its operations that may have affected parity. Based on the CCOs' responses, there were no changes to the use of FRs, AL/ADLs, and QTLs as these treatment limitations continued to be not applicable in alignment with the regulatory structure of the Oregon Medicaid program. The *MHP Treatment Limitation Supplemental Questionnaire* was utilized by organizations to address 2023 MHP Evaluation findings that were less than *Compliant*.

Financial Requirements

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

³⁵ Soft limits, or benefit limits that allow an individual to exceed numerical limits for MH/SUD or M/S benefits on the basis of medical necessity, are considered NQTLs.

Aggregate Lifetime or Annual Dollar Limits

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

Quantitative Treatment Limitations

Nearly all CCOs reported no changes to the use of QTLs in the administration of MH/SUD or M/S benefits across IP, OP, Rx, or EC services. However, one CCO (IHN) reported implementing changes to its management of MH/SUD or M/S benefits using QTLs. Specifically, IHN reported it removed its PA requirement for the first 30 occupational/physical therapy/speech therapy visits, as well as 76 presumptive and 24 definitive urine drug tests. Upon review, HSAG confirmed IHN's QTLs represented soft limits and should have been categorized as NQTLs since IHN allowed members to receive additional services beyond the quantity limit based on an approved PA. As such, none of the CCOs reported the use of QTLs in the administration of MH/SUD or M/S benefits across IP, OP, Rx, or EC services.

Non-Quantitative Treatment Limitations

Since the regulatory structure of Medicaid and OHP makes the implementation of FRs, AL/ADLs, and QTLs unlikely, NQTLs represent a key mechanism used by the CCOs to manage and ensure members' health care is necessary and appropriate. To facilitate the review of the changes to NQTLs implemented by the CCOs, the *MHP Treatment Limitation Attestation Tool* included questions pertaining to the CCOs' organizational structure and three domains—i.e., Medical Management, Provider Network, and Pharmacy Management. Overall, nine of the 16 organizations noted changes in their organizational structures, of which, the most prevalent changes were related to subcontractors or the delegation of managed care functions to existing subcontractors, including updates to medical guidelines. However, none of the changes implemented by the CCOs affected parity and highlighted continued compliance with MHP requirements.

To assist in HSAG's review of NQTLs receiving *Partially Compliant* or *Not Compliant* ratings in 2023, the *MHP Treatment Limitation Supplemental Questionnaire* required the organizations to describe actions taken to resolve findings and, when appropriate, provide documentation that addressed the following questions:

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

Table 4-37 highlights the overall ratings of compliance with parity requirements for the CCOs for NQTLs, by domain and overall.

Table 4-37—Compliance With Parity Requirements by CCO by NQTL Domain and Overall

CCO	Medical Management	Provider Network	Pharmacy Management	Overall Compliance Rating
AH	Compliant	Compliant	Compliant	Compliant
AllCare	Compliant	Compliant	Compliant	Compliant
CHA	Compliant	Compliant	Compliant	Compliant
CPCCO	Compliant	Compliant	Compliant	Compliant
EOCCO	Compliant	Compliant	Compliant	Compliant
HSO	Compliant	Compliant	Partially Compliant	Partially Compliant
IHN	Compliant	Compliant	Compliant	Compliant
JCC	Compliant	Compliant	Compliant	Compliant
PCS-CO	Compliant	Compliant	Compliant	Compliant
PCS-CG	Compliant	Compliant	Compliant	Compliant
PCS-LN	Compliant	Compliant	Compliant	Compliant
PCS-MP	Compliant	Compliant	Compliant	Compliant
TCHP-SW	Compliant	Compliant	Compliant	Compliant
TCHP-TC	Compliant	Compliant	Compliant	Compliant
UHA	Compliant	Compliant	Compliant	Compliant
YCCO	Compliant	Compliant	Compliant	Compliant

Compliant—indicates the CCO NQTL processes, strategies, evidentiary standards, and other factors were in alignment with parity requirements.

Partially Compliant—indicates the CCO NQTL was either comparable or applied with similar stringency, but not both, or due to insufficient information or clear evidence of parity associated with implemented NQTLs.

Not Compliant—indicates the CCO organizational structure did not meet comparability or stringency criteria, or no documentation was submitted to evaluate the consistency and stringency of NQTLs.

Availability of Information

In addition to ensuring the various financial and treatment limitations that affect the administration of MH/SUD and M/S benefits are applied with comparable frequency and rigor, the Medicaid/CHIP parity rule also includes a requirement regarding the availability of information related to MH/SUD benefits. Specifically, the CCOs must make the criteria for medical necessity determinations for MH/SUD benefits available to members, potential members, and affected providers, upon request. Table 4-38 shows the parity ratings for the CCOs related to compliance with the availability of information requirements, and whether changes were made to the process, policies, or procedures since the 2023 MHP Evaluation.

Table 4-38—Overall Compliance With Availability of Information Requirements by Organization

CCO	Compliance Rating	Changes Made Since 2023
AH	Compliant	—
AllCare	Compliant	—
CHA	Compliant	—
CPCCO	Compliant	—
EOCCO	Compliant	—
HSO	Compliant	Yes
IHN	Compliant	—
JCC	Compliant	—
PCS-CO	Compliant	—
PCS-CG	Compliant	—
PCS-LN	Compliant	—
PCS-MP	Compliant	—
TCHP-SW	Compliant	—
TCHP-TC	Compliant	—
UHA	Compliant	—
YCCO	Compliant	—

“—” indicates the CCO reported it did not implement changes to the way it makes medical necessity criteria available to members.

Administrative Data Profiles

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

- Claims, including IP and OP services³⁶
- UM, including IP, OP, and Rx coverage determinations
- Provider enrollment

Each of the following subsections examines the extent to which performance metrics differed for MH/SUD and M/S services in order to identify potential areas of parity concerns. To facilitate the presentation of results, the differences noted between MH/SUD and M/S performance metrics are displayed as an absolute value, or difference.³⁷ As such, the larger the number in the figure, the greater the difference between the MH/SUD and M/S performance metrics.

Claims

To conduct the claims analysis, the CCOs submitted claims counts that encompassed all covered services (except NEMT and Rx³⁸) by claim type (i.e., IP and OP) and provider network status (i.e., in-network and out-of-network) at the header and detail claim level. Since claims are paid at the detail (service) line level, aggregate header counts were categorized as paid, partially paid, and denied. Claims were defined as *partially paid* if at least one detail claim line was denied; claims that included all paid detail lines or all denied detail lines should be classified as paid claims and denied claims, respectively. The total number of IP and OP claims was evaluated at the header level and reported as the total number paid (i.e., paid and partially paid claims) and denied overall, and by network status. The aggregate counts from the CCOs were then used to generate the percentage of claims paid by benefit type; the difference between the percentage of paid claims for MH/SUD versus M/S services was then evaluated as the core metric for evaluating parity. The absolute difference was used to classify the deviation in the rates of claims paid between MH/SUD and M/S services to determine if the difference was negligible (less than 5 percentage points), moderate (greater than or equal to 5 percentage points, but less than 10 percentage points), or substantial (greater than or equal to 10 percentage points).

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

³⁶ Claims data included dental claims but excluded NEMT and Rx claims.

³⁷ The *absolute value* is the actual magnitude of a numerical value or measurement. As such, the *absolute difference* represents the difference, taken without regard to sign, between the values of two variables.

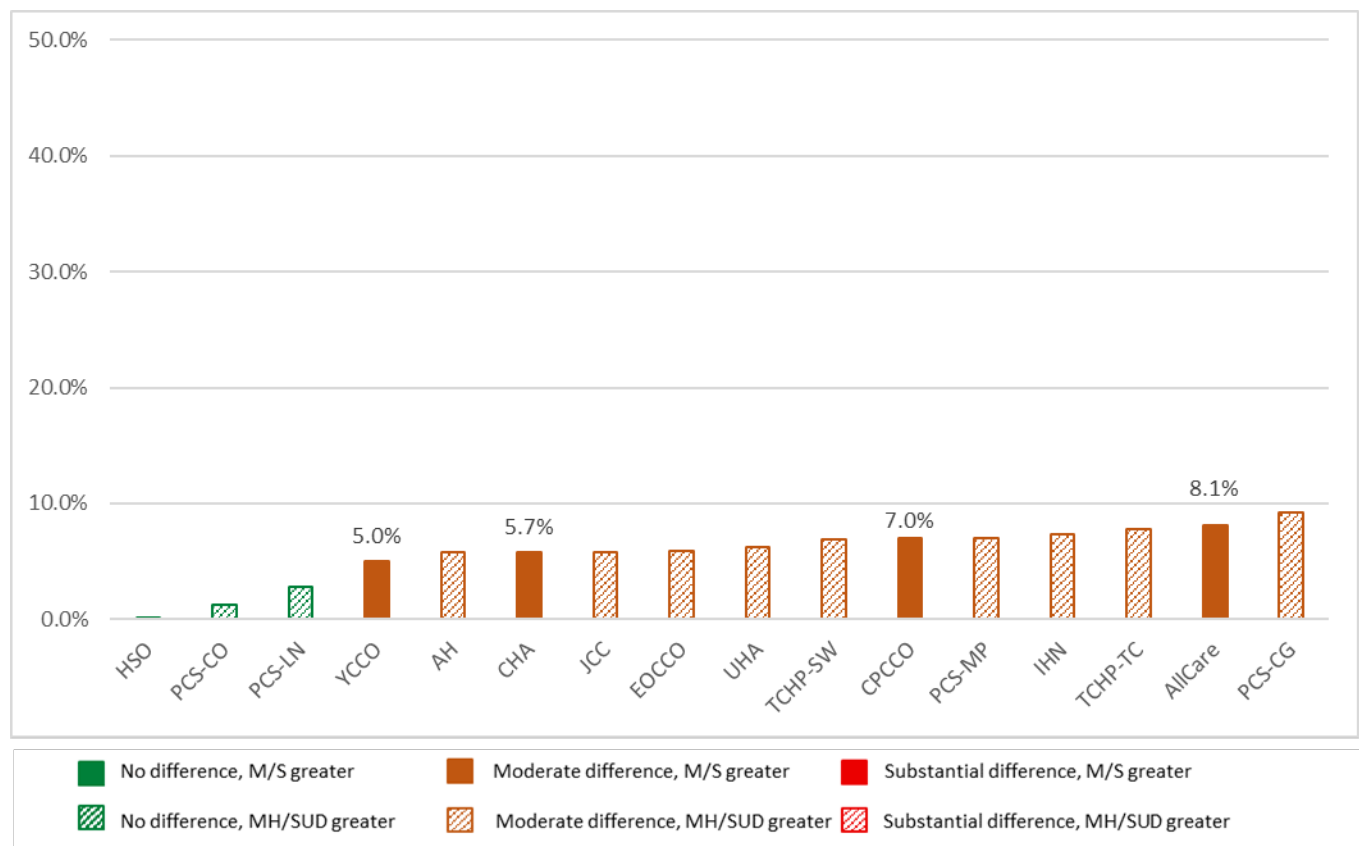
³⁸ NEMT and Rx claims were excluded from the analysis due to a general diagnosis code used for NEMT and the absence of a diagnosis code on incoming Rx claims. As a result, the CCOs were unable to distinguish and classify individual claims as MH/SUD or M/S.

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

Inpatient Claims

Figure 4-15 shows the absolute difference in the percentage of paid MH/SUD and M/S IP claims for all CCOs.

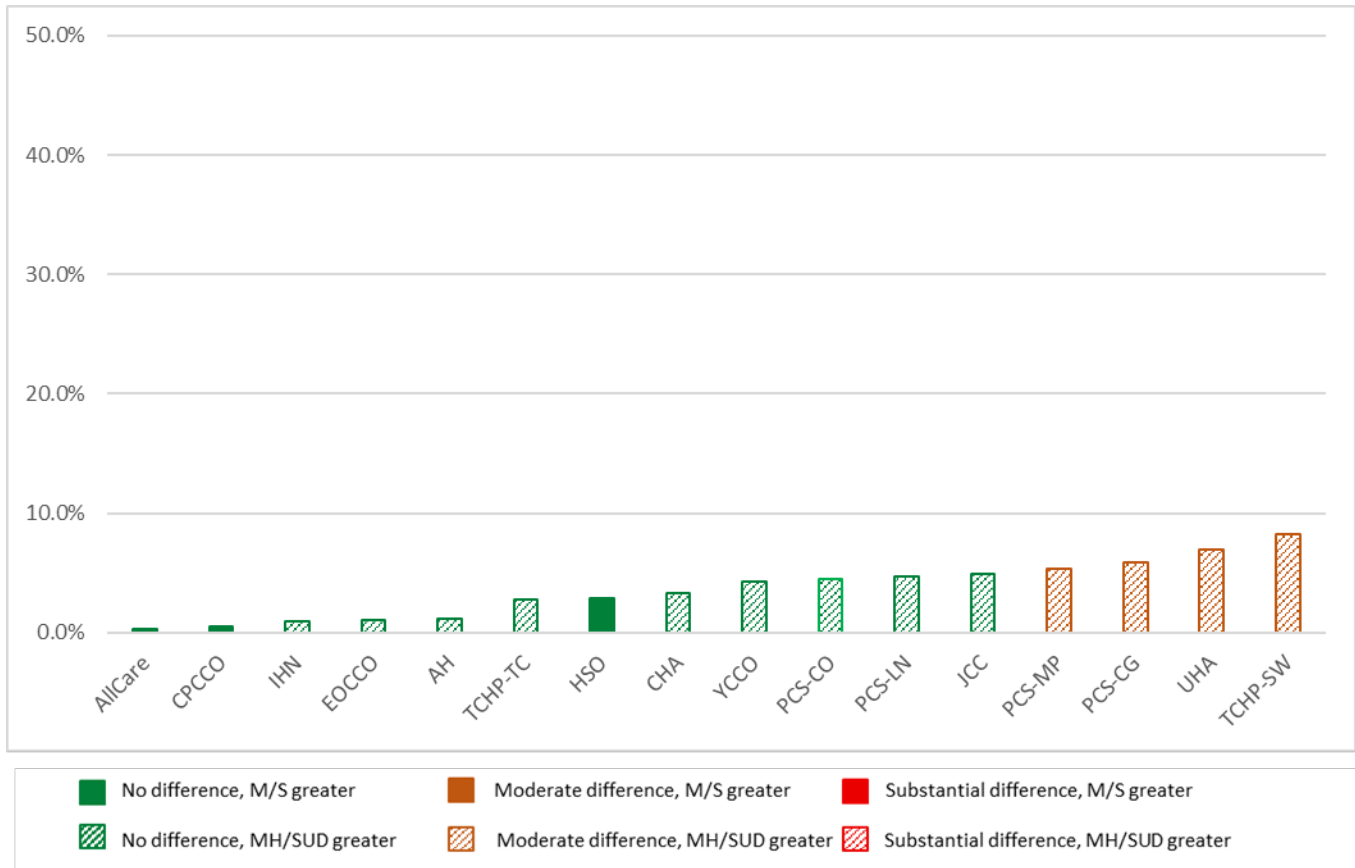
Figure 4-15—Absolute Difference in the Percentage of Paid Inpatient Claims



Outpatient Claims

Figure 4-16 shows the absolute difference in the percentage of paid MH/SUD and M/S OP claims for all CCOs.

Figure 4-16—Absolute Difference in the Percentage of Paid Outpatient Claims



Out-of-Network Paid Claims

Figure 4-17 shows the absolute difference in the percentage of paid MH/SUD and M/S IP claims for out-of-network providers for all CCOs.

Figure 4-17—Absolute Difference in the Percentage of Inpatient Paid Claims for Out-of-Network Providers

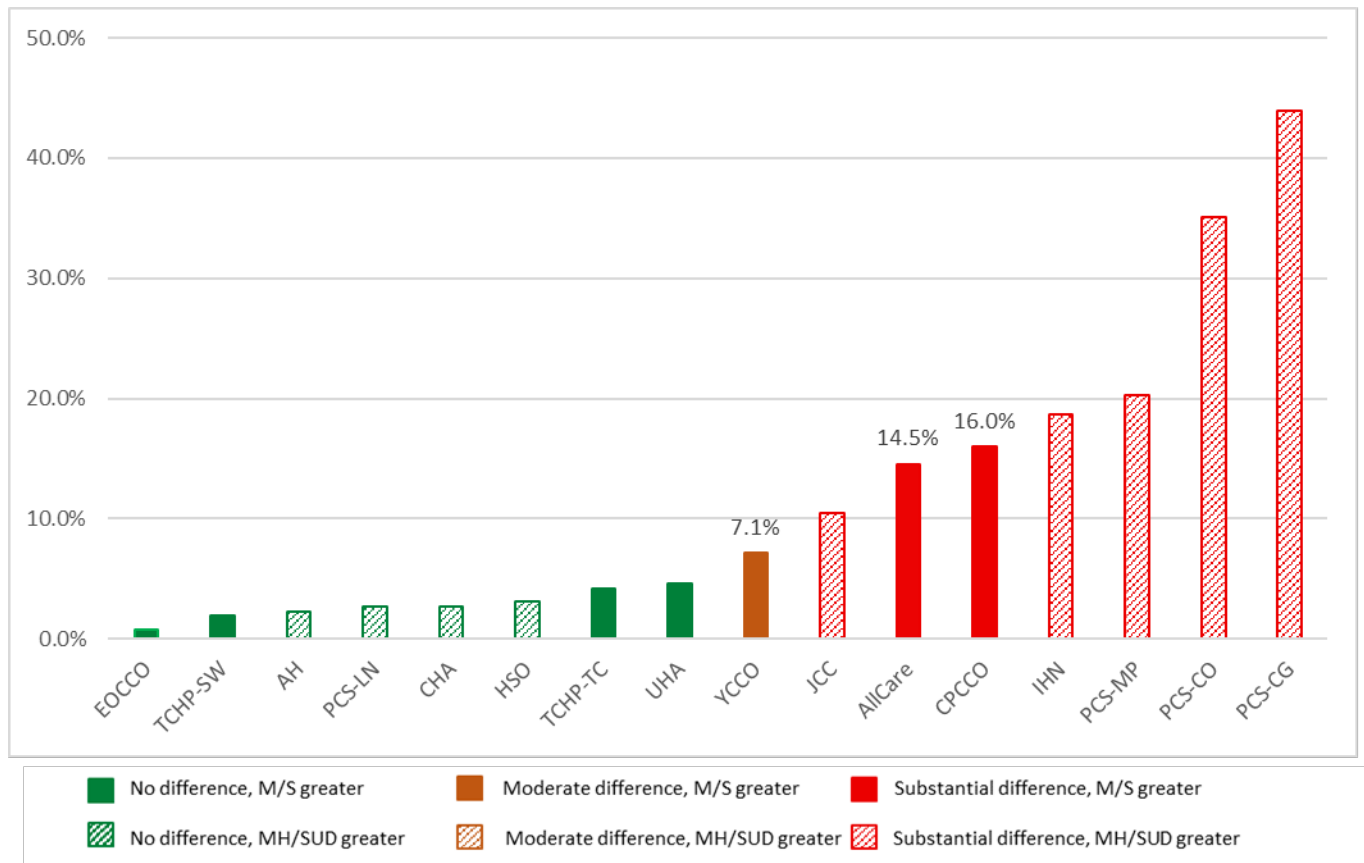
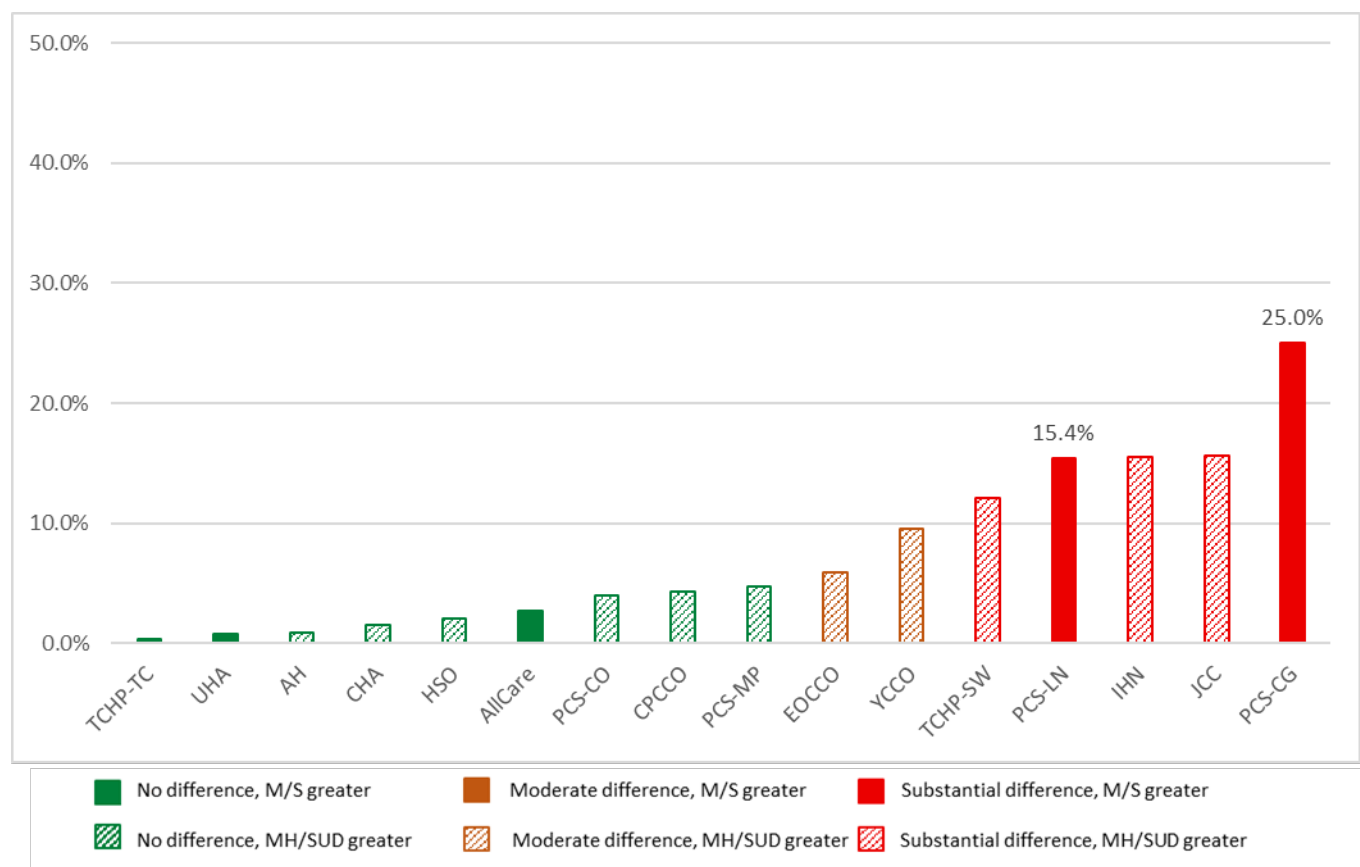


Figure 4-18 shows the absolute difference in the percentage of paid MH/SUD and M/S OP claims for out-of-network providers for all CCOs.³⁹

³⁹ During its review of the draft report, CPCCO identified a data quality issue related to their IP claims summary count submission. The CCO confirmed it included institutional claims from a CMS Coordination of Benefits Agreement (COBA) contractor which should have been excluded from the analysis. These claims were rebilled and paid by the CCO and included as in-network professional MH/SUD claims. Although the CCO resubmitted revised claims data counts, the information was not received in time for inclusion in the report. However, preliminary review suggests that the difference in the percent of paid MH/SUD and M/S IP claims was negligible.

Figure 4-18—Absolute Difference in the Percentage of Outpatient Paid Claims for Out-of-Network Providers



Utilization Management

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

addition to assessing the absolute difference in the percentage of authorization denials, the analysis indicates whether the difference identified greater denial rates for MH/SUD services over M/S services.

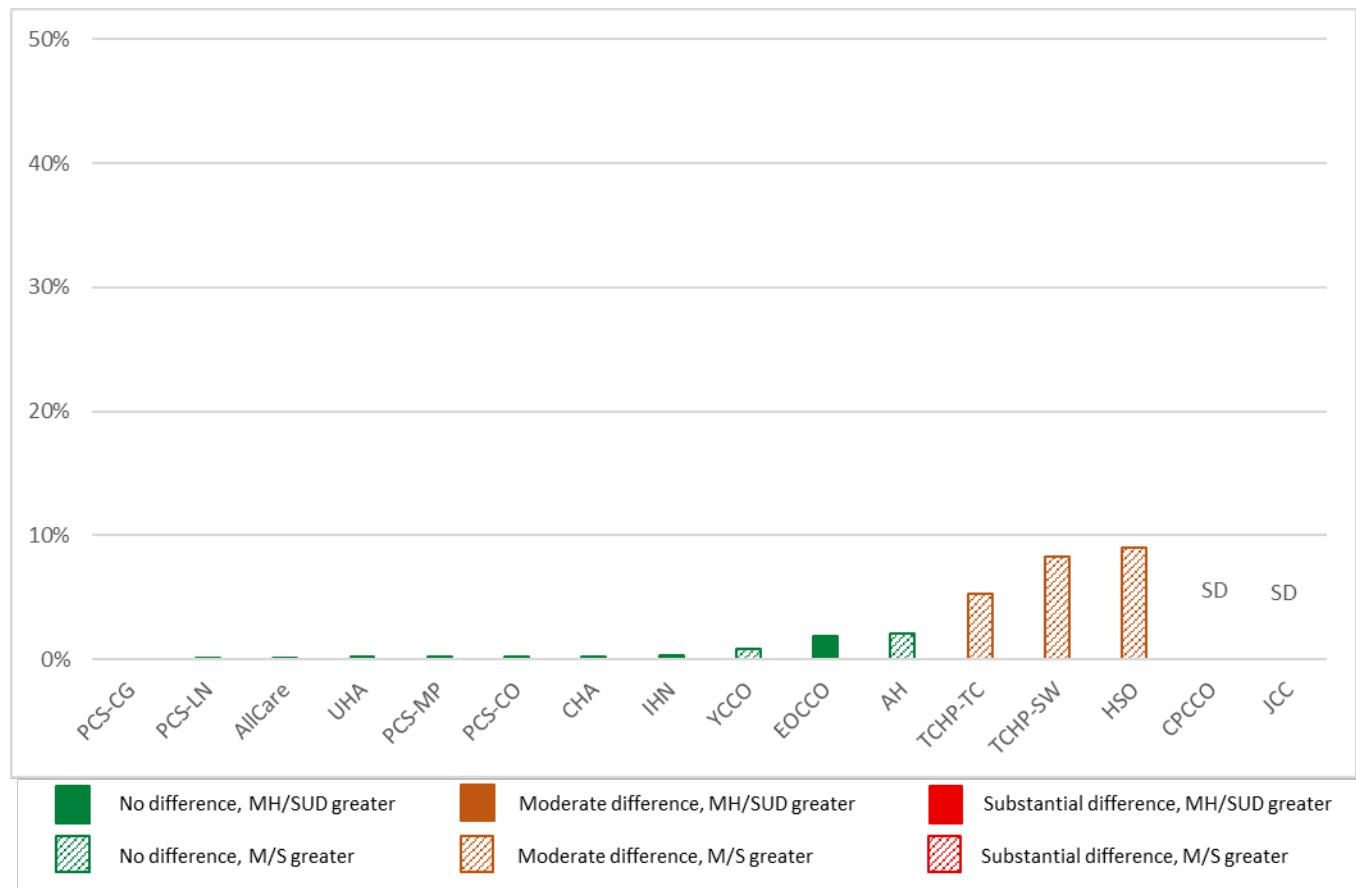
Member-level data were also captured for all PA denials. These data were reviewed to provide context for identifying potential factors contributing to moderate and substantial differences in aggregate denial rates. Results from this analysis are presented at the end of this section.

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

Inpatient Authorization Denials

Figure 4-19 shows the absolute difference in the percentage of denied MH/SUD and M/S IP PA requests for all CCOs.

Figure 4-19—Absolute Difference in the Percentage of Inpatient PA Denials

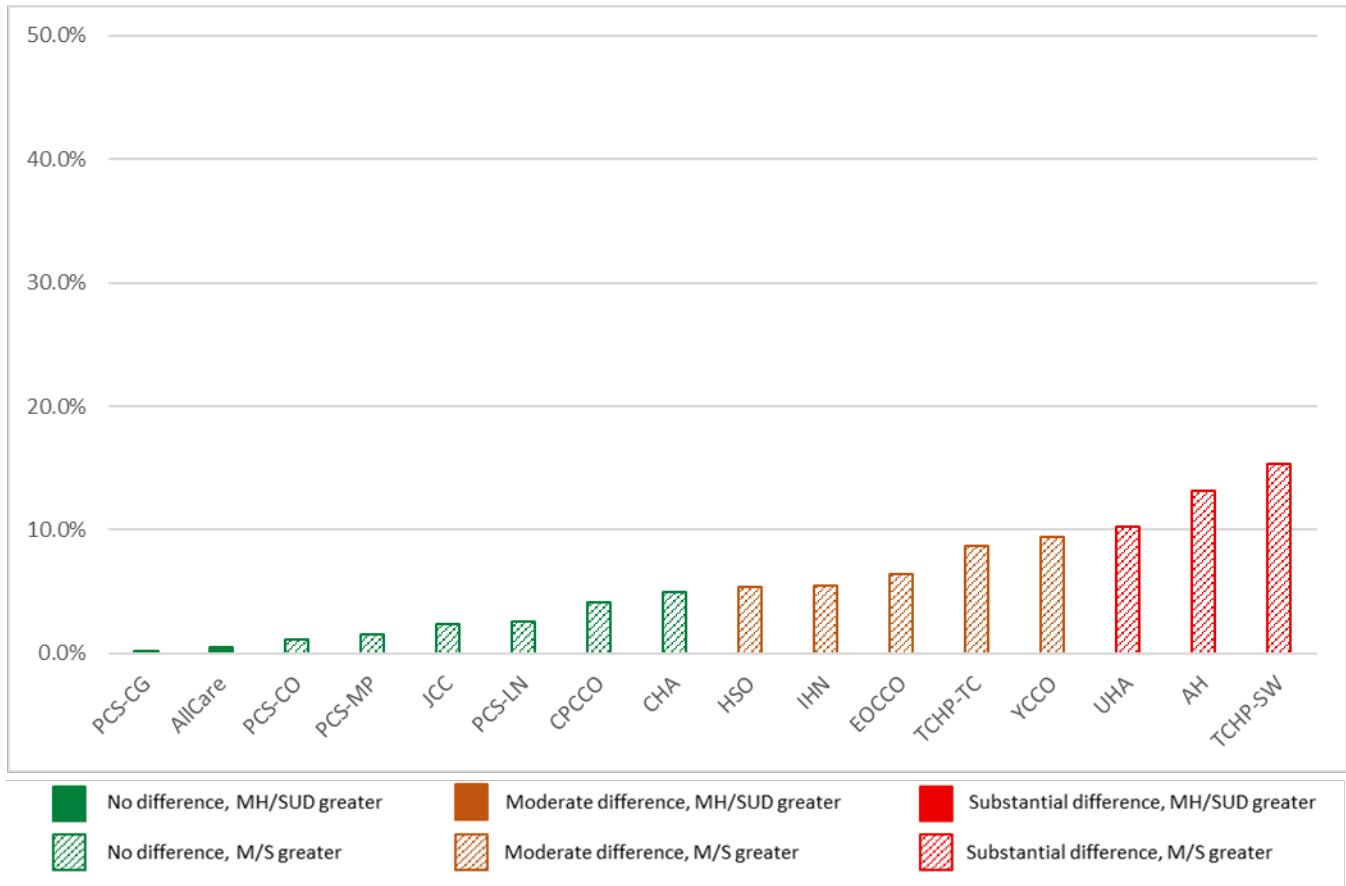


SD (Small Denominator) indicates reported data are valid, but the denominator is too small to support reporting.

Outpatient Authorization Denials

Figure 4-20 shows the absolute difference in the percentage of denied MH/SUD and M/S OP PA requests for all CCOs.

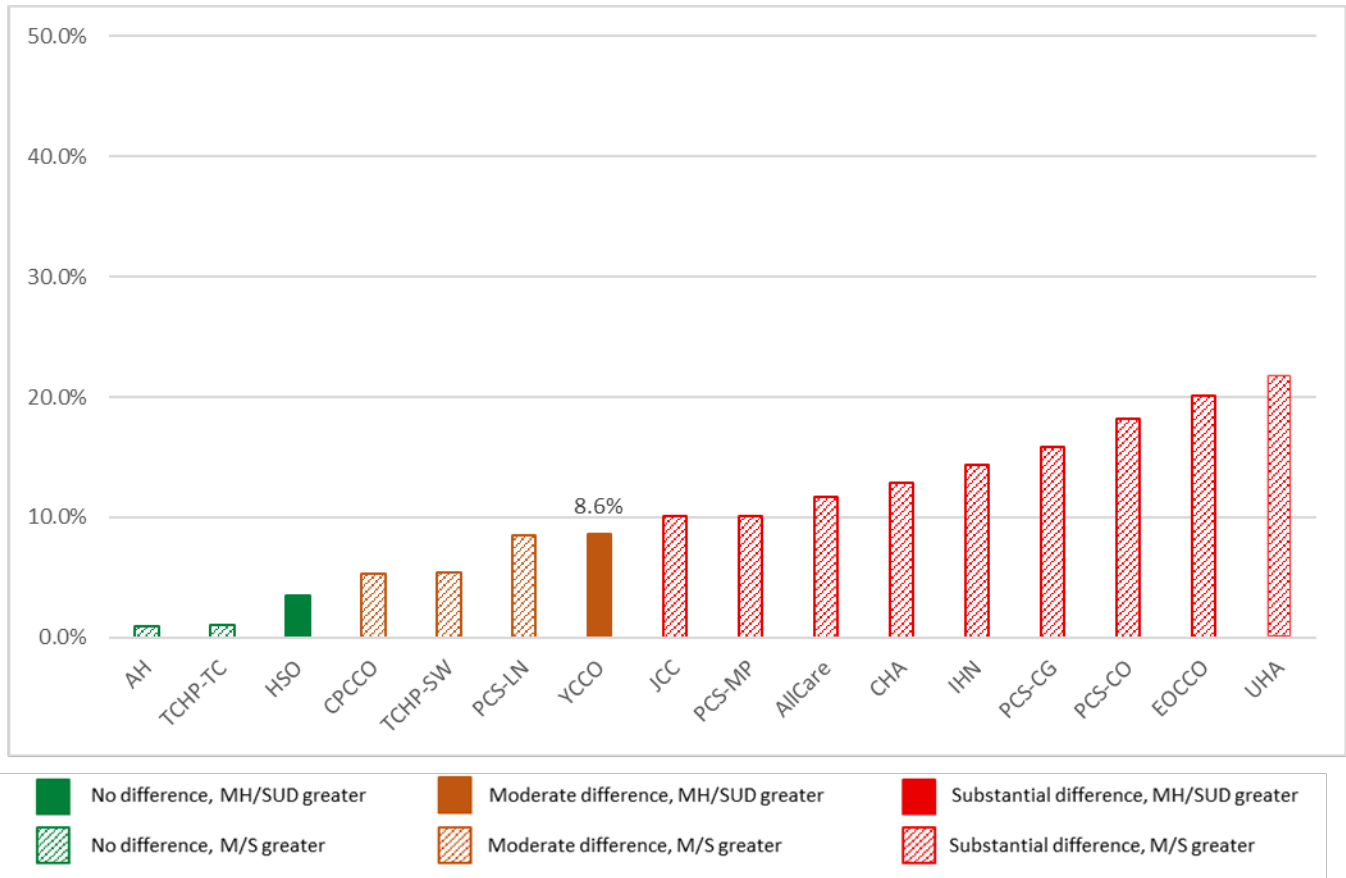
Figure 4-20—Absolute Difference in the Percentage of Outpatient PA Denials



Pharmacy Authorization Denials

Figure 4-21 shows the absolute difference in the percentage of denied MH/SUD and M/S Rx PA requests for all CCOs.

Figure 4-21—Absolute Difference in the Percentage of Pharmacy PA Denials



Member-Level Denial Reasons

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

- Does Not Meet Criteria—requested service does not meet clinical treatment guidelines for medical necessity or appropriateness
- Not a Covered Benefit—variety of noncoverage denials (e.g., noncovered services, benefit exclusions)
- Service is *Below the Line*—service requested was below the line on the OHP Prioritized List⁴⁰
- Treatment Limitations—UM controls implemented by health plans to manage member health care (i.e., provider network, visit limits, drug utilization procedures)
- Out-of-Network Provider—service requested is delivered by a provider outside the network
- Administrative Denial—denial due to administrative issues associated with the PA request (e.g., insufficient documentation, member eligibility)
- Unknown—documentation insufficient to categorize

Table 4-39 shows the statewide aggregate percentage of denial reasons by benefit (i.e., MH/SUD and M/S) for IP, OP, and Rx PA requests. Results are sorted in descending order from the most to least frequent denial reason.

Table 4-39—Statewide PA Denial Reasons by Service Type and Benefit

Denial Reason	Total	Inpatient		Outpatient		Pharmacy	
		MH/SUD	M/S	MH/SUD	M/S	MH/SUD	M/S
Does Not Meet Criteria	45.0%	78.1%	85.8%	43.9%	45.7%	63.7%	39.6%
Not a Covered Benefit	21.8%	11.3%	7.0%	8.1%	30.5%	7.7%	16.1%
Service is <i>Below the Line</i>	13.1%	0.0%	1.2%	0.3%	12.9%	3.1%	15.8%
Treatment Limitation	12.2%	0.0%	0.2%	0.4%	1.2%	23.3%	23.0%
Out-of-Network Provider	3.9%	1.5%	1.2%	40.3%	6.8%	0.0%	0.1%
Administrative Denial	3.5%	6.9%	3.2%	6.1%	2.1%	2.2%	5.1%
Unknown	0.5%	2.2%	1.4%	0.9%	0.8%	0.0%	0.3%

⁴⁰ Oregon Health Authority. Prioritized List of Health Services. Available at: <https://www.oregon.gov/oha/hsd/ohp/pages/prioritized-list.aspx>. Accessed on: Mar 3, 2025.

Appeals and Hearings

In addition to evaluating UM service denials, HSAG also reviewed appeals and administrative hearings decisions. However, due to the small number of appeals and hearings at the organization level, formal analyses were not performed. Overall, less than 10 percent of all denials resulted in an appeal with the percentage of appeals by benefit type ranging from 3.9 percent for IP appeals, 7.8 percent for Rx appeals, and 8.1 percent for OP appeals. On average, MH/SUD appeals account for 10 percent of the appeals in 2023; however, a review of the percentage of overturned appeal decisions showed some differences. While MH/SUD appeals were overturned less frequently than M/S appeals (27.6 percent versus 43.0 percent, respectively), the outcomes show that more than a quarter of all MH/SUD decisions are overturned on appeals. For IP and Rx appeals, the percentage of overturned MH/SUD appeals was substantially higher for MH/SUD IP appeals (42.8 percentage points) and negligibly higher for MH/SUD Rx appeals (2.7 percentage points). While these results should be viewed with caution given the small number of appeals, the relatively high percentage of overturned denial decisions suggest potential barriers to care that may impact the timeliness of MH/SUD services to members. No data are presented on administrative hearings as only 1.5 percent, or a total of 153 hearings, were requested across all organizations in 2023.

Provider Enrollment

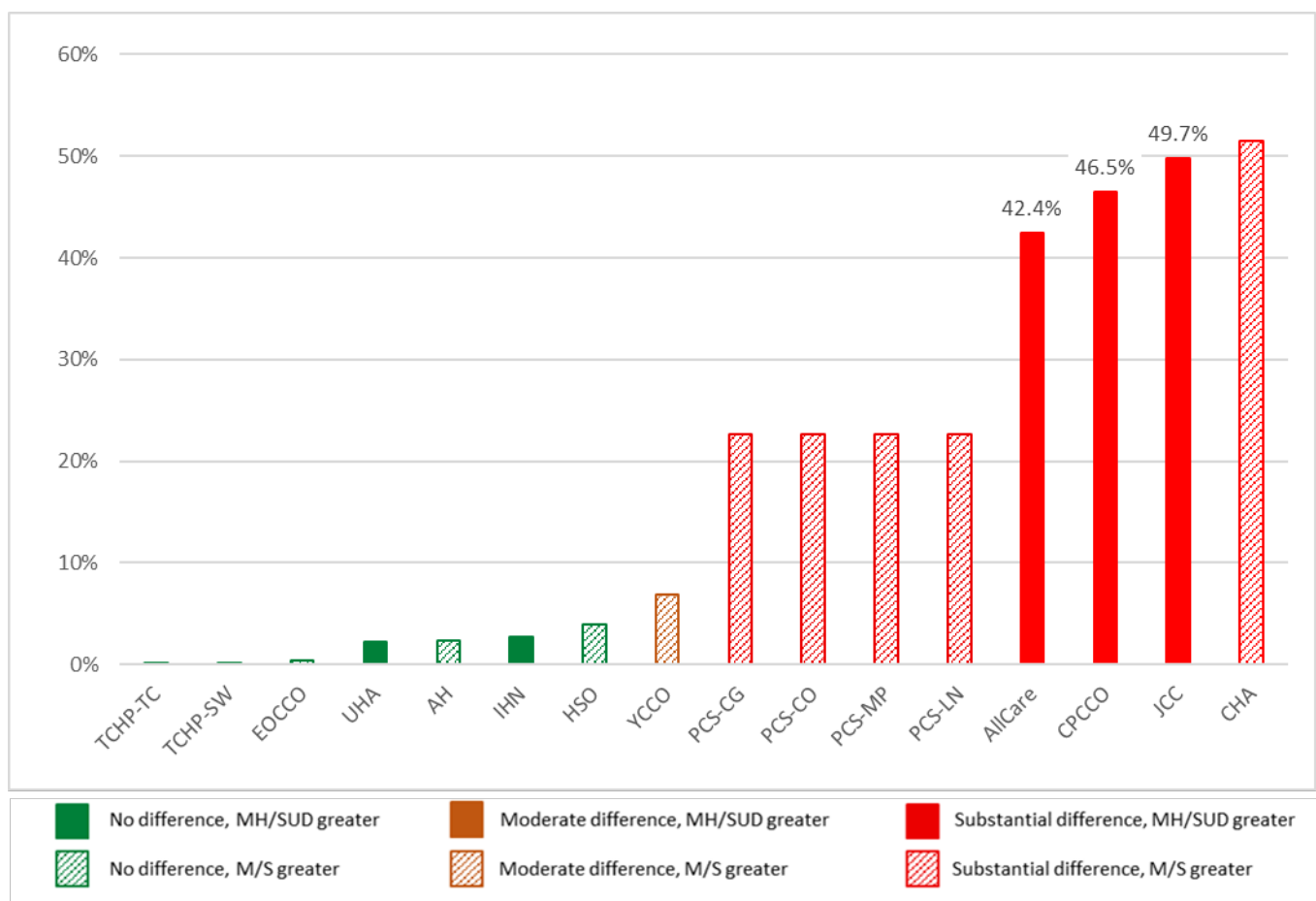
In order to assess parity related to management of provider networks, the CCOs submitted the average monthly count of MH/SUD and M/S providers along with the total number of provider applications or renewals received, approved and denied, as well as the number of providers terminated in CY 2023. All counts were stratified by benefit type to facilitate comparisons. These data points were collected to offer information on parity of provider credentialing practices between MH/SUD and M/S. The aggregate counts from the CCOs were then used to generate the percentage of providers terminated and approved by benefit type; the difference between the percentage of providers terminated and approved MH/SUD and M/S providers was then evaluated as the core metric for evaluating parity. The absolute difference was used to classify the deviation in termination and approval rates between MH/SUD and M/S providers to determine if the difference was negligible (less than 5 percentage points), moderate (greater than or equal to 5 percentage points, but less than 10 percentage points), or substantial (greater than or equal to 10 percentage points). In addition to assessing the absolute difference in the percentage of terminated and approved providers, the analysis indicated whether the difference identified greater rates of termination/approval for MH/SUD providers versus M/S providers.

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

Provider Terminations

Figure 4-22 shows the absolute difference in the percentage of terminated MH/SUD and M/S providers for all CCOs. The larger the number, the greater the difference between the percentage of MH/SUD and M/S provider terminations. Green bars indicate a deviation rating of *None*, while the orange and red bars indicate a *Moderate* or *Substantial* difference, respectively. Solid bars, along with the absolute percentage-point difference, indicate that a higher percentage of MH/SUD providers were terminated compared to M/S providers.

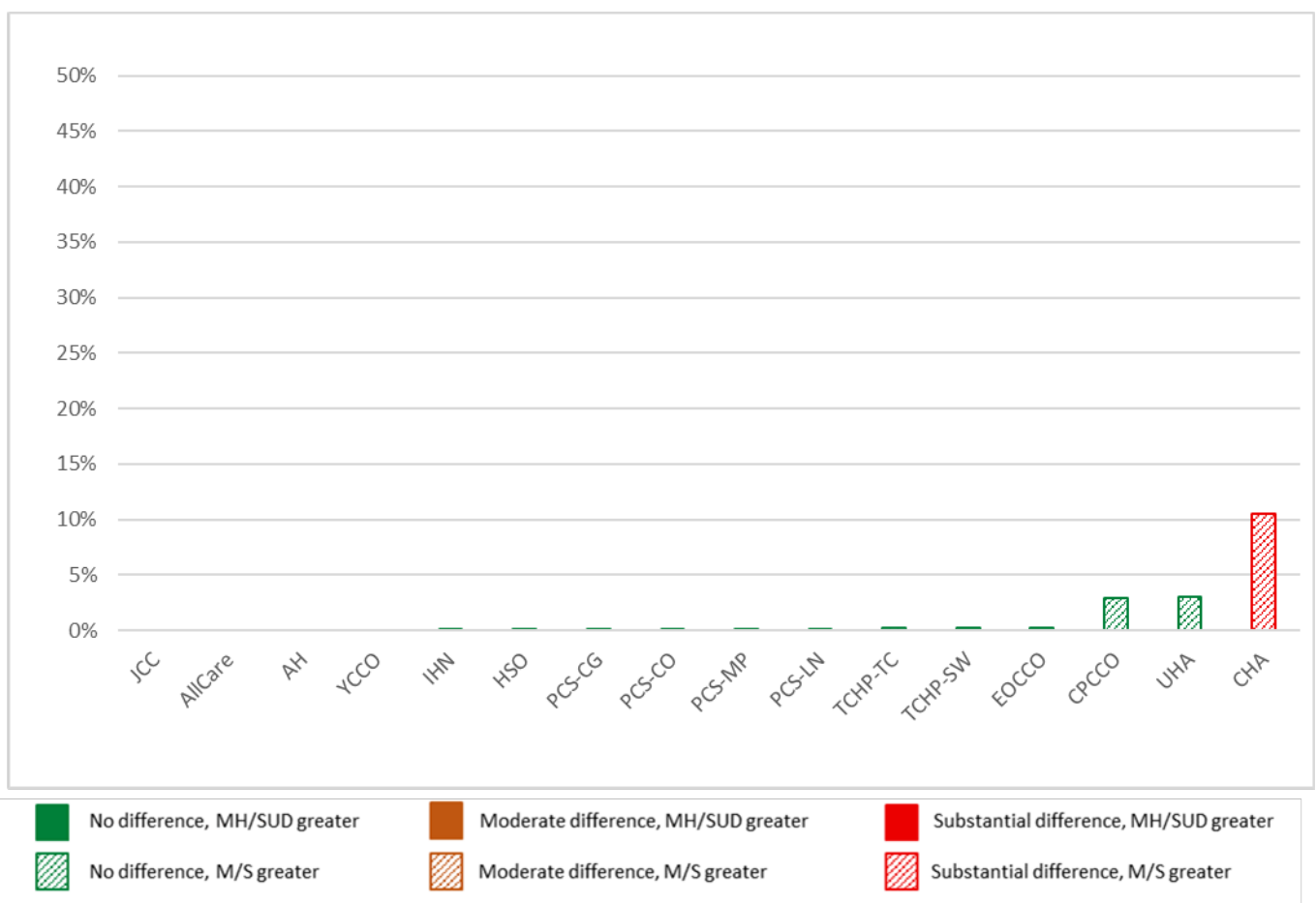
Figure 4-22—Absolute Difference in the Percentage of Providers Terminated



Provider Approvals

Figure 4-23 shows the absolute difference in the percentage of approved provider applications for MH/SUD and M/S providers for all CCOs. The larger the number, the greater the difference between the percentage of approvals between MH/SUD and M/S provider applications. Green bars indicate a deviation rating of *None*, while the orange and red bars indicate a *Moderate* or *Substantial* difference, respectively. Solid bars, along with the absolute percentage-point difference, indicate that a higher percentage of M/S provider applications were approved compared to MH/SUD provider applications.

Figure 4-23—Absolute Difference in the Percentage of Provider Applications Approved



Adequacy of MH/SUD Provider Networks

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

Provider Network Capacity

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

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

Provider Counts

Table 4-40 shows the total number of providers in network (i.e., Total) and total number and percentage of MH providers contracted with each CCO (i.e., MH [#] and MH [%], respectively). The table also indicates, for each CCO, whether the change from Q1 2023 to Q1 2024 resulted in a substantial increase (i.e., ▲, or 10 percent) or decrease (i.e., ▼, or 10 percent) in the total number of MH providers. The data represent a calendar difference of one year. Although a comparative review of the distribution of providers showed substantial changes in some cases, caution should be used when interpreting network stability due to differences in reporting across calendar years, in accordance with OHA reporting requirements.

Table 4-40—Number and Percentage of MH Providers by Quarter

CCO	Q1 2023			Q1 2024			Difference	
	Total	MH (#)	MH (%)	Total	MH (#)	MH (%)	#	% Change
AH	501	182	36.3%	611	250	40.9%	68	37.4% ▲
AllCare	1,501	488	32.5%	1,451	501	34.5%	13	2.7%
CHA	410	123	30.0%	369	120	32.5%	-3	-2.4%
CPCCO	8,559	1,987	23.2%	9,180	2,467	26.9%	480	24.2% ▲
EOCCO	6,803	1,100	16.2%	6,473	1,246	19.2%	146	13.3% ▲
HSO	10,833	2,012	18.6%	11,535	2,964	25.7%	952	47.3% ▲
IHN	5,306	1,217	22.9%	5,260	1,265	24.0%	48	3.9%
JCC	8,684	2,108	24.3%	9,458	2,661	28.1%	553	26.2% ▲
PCS-CO	9,322	3,682	39.5%	9,460	4,079	43.1%	397	10.8% ▲
PCS-CG	9,159	3,681	40.2%	9,306	4,079	43.8%	398	10.8% ▲
PCS-LN	9,472	3,681	38.9%	9,577	4,079	42.6%	398	10.8% ▲
PCS-MP	9,480	3,684	38.9%	9,646	4,082	42.3%	398	10.8% ▲
TCHP-SW	4,452	1,739	39.1%	5,188	2,519	48.6%	780	44.9% ▲

CCO	Q1 2023			Q1 2024			Difference	
	Total	MH (#)	MH (%)	Total	MH (#)	MH (%)	#	% Change
TCHP-TC	5,241	1,660	31.7%	6,840	1,933	28.3%	273	16.4% ▲
UHA	586	139	23.7%	1,173	209	17.8%	70	50.4% ▲
YCCO	5,650	2,013	35.6%	6,835	2,292	33.5%	279	13.9% ▲

Table 4-41 shows the total number of providers in network (i.e., Total) and total number and percentage of SUD providers contracted with each CCO (i.e., SUD [#] and SUD [%], respectively). The table also indicates, for each CCO, whether the change from Q1 2023 to Q1 2024 resulted in a substantial increase (i.e., ▲, or 10 percent) or decrease (i.e., ▼, or 10 percent) in the total number of SUD providers. The data represent a calendar difference of one year. Although a comparative review of the distribution of providers showed substantial changes in some cases, caution should be used when interpreting network stability due to differences in reporting across calendar years, in accordance with OHA reporting requirements.

Table 4-41—Number and Percentage of SUD Providers by Quarter

CCO	Q1 2023			Q1 2024			Difference	
	Total	SUD (#)	SUD (%)	Total	SUD (#)	SUD (%)	#	% Change
AH	501	56	11.2%	611	74	12.1%	18	32.1% ▲
AllCare	1,501	144	9.6%	1,451	121	8.3%	-23	-16.0% ▼
CHA	410	69	16.8%	369	49	13.3%	-20	-29.0% ▼
CPCCO	8,559	528	6.2%	9,180	511	5.6%	-17	-3.2%
EOCCO	6,803	292	4.3%	6,473	409	6.3%	117	40.1% ▲
HSO	10,833	582	5.4%	11,535	558	4.8%	-24	-4.1%
IHN	5,306	411	7.7%	5,260	464	8.8%	53	12.9% ▲
JCC	8,684	534	6.1%	9,458	536	5.7%	2	0.4%
PCS-CO	9,322	550	5.9%	9,460	578	6.1%	28	5.1%
PCS-CG	9,159	550	6.0%	9,306	578	6.2%	28	5.1%
PCS-LN	9,472	550	5.8%	9,577	578	6.0%	28	5.1%
PCS-MP	9,480	550	5.8%	9,646	578	6.0%	28	5.1%
TCHP-SW	4,452	414	9.3%	5,188	455	8.8%	41	9.9%
TCHP-TC	5,241	292	5.6%	6,840	358	5.2%	66	22.6% ▲
UHA	586	100	17.1%	1,173	150	12.8%	50	50.0% ▲
YCCO	5,650	417	7.4%	6,835	352	5.1%	-65	-15.6% ▼

Provider-to-Member Ratios

Table 4-42 shows the unique counts of MH and SUD providers, the number of members identified as having an MH or SUD diagnosis,⁴¹ and the ratio of providers to members within each CCO's network. The provider-to-member ratio was calculated by dividing the number of members with an MH or SUD diagnosis enrolled with a CCO by the number of MH or SUD providers in the CCO's network. This metric serves as a way to standardize estimations of a CCO's provider network as it adjusts for membership size. Since OHA did not have specific provider-to-member ratio standards for any provider type, the results below are presented for information only.

Table 4-42—Provider-to-Member Ratios by CCO and Provider Type

CCO	MH			SUD		
	Providers (N)	Members (N)	Ratio	Providers (N)	Members (N)	Ratio
AH	250	4,879	1:20	74	8,920	1:121
AllCare	501	10,707	1:22	121	3,792	1:32
CHA	120	6,984	1:59	49	2,729	1:56
CPCCO	2,467	7,089	1:3	511	2,069	1:5
EOCCO	1,246	14,016	1:12	409	3,431	1:9
HSO	2,964	87,555	1:30	558	20,718	1:38
IHN	1,265	57,195	1:46	464	44,281	1:96
JCC	2,661	13,368	1:6	536	1,899	1:4
PCS-CO	4,079	19,489	1:5	578	4,498	1:8
PCS-CG	4,079	3,403	1:1	578	861	1:2
PCS-LN	4,079	24,896	1:7	578	5,520	1:10
PCS-MP	4,082	28,143	1:7	578	6,973	1:13
TCHP-SW	2,519	6,866	1:3	455	2,151	1:5
TCHP-TC	1,933	5,497	1:3	358	1,745	1:5
UHA	209	8,783	1:43	150	2,961	1:20
YCCO	2,292	9,312	1:5	352	3,819	1:11

⁴¹ The member population used to determine provider-to-member ratios was restricted to members with at least one IP or OP claim with an MH or SUD diagnosis during CY 2023 to better reflect the population in need of MH and SUD providers.

Time and Distance

As part of its evaluation, HSAG reviewed the geographic distribution of MH and SUD providers relative to members with an MH or SUD diagnosis⁴² to assess the percentage of members with access to an MH or SUD provider within the OHA-defined, acceptable travel times and distances. This review included the average travel time (in minutes) and driving distance (in miles) to the nearest provider by provider type, as well as to the subsequent second and third nearest provider to further assess the overall availability of MH and SUD providers.

Table 4-43 presents the average time and distance to the nearest three MH and SUD providers, by organization and geographic setting (i.e., large urban). If the average driving time or distance exceeded the acceptable travel time and distance requirements set forth by OHA, the result is shaded in red. CCOs that do not have a large urban setting within their service region are not listed within the table.

Table 4-43—Average Time and Distance to the Nearest Three MH and SUD Providers by CCO and Geography—Large Urban

CCO	MH						SUD					
	Distance (Miles)			Time (Min)			Distance (Miles)			Time (Min)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
HSO	0.7	0.9	1.0	1.2	1.4	1.6	1.5	1.8	1.9	2.4	2.9	3.1
TCHP-TC	0.8	0.9	1.0	1.3	1.5	1.7	1.6	1.8	1.8	2.7	3.0	3.0
YCCO	1.6	2.1	2.2	1.7	2.2	2.4	4.1	4.3	4.3	4.7	4.9	5.0

Table 4-44 presents the average time and distance to the nearest three MH and SUD providers, by organization and geographic setting (i.e., urban). If the average driving time or distance exceeded the acceptable travel time and distance requirements set forth by OHA, the result is shaded in red. CCOs that do not have an urban setting within their service region are not listed within the table.

Table 4-44—Average Time and Distance to the Nearest Three MH and SUD Providers by CCO and Geography—Urban

CCO	MH						SUD					
	Distance (Miles)			Time (Min)			Distance (Miles)			Time (Min)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
AllCare	1.1	1.4	1.5	1.2	1.5	1.7	1.6	2.4	2.5	1.9	2.8	2.9
IHN	0.8	1.1	1.2	0.8	1.1	1.2	1.4	1.6	1.8	1.5	1.7	1.9

⁴² The member population used to determine time and distance was restricted to members with at least one IP or OP claim with an MH or SUD diagnosis during CY 2023 to better reflect the population in need of MH and SUD providers. These results differ from the 2024 DSN Evaluation as the results in that report reflect full CCO membership.

CCO	MH						SUD					
	Distance (Miles)			Time (Min)			Distance (Miles)			Time (Min)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
JCC	0.8	0.9	1.1	0.9	1.0	1.2	2.6	2.6	2.7	3.0	3.0	3.1
PCS-CO	0.6	0.8	0.9	0.6	0.8	0.9	1.4	1.8	2.0	1.4	1.9	2.2
PCS-LN	0.7	0.9	1.2	0.9	1.2	1.5	1.6	1.7	2.0	2.0	2.2	2.8
PCS-MP	0.8	0.9	1.1	0.9	1.1	1.4	1.4	1.7	1.8	1.8	2.2	2.3
TCHP-SW	1.0	1.2	1.2	1.3	1.7	1.7	1.8	2.1	2.1	2.4	2.9	2.9
YCCO	1.2	1.5	1.7	1.2	1.7	1.9	1.6	1.6	1.6	1.8	1.8	1.8

Table 4-45 presents the average time and distance to the nearest three MH and SUD providers, by organization and geographic setting (i.e., rural). If the average driving time or distance exceeded the acceptable travel time and distance requirements set forth by OHA, the result is shaded in red. All CCOs include rural urbanities within their service regions.

Table 4-45—Average Time and Distance to the Nearest Three MH and SUD Providers by CCO and Geography—Rural

CCO	MH						SUD					
	Distance (Miles)			Time (Min)			Distance (Miles)			Time (Min)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
AH	3.0	3.8	4.6	3.2	4.1	5.0	10.3	11.2	11.2	11.2	12.2	12.2
AllCare	4.2	4.3	4.4	4.6	4.6	4.7	5.1	5.5	6.2	5.5	6.0	6.8
CHA	4.4	4.5	5.2	4.8	4.9	5.6	4.7	4.8	5.5	5.0	5.2	6.0
CPCCO	3.0	3.7	5.1	3.2	4.0	5.6	6.7	6.7	6.9	7.3	7.3	7.5
EOCCO	2.9	3.8	3.9	3.1	4.1	4.2	3.7	3.9	6.7	4.0	4.2	7.2
HSO	3.2	4.6	4.9	3.4	5.0	5.3	13.3	13.9	14.0	15.3	16.0	16.0
IHN	1.9	2.5	3.0	2.1	2.6	3.2	5.8	10.3	10.4	6.3	11.2	11.3
JCC	3.4	4.1	4.3	3.7	4.5	4.6	15.9	15.9	16.0	18.1	18.2	18.2
PCS-CO	2.6	3.0	3.4	2.8	3.3	3.6	4.9	5.1	5.1	5.3	5.5	5.6
PCS-CG	2.8	3.3	3.5	3.1	3.6	3.7	10.0	10.0	10.0	10.9	10.9	10.9
PCS-LN	2.8	3.3	3.7	3.0	3.6	4.0	9.0	9.0	16.5	9.8	9.8	18.1
PCS-MP	1.7	2.1	2.4	1.8	2.2	2.6	2.9	7.8	9.9	3.1	8.6	11.1
TCHP-SW	3.0	3.7	3.9	3.3	4.0	4.3	11.7	12.0	19.0	12.8	13.1	20.7
TCHP-TC	6.1	6.2	6.2	6.6	6.7	6.7	14.1	15.0	15.1	15.8	17.0	17.1
UHA	3.5	5.4	5.5	3.8	5.8	6.0	6.9	7.3	8.8	7.5	7.9	9.6
YCCO	2.4	2.9	3.1	2.6	3.1	3.4	3.7	3.8	5.3	4.0	4.2	5.8

Table 4-46 presents the average time and distance to the nearest three MH and SUD providers, by organization and geographic setting (i.e., extreme access). If the average driving time or distance exceeded the acceptable travel time and distance requirements set forth by OHA, the result is shaded in red. CCOs that do not have an extreme access setting within their service region are not listed within the table.

Table 4-46—Average Time and Distance to the Nearest Three MH and SUD Providers by CCO and Urbanicity—Extreme Access

CCO	MH						SUD					
	Distance (Miles)			Time (Min)			Distance (Miles)			Time (Min)		
	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd	1st	2nd	3rd
EOCCO	6.6	7.9	8.2	7.2	8.6	8.9	7.3	7.7	7.8	8.0	8.3	8.4
PCS-CO	2.2	3.3	3.4	2.4	3.6	3.6	4.1	4.6	4.6	4.4	4.9	4.9

Table 4-47 presents the percentages of CCO members⁴³ with acceptable access (i.e., travel time or distance) to MH and SUD services, by CCO and geographic setting. The results are aggregated across all members and not stratified by adult and pediatric populations. CCOs that do not have one of the geographic settings within their service regions are listed as *NA* and shaded gray for those categories. Results showing less than 95 percent of members meeting the acceptable travel times and distances for each urbanicity are shaded red “R.”⁴⁴

Table 4-47—Time and Distance Results for Tier 1 Providers by CCO and Urbanicity

CCO	MH				SUD			
	Large Urban	Urban	Rural	Extreme Access	Large Urban	Urban	Rural	Extreme Access
AH	NA	NA	>99.9%	NA	NA	NA	92.2%	NA
AllCare	NA	100%	99.7%	NA	NA	100%	97.9%	NA
CHA	NA	NA	97.6%	NA	NA	NA	96.9%	NA
CPCCO	NA	NA	100%	NA	NA	NA	97.1%	NA
EOCCO	NA	NA	99.6%	96.7%	NA	NA	99.7%	96.8%
HSO	100%	NA	100%	NA	99.4%	NA	94.8%	NA
IHN	NA	100%	100%	NA	NA	100%	98.4%	NA

⁴³ The member population used to determine time and distance was restricted to members with at least one IP or OP claim with an MH or SUD diagnosis during CY 2023 to better reflect the population in need of MH and SUD providers.

⁴⁴ Although OHA has established time and distance standards, CCO compliance is not assessed as part of this evaluation. OHA assesses CCO compliance to time and distance standards based on adult and pediatric provider types comprising three tiers; 95 percent or more pediatric and adult members must meet the acceptable travel times and distances to the nearest adult and pediatric provider, regardless of urbanicity.

CCO	MH				SUD			
	Large Urban	Urban	Rural	Extreme Access	Large Urban	Urban	Rural	Extreme Access
JCC	NA	100%	99.9%	NA	NA	100%	92.5%	NA
PCS-CO	NA	100%	99.7%	99.8%	NA	100%	98.5%	99.3%
PCS-CG	NA	NA	98.2%	NA	NA	NA	95.4%	NA
PCS-LN	NA	100%	100%	NA	NA	100%	91.2%	NA
PCS-MP	NA	100%	>99.9%	NA	NA	100%	99.6%	NA
TCHP-SW	NA	100%	99.5%	NA	NA	100%	92.0%	NA
TCHP-TC	99.8%	NA	99.2%	NA	98.3%	NA	93.8%	NA
UHA	NA	NA	99.8%	NA	NA	NA	97.6%	NA
YCCO	100%	100%	100%	NA	90.1%	100%	100%	NA

Access-Related Grievances

The CY 2024 MHP Evaluation also reviewed the percentage of access-related MH and SUD grievances to identify potential areas of concern with the availability of MH and SUD providers within each CCO's network. Table 4-48 shows the percentage of access-related grievances compared to the overall number of grievances for MH and SUD services.

Table 4-48—Percentage of Access-Related MH/SUD Grievances

CCO	Total Grievances	MH/SUD		Access-Related MH/SUD Grievances	
		Number	Percent	Number	Percent
AH	568	10	1.8%	0	0.0%
AllCare	276	65	23.6%	11	16.9%
CHA	171	1	0.6%	0	0.0%
CPCCO	341	3	0.9%	1	33.3%
EOCCO	1,020	41	4.0%	10	24.4%
HSO	7,974	197	2.5%	28	14.2%
IHN	963	16	1.7%	1	6.3%
JCC	509	21	4.1%	2	9.5%
PCS-CO	820	15	1.8%	1	6.7%
PCS-CG	141	2	1.4%	2	100%
PCS-LN	2,565	26	1.0%	7	26.9%
PCS-MP	2,173	79	3.6%	10	12.7%

CCO	Total Grievances	MH/SUD		Access-Related MH/SUD Grievances	
		Number	Percent	Number	Percent
TCHP-SW	488	12	2.5%	3	25.0%
TCHP-TC	753	26	3.5%	2	7.7%
UHA	522	53	10.2%	35	66.0%
YCCO	203	4	2.0%	1	25.0%
CCO Aggregate	19,487	571	2.9%	114	20.0%

Special Topic Evaluation—Peer Support Services

To conduct the peer support services evaluation, OHA extracted data on OHP Medicaid beneficiaries with an MH and SUD diagnosis and claims for self-help/peer services for CY 2023. The data were then aggregated by CCO and county to generate a series of counts and description statistics including:

- Total number of members with a primary MH or SUD diagnosis and associated MM
- Number of paid and denied peer support services claims, where HCPCS = H0038
- Utilization of peer support services per 1,000 MM
- The average, median, minimum, and maximum number of days between bill date and paid date
- The average, median, minimum, and maximum number of days between date of service (DOS) and paid date.

This information was then aggregated to generate baseline information on the extent to which peer support services are used by members with MH and SUD diagnoses, differences in the percentage of paid vs. denied peer support services claims, and median time between the date peer support services were rendered and the claim was paid. The analysis was stratified by CCO and by county to better understand utilization patterns and reported individually for members with a primary diagnosis of MH and SUD. As utilization metrics are not inherently “good or bad,” the baseline utilization and timeliness results presented in this section are for informational purposes only.

Peer Support Services Results by CCO

Table 4-49 displays the peer support services utilization results for claims with dates of service in 2023 among members with an MH diagnosis. As a baseline measurement year, results are presented for informational purposes only.

Table 4-49—Baseline Peer Support Services Evaluation Results for Members With MH Diagnosis

CCO	Number of Peer Support Services Claims	Peer Support Services / 1,000 MM	Paid Peer Support Services Claims (Percent)	Median Days From DOS to Payment
AH	145	0.441	66.7%	35
AllCare	170	0.223	97.5%	91
CHA	484	1.559	88.8%	58
CPCCO	202	0.464	85.0%	110
EOCCO	689	0.781	99.0%	41
HSO	1,048	0.199	92.5%	42
IHN	149	0.151	76.6%	50
JCC	336	0.436	87.7%	90
PCS-CO	546	0.606	89.3%	48
PCS-CG	106	0.506	93.7%	27
PCS-LN	529	0.484	92.0%	25
PCS-MP	967	0.552	96.6%	27
TCHP-SW	210	0.487	87.3%	48
TCHP-TC	38	0.069	77.0%	35
UHA	133	0.295	89.5%	41
YCCO	239	0.555	96.6%	35

Table 4-50 displays the peer support services utilization results for claims with dates of service in 2023 among members with an SUD diagnosis. As a baseline measurement year, results are presented for informational purposes only.

Table 4-50—Baseline Peer Support Services Evaluation Results for Members With SUD Diagnosis

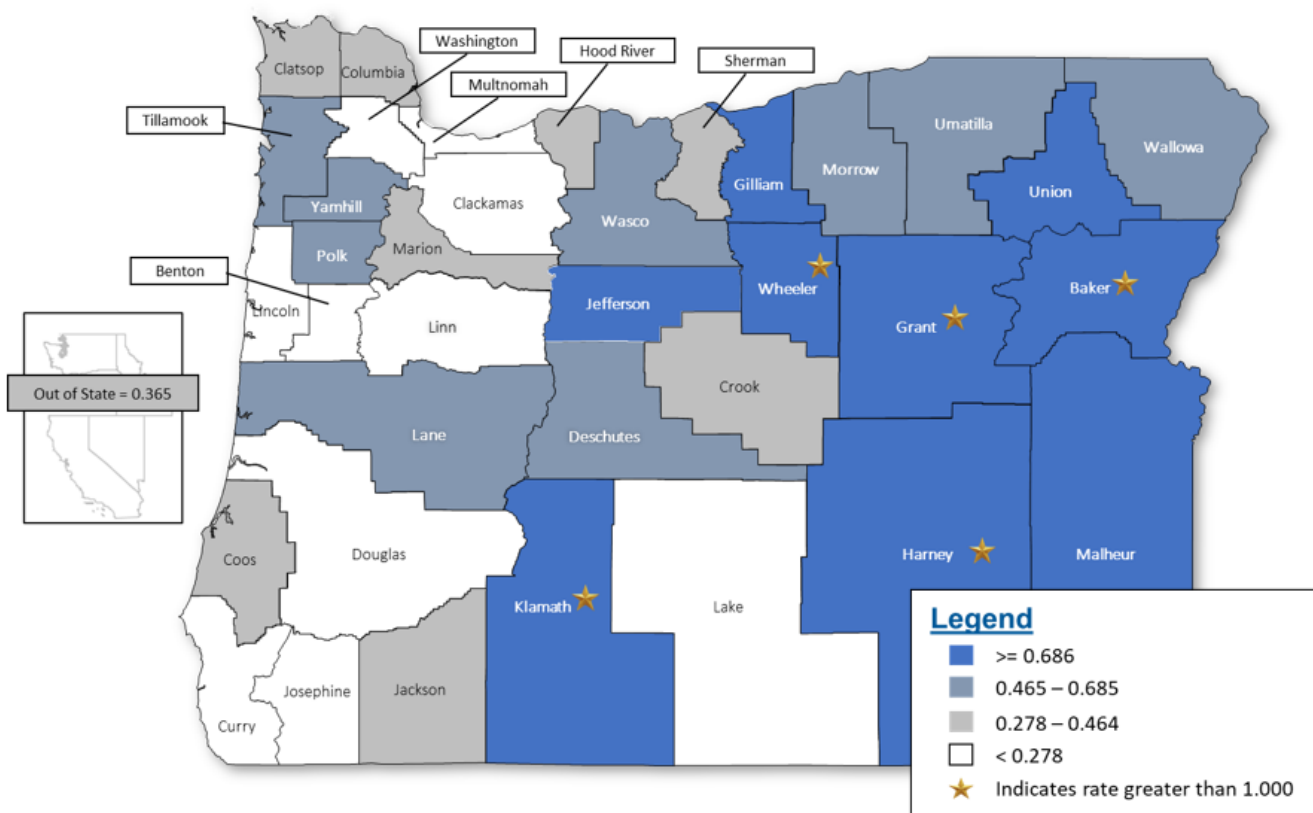
CCO	Number of Peer Support Services Claims	Peer Support Services / 1,000 MM	Paid Peer Support Services Claims (Percent)	Median Days From DOS to Payment
AH	190	0.578	76.1%	35
AllCare	696	0.915	97.0%	43
CHA	200	0.644	84.9%	52

CCO	Number of Peer Support Services Claims	Peer Support Services / 1,000 MM	Paid Peer Support Services Claims (Percent)	Median Days From DOS to Payment
CPCCO	230	0.528	92.2%	50
EOCCO	667	0.756	91.4%	35
HSO	2,458	0.466	93.0%	40
IHN	746	0.758	94.7%	24
JCC	699	0.908	96.6%	36
PCS-CG	61	0.291	61.8%	29
PCS-CO	612	0.680	97.0%	21
PCS-LN	335	0.307	91.0%	30
PCS-MP	913	0.521	94.5%	22
TCHP-SW	187	0.434	85.3%	30
TCHP-TC	211	0.383	85.6%	31
UHA	327	0.724	94.8%	31
YCCO	163	0.379	92.5%	31

Peer Support Services Results by County

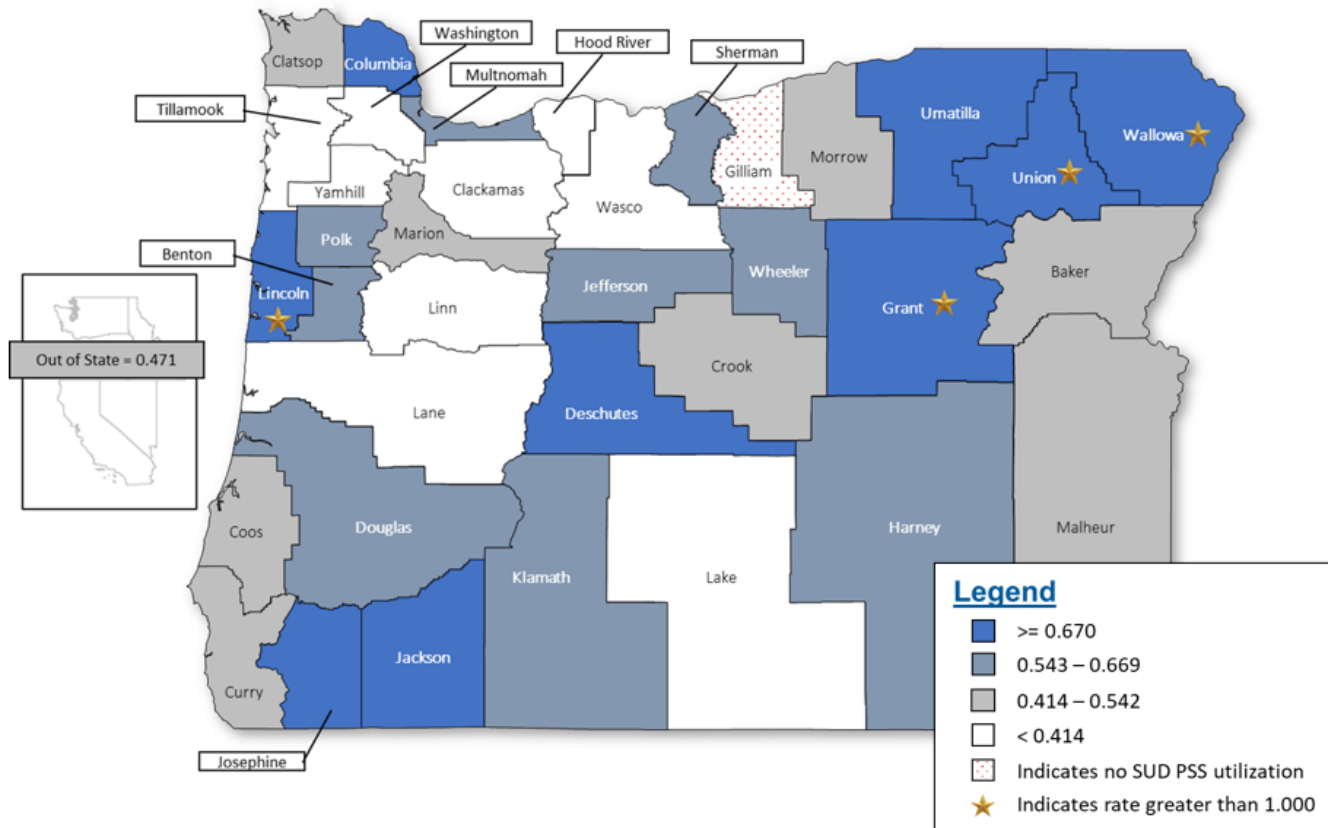
Figure 4-24 and Figure 4-25 show peer support services utilization rates for members with an MH diagnosis by county based on quartiles.⁴⁵ Detailed results related to county-specific utilization rates, percentage of paid peer support services claims, and the timeliness of payment are presented in Appendix S and summarized below. Overall, peer support services utilization results by county generally aligned with MH and SUD peer support services utilization results by organization. Given the region-based structure of the Oregon CCO program, similarities in performance are expected.

Figure 4-24—Peer Support Services Utilization by County for MH Members



⁴⁵ A *quartile* is a division of peer support services utilization rates into four defined intervals (i.e., < 25th percentile, 25th–50th percentile, 50th–75th percentile, and > 75th percentile) based on the values of the data and how they compare to the entire set of peer support services utilization rates.

Figure 4-25—Peer Support Services Utilization by County for SUD Members



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

For the CCOs statewide, the following conclusions were made:

- Based on the findings outlined in the 2024 MHP Evaluation, and in collaboration with the community partner groups, the administration of MH/SUD and M/S benefits was largely found to be in parity for the CCOs. Although the evaluation identified several opportunities for improvement, results did not identify systemic issues that negatively impacted parity between MH/SUD and M/S services. Rather, findings frequently highlighted general regulatory compliance issues affecting both MH/SUD and M/S benefits uniformly.
- The results continue to demonstrate challenges related to the availability and accessibility of MH and SUD services. While the CCOs have largely established mechanisms to support the fair and appropriate management of MH/SUD and M/S benefits, results from the Administrative Data Profile and adequacy of MH/SUD provider networks identified several opportunities for improvement and potential barriers to care.

- Overall, the CCOs did not report making any changes to, nor do the CCOs apply FRs or AL/ADLs in the administration of, MH/SUD and M/S benefits for IP, OP, Rx, or EC services. Additionally, while one CCO reported using QTLs in its management of MH/SUD and M/S benefits, the QTLs were actually soft limits and should have been categorized as NQTLs since members can receive additional services based on medical necessity.
- Overall, the evaluation of reported changes applied to NQTLs (i.e., Medical Management, Provider Network, and Pharmacy Management) by the CCOs continued to demonstrate parity across MH/SUD and M/S benefits; no CCO recommendations were identified based on the 2024 MHP attestation review.
- Overall, documentation demonstrated the CCOs maintained standardized processes to support the management of NQTLs across benefit types.
- Of the nine CCOs that received *Partially Compliant* and *Not Compliant* findings in 2023 MHP Evaluation related to NQTLs, eight were able to provide additional documentation to support parity and resolve findings. The remaining organization (HSO) continued to demonstrate insufficient oversight of subcontractors and vendors to ensure parity in the administration of NQTLs for MH/SUD and M/S benefits. Three CCOs (TCHP-SW, TCHP-TC, and YCCO) attested to the absence of operational changes to existing processes, policies, or procedures that were previously found to support the parity of MH/SUD and M/S benefits. Overall, documentation demonstrated the CCOs maintained standardized processes to support the management of NQTLs across benefit types.
- Overall, the CCOs continued to demonstrate that medical necessity criteria information was made available to members, potential members, and network providers through a variety of formats, including member handbooks, provider manuals, CCO websites, and via notices to members when a service or reimbursement for an MH/SUD service was denied.
- For the Administrative Data Profile, parity between MH/SUD and M/S benefit administration was evaluated across three domains: claims (i.e., paid IP and OP claims, including in-network and out-of-network providers); UM (i.e., IP, OP, and Rx PA denials); and provider enrollment (i.e., terminations and provider application approvals). Overall, CCO aggregate results across each domain continued to show minimal differences in the administration of MH/SUD and M/S benefits across the CCOs, although considerable variation in CCO performance remains within each of the measures.
- Overall, the difference in the percentage of paid MH/SUD and M/S claims for the CCO aggregate across all claims (i.e., IP, OP, in-network, and out-of-network) was negligible, although individual CCOs exhibited considerable variation in payment rates across all stratifications. When individual CCO differences were moderate or substantial for paid IP and OP claims, the deviation was generally due to a higher percentage of paid MH/SUD claims versus paid M/S claims.
- Overall, differences in the percentage of denials for MH/SUD and M/S PA requests continued to vary across all service types (i.e., IP, OP, and Rx). While the percentage point differences in the CCO aggregate denial rates were negligible between MH/SUD and M/S IP services, the percentage point difference in the CCO aggregate OP and Rx denial rates was moderate (between 5 and 10 percentage points).

- The difference in the statewide CCO percentage of terminated providers for MH/SUD and M/S providers was either negligible or substantial with seven CCOs exhibiting little to no difference in the percentage of MH/SUD and M/S providers terminated or not recredentialed, four CCOs with substantial differences in the number of M/S providers compared to MH/SUD providers, and five CCOs unable to report due to data quality concerns. Similar to prior years, the difference in the statewide CCO percentage of provider applications approved for MH/SUD and M/S providers was also negligible, with all but one of the CCOs exhibiting little to no difference in the percentage of MH/SUD and M/S provider applications approved.
- Between 2023 and 2024, the CCOs continued to show general increases in the number of contracted MH and SUD provider counts across all CCOs, with only a few CCOs demonstrating substantial decreases in the count of SUD providers. Several factors likely contributed to these increases, including the CCOs' efforts to increase enrollment and contracting with MH and SUD providers in response to members' needs as well as ongoing QI efforts to address data quality. Additionally, provider-to-member ratios were generally low, indicating the CCOs had a large number of providers contracted to perform MH and SUD services relative to members with an MH or SUD diagnosis.
- In 2024, OHA updated its acceptable travel time and distance requirements for providers across four urbanities (i.e., large urban, urban, rural, and extreme access) for select provider types. To ensure appropriate comparisons, the 2024 MHP Evaluation assessed the geographic distribution of MH and SUD providers relative to members with an MH or SUD diagnosis. In general, the results demonstrated that the average drive time and distance to the nearest three MH and SUD providers were within acceptable travel times and distances within most large urban, urban, and extreme access urbanities, with mixed performance for the CCOs' rural service areas. While more than 95 percent of members enrolled in CCOs were within acceptable travel times and distances to MH providers across all urbanities, results for SUD providers showed challenges in the rural (six CCOs) and large urban (one CCO) geographic areas. However, in all cases, the percentage of members within acceptable travel times and distances was greater than 90 percent. Although, these results suggest that MH and SUD providers were generally distributed in proportion to members' locations, the findings should be interpreted with caution, as time and distance metrics represent only one of several network monitoring metrics used to assess provider network adequacy.
- Overall, only 2.9 percent of all CCO grievances were associated with MH/SUD benefits or service, with an average CCO rate of 4.1 percent demonstrating a small increase from prior years. Similar to prior findings, the results showed a consistent distribution of MH/SUD-related grievances, with most CCOs having less than 5 percent of all grievances related to MH/SUD services except for two CCOs. Further, while the percentage of access-related grievances associated with MH/SUD services was high for CCOs, with an aggregate rate of 20.0 percent, the range of access-related MH/SUD grievances varied considerably across individual CCOs (i.e., 0.0 percent to 100 percent). It is important to note that grievances are a limited monitoring tool for the CCOs, given that members must have both the means and the inclination to file a grievance. These results reinforce OHA's guidance that grievance monitoring, while required and valuable, likely captures only a fraction of members' overall experiences and should not be used as the total or primary mechanism for monitoring network adequacy and decision making. Further, due to the nature of MH/SUD clinical conditions, members with MH/SUD diagnoses may be less likely to file a grievance with the health

plan than those with an M/S diagnosis, contributing to the low rate of grievances and thereby underestimating these results.

- Overall, the utilization of peer support services among members with an MH diagnosis was 0.484/1,000 MM with individual CCO and OHP utilization, demonstrating considerable variation across organizations.
- Generally, the CCOs with services comprised of largely rural and extreme access urbanities exhibited higher utilization of peer support services compared to the CCOs with services of urban and large urban areas.
- Overall, the median peer support services utilization rate for members with an SUD diagnosis was somewhat higher (0.578/1,000 MM) compared to members with an MH diagnosis, with individual CCO utilization rates demonstrating less variation across organizations than among MH members receiving peer support services.

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

- The review of availability of information identified that several CCOs continued to include links to the Health Evidence Review Commission Prioritized List of Health Services without interpretive guidelines or instructions, which could represent a barrier to members' understanding of these resources.
- As noted in earlier MHP evaluations, the data submitted by the CCOs continue to raise concerns related to the quality and consistency of data and/or implementation of claims, UM, and provider enrollment processes. The presence of outlier counts, incomplete data, and inconsistent trends all suggest issues with data collection, extraction, and/or reporting which may mask or bias outcomes associated with the study, although this is not necessarily indicative of an impact on parity across benefit types.
- One CCO (HSO) was unable to show evidence of sufficient oversight of subcontractors or vendors to assess parity.
- A review of denial reasons across benefit type and services revealed that most denials were related to services not meeting clinical criteria or for non-covered services. However, while patterns of denial reasons were relatively stable, OP PA denials demonstrated variations between MH/SUD and M/S services with a greater percentage of MH/SUD OP PA denials related to UM controls and treatment limitations, administrative denials, and out-of-network providers, suggesting an area requiring greater review to ensure parity across MH/SUD and M/S services.
- Although OP MH/SUD appeals were overturned less frequently than OP M/S appeals, the appeals outcomes showed that more than a quarter of all MH/SUD decisions were overturned on appeals. For IP and Rx appeals, the percentage of overturned MH/SUD appeals was substantially higher for IP MH/SUD appeals and negligibly higher for Rx MH/SUD appeals. While these results should be viewed with caution given the small number of appeals, the relatively high percentage of overturned denial decisions suggest potential barriers to care that may impact the timeliness of MH/SUD services to members.
- When restricting the analysis to paid out-of-network IP and OP claims, at least half of the CCOs continued to exhibit moderate or substantial differences in the percentages of paid out-of-network IP

and OP claims; however, for all but two CCOs for IP and OP paid claims, the deviation was due to a higher percentage of paid MH/SUD claims compared to paid M/S claims. Although differences in the percentage of paid out-of-network claims may be legitimate, they may also indicate procedural or network differences that highlight potential barriers to members' access to MH/SUD services.

For the CCOs statewide, the following recommendations were identified:

- HSAG recommends that, in addition to completing planned attestations in 2025, any CCO that received a less than *Compliant* treatment limitation rating should be required to resubmit responses and documentation to demonstrate compliance with parity requirements until all outstanding items are resolved.
- The CCOs should take steps to ensure that available information is readily accessible to members.
- Identified differences in claims, UM, and provider enrollment outcome patterns suggest additional review by the CCOs is needed.
- The CCOs should review out-of-network claim denials to understand factors affecting the lower percentage of paid MH/SUD IP and OP claims compared to M/S IP and OP claims, and assess whether any barriers exist for members accessing MH/SUD services, including the need to seek services outside the CCO's network (e.g., appointment availability).

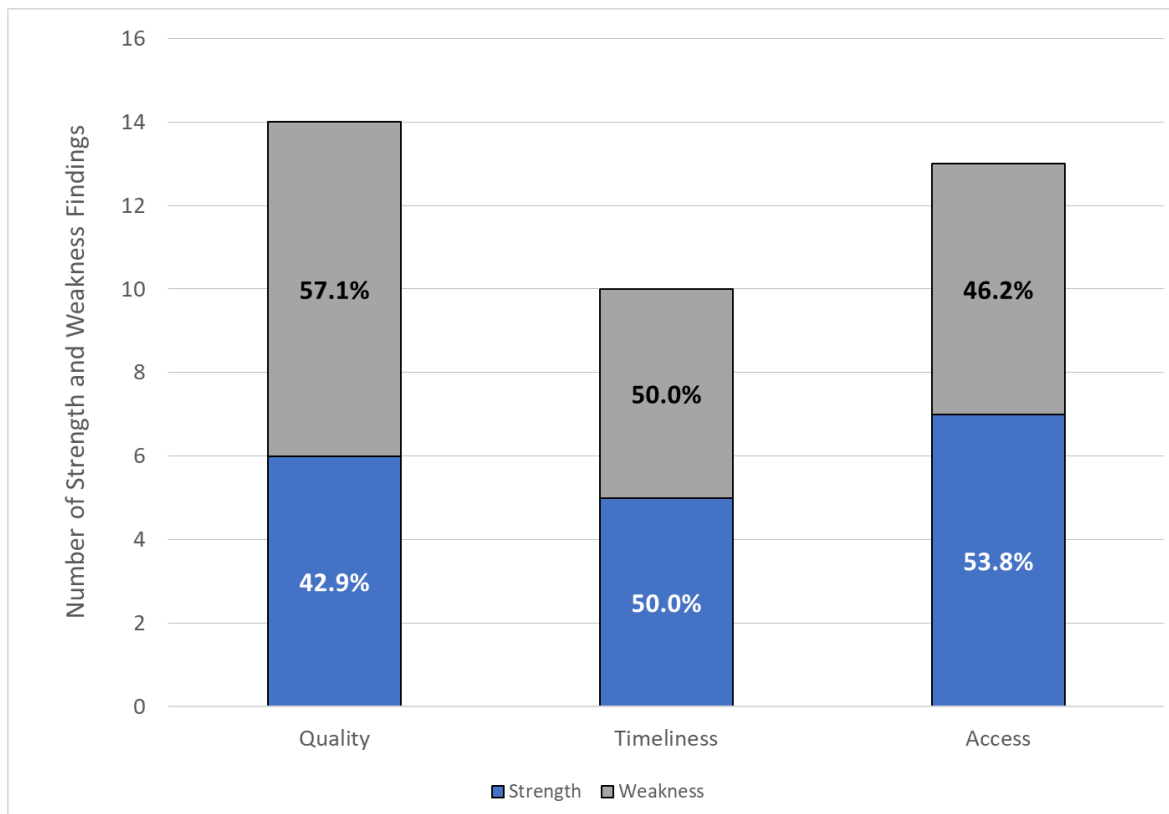
5. CCO Individual Plan Results and Conclusions

Advanced Health

Results and Conclusions

HSAG assessed the strengths and weaknesses of each CCO with respect to the quality, timeliness, and accessibility of health care services. Figure 5-1 illustrates the number of strengths exhibited by AH relative to the number of weaknesses identified during the CY 2024 EQR activities across the three domains. The greater the proportion of weaknesses, the greater opportunities for improvement.

Figure 5-1—AH Overall Number of Findings (Strengths and Weaknesses) by Domain



Detailed results from the EQR’s substantive findings are summarized in Table 5-1 for each activity. This table highlights the extent to which AH furnishes high quality, timely, and appropriate access to health care services, and recommendations for how AH can best address issues identified for each activity.⁴⁶

⁴⁶ See Section 4—Comparative Statewide Results for detailed, CCO-specific scores associated with EQR activity.

Table 5-1—AH Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s) ⁴⁷
Compliance Monitoring Review		
	Strength: AH achieved full compliance with the <i>Practice Guidelines</i> standard, demonstrating that the CCO had established policies and procedures, along with the appropriate structure, to ensure that clinical practice guidelines were adopted, reviewed, updated, and disseminated. These guidelines took into account the needs of members and were based on evidence or on a consensus among providers in the relevant field. Additionally, decision-making was aligned with these guidelines.	 
	Weakness: AH received a score of 86.8 percent in the <i>Assurance of Adequate Capacity and Availability of Services</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements, the inability to demonstrate sufficient implementation of established processes, and deficiencies within its monitoring activities impacting the CCO’s ability to ensure timely access to care and services. Why the weakness exists: AH policies and procedures implemented did not fully align with State-established time and distance standards and provision of access, accommodations, and equipment for members with physical and mental disabilities. Also, the CCO failed to demonstrate the appropriate mechanisms for monitoring or provide evidence of monitoring provider compliance with State-established appointment standards and taking corrective action when providers fail to meet appointment standards in accordance with its policy and procedures. Recommendations: AH should revise its policies and procedures to align with State-established requirements for timely access to care and services and demonstrate implementation. The CCO should also demonstrate corrective action when providers fail to meet appointment standards.	  
	Weakness: AH received a score of 91.7 percent in the <i>Provider Selection</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements for selecting and retaining network providers. Why the weakness exists: AH lacked policies and procedures for selecting and retaining network providers. Recommendations: AH should develop written policies and procedures for selecting and retaining providers.	 

⁴⁷  = Quality,  = Timeliness,  = Access

Strength/ Weakness	Description	Domain(s) ⁴⁷
	Weakness: AH received a score of 87.5 percent in the <i>Subcontractual Relationships and Delegation</i> standard due to insufficient documentation to support operations and ensure compliance with federal requirements for written agreements between the CCO and its subcontractors. Why the weakness exists: AH contracts with the subcontractors failed to include federally required language for written agreements with subcontractors. Recommendations: AH should revise its written agreements to align with federally required language for written agreements with subcontractors.	
Performance Improvement Projects		
Statewide Mental Health Service Access Monitoring PIP		
	Strength: AH successfully continued the Implementation stage for the PIP, receiving a <i>Met</i> score for 100 percent of applicable evaluation elements in the PIP Validation Tool. In the Implementation stage, AH accurately reported baseline and RY 2 performance indicator data, identified and analyzed barriers to improving MH service access, carried out interventions to address those barriers, and refined interventions based on intervention evaluation results.	
	Strength: AH's RY 2 performance indicator results demonstrated sustained improvement in MH service access compared to baseline indicator results.	
Statewide Substance Use Disorder PIP		
	Strength: AH accurately reported baseline and RY 1 performance indicator data; identified and analyzed barriers for initiation, engagement, and treatment of alcohol and other drug use disorders; and began to carry out interventions to address those barriers.	
	Weakness: AH received a <i>Moderate Confidence</i> rating for overall confidence that the <i>Substance Use Disorder</i> PIP achieved significant improvement. Why the weakness exists: AH's RY 1 improvement noted for both indicators (<i>Percentage of new SUD episodes that result in treatment and initiation within 14 days</i> and <i>Percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation</i>) over BY was not statistically significant. Recommendations: AH should revisit root cause analyses identifying barriers to improving initiation, engagement, and treatment of alcohol and other drug use disorders to determine which barriers to improvement were not effectively addressed. AH should use intervention-specific evaluation results and updated barrier analyses to	

Strength/ Weakness	Description	Domain(s) ⁴⁷
	identify new or revised interventions with the potential to further improve the percentage of new SUD episodes that result in treatment and initiation within 14 days and the percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation indicator results.	
Performance Measure Validation		
	Strength: AH's MY 2023 performance on the <i>Child and Adolescent Well-Care Visits—Ages 3 to 6 Years</i> measure indicator demonstrated ongoing improvement since MY 2021.	
	Strength: AH's MY 2023 performance on the <i>Members Receiving Preventive Dental or Oral Health Services—Ages 1 to 5 Years and Ages 6 to 14 Years</i> measure indicators improved by more than 5 percentage points compared to MY 2022; 7.3 percentage points for members ages 1 to 5 years and 5.6 percentage points for members ages 6 to 14 years. The CCO's performance on this measure demonstrated ongoing improvement for members in both age groups since MY 2021. In addition, the CCO's MY 2023 rates in both age groups exceeded the benchmark set by OHA for MY 2023 by 5 percentage points or more.	
	Strength: AH's MY 2023 performance on the <i>Oral Evaluation for Adults With Diabetes</i> measure demonstrated ongoing improvement since MY 2021.	
	Weakness: AH's MY 2023 rate for the <i>Initiation of SUD Treatment</i> measure indicator for members ages 18 years and older fell below the benchmark set by OHA for MY 2023 by 5 percentage points or more (5.5 percentage points). Why the weakness exists: In response to prior year recommendations, AH noted barriers to full-scale implementation of improvement initiatives, including provider shortages in remote areas; challenges engaging members in treatment after initial contact, especially in underserved regions; and member transportation barriers. Additionally, limited access to telehealth services in rural areas was noted. Recommendations: AH took several steps in MY 2023 to improve performance on this measure. AH reported enhancing internal claims-based dashboards to visualize utilization of SUD treatment services, enabling AH to identify gaps in the provider network to improve access to treatment. AH continued participation in the statewide <i>Substance Use Disorder</i> PIP introduced by OHA in 2022 and supported work by peer support specialists to engage members that are ready to receive SUD treatment regardless of their geographic location and assist in navigating SUD treatment options. Additionally, AH collaborated with key partners, including but not limited to, Advanced Health Clinical Advisory Panel, Southwest Oregon Independent Practice Association, and North Bend Medical Center to strengthen the network's ability to	

Strength/ Weakness	Description	Domain(s) ⁴⁷
	respond to SUD needs. AH should continue implementing these efforts to raise its rate on this measure indicator for members ages 18 years and older to the level of the benchmarks set by OHA.	
Validation of Network Adequacy		
Network Adequacy Validation Audit		
The CCO met performance expectations. No significant strengths or weaknesses were noted during the review.		
Delivery System Network Evaluation		
	Weakness: AH did not fully demonstrate key components of its DSN monitoring and analysis process. Why the weakness exists: The CCO's DSN Provider Narrative submission did not sufficiently describe how collected information on wait time to appointment availability and the availability of physical accessibility accommodations was used to inform its network adequacy monitoring and decision making. Recommendations: AH should ensure that its responses within the <i>DSN Provider Narrative Template</i> submission describe and demonstrate how information collected for wait time to appointment availability and the availability of physical accessibility accommodations is used to inform and support its network adequacy monitoring and decision making.	
	Weakness: AH did not have any END, GST, PUL, or RHEU providers within network and failed to meet adult, pediatric, and facility network adequacy standards for these provider types. Why the weakness exists: AH stated it did not have any END, GST, PUL, RHEU, or MTD providers available for contracting within or near its service region. However, it is expected that the CCO would have at least one provider of all monitored types within its larger provider network, regardless of compliance with time and distance standards, rather than rely on single case agreements or similar methods. Recommendations: AH should ensure that it takes the necessary steps to maintain an adequate network that can provide all covered and necessary care. AH should work to contract with at least one provider or facility of each missing type that can supply such services as part of the CCO's network, even if that provider is not within the service region. Such providers should still be meaningfully accessible through regional transportation (e.g., driving to a nearby population center). The CCO should engage with OHA on potential solutions for these needs via the time and distance standard exception request process.	

Strength/ Weakness	Description	Domain(s) ⁴⁷
Revealed Telephone Survey		
	Strength: Of the total PCP and OP SUD cases reached, 100 percent confirmed the correct location.	
	Strength: Of the OP SUD cases that offered an appointment, 100 percent of OP SUD appointments for pregnant members were compliant with the wait time standard.	
	Strength: Of the OP SUD cases that accepted the CCO, 100 percent offered translation or interpreter services.	
	Weakness: Overall, 88.9 percent of the total PCP and OP SUD sampled cases were reached. Among the cases reached, 87.5 percent offered the requested services, 83.3 percent accepted OHP Medicaid, and 79.2 percent accepted AH. Also, 66.7 percent of PCP cases offered translation or interpreter services. Why the weakness exists: In addition to limitations related to the revealed survey approach, inaccuracies found in AH's provider data may have contributed to the low response rate and accuracy results. Recommendations: AH should use the case-level analytic data files to address the data deficiencies identified during the survey calls (e.g., incorrect or disconnected telephone numbers; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
	Weakness: Among the total PCP and OP SUD cases reached, 79.2 percent accepted new patients. In addition, appointments were offered for less than 65.0 percent of PCP cases and 70.0 percent of OP SUD cases. Of the PCP appointments that were offered, compliant appointment rates ranged from 44.4 percent for new patient routine visits to 85.7 percent for existing patient urgent visits. Additionally, of the OP SUD appointments that were offered, 50.0 percent of urgent visits, 66.7 percent of routine visits, and 83.3 percent of opioid use disorder visits were compliant with the wait time standards. Why the weakness exists: In addition to limitations related to the revealed survey approach, inaccuracies found in AH's provider data and insufficient provider panel capacity may have contributed to low access and availability rates (i.e., new patient acceptance, appointment availability, and wait times). Also, internal office staffing structures and procedures may have contributed to the long wait times. Recommendations: AH should confirm appointment availability with providers, including panel capacity to accept new patients. Further, AH should use the case-level analytic data files containing data deficiencies identified during the survey calls.	

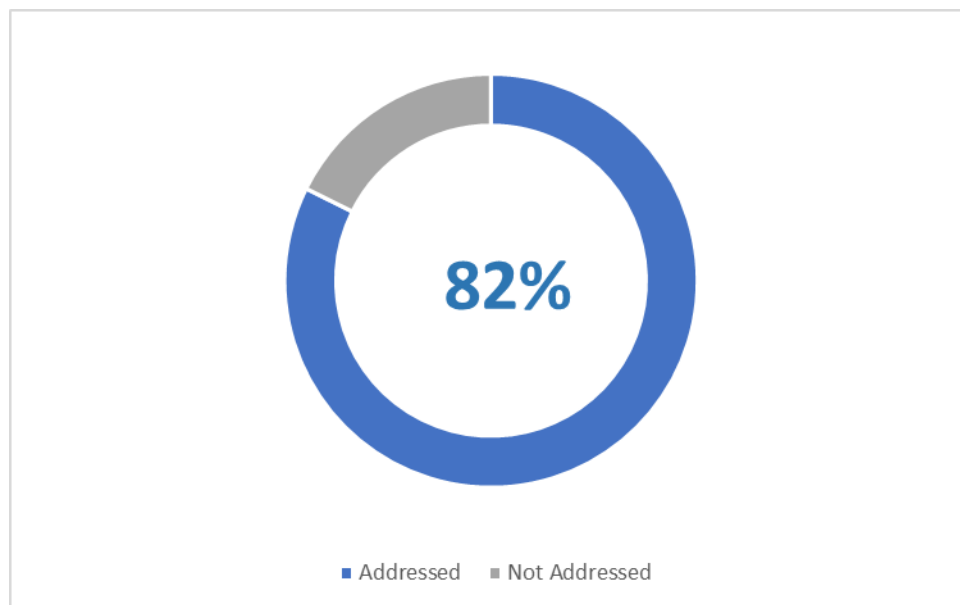
Strength/ Weakness	Description	Domain(s) ⁴⁷
Encounter Data Validation		
	Since EDV results were not available for inclusion in the 2024 EQR technical report, the strengths and weaknesses for each CCO could not be assessed. The findings will be incorporated in next year’s EQR technical report.	
Mental Health Parity Evaluation		
	The CCO met performance expectations. No significant strengths or weaknesses were noted during the review.	

Follow-Up on Prior Year Recommendations

HSAG evaluated AH's approach to addressing the recommendations related to findings issued during CY 2023 and unresolved findings from CY 2020, CY 2021, and CY 2022 while conducting the CY 2024 EQR activities. The CCOs not addressing recommendations are at risk of being out of compliance with their contracts.

Figure 5-2 illustrates the degree in which the CCO sufficiently addressed the recommendations for QI made by HSAG during the CY 2023 EQR.

Figure 5-2—Percentage of CY 2023 EQR Recommendations Addressed by AH



AH-specific CY 2023 recommendations and follow-up CY 2024 assessments are summarized in Table 5-2.

Table 5-2—Assessment of AH’s Approach to Addressing Previous Annual Recommendations

CY 2023 Recommendation	CY 2024 Assessment
Compliance Monitoring Review	
Standard I—Assurance of Adequate Capacity and Availability of Services*	
This recommendation was initially given during the CY 2021 EQR. HSAG recommends AH implement processes to ensure ongoing monitoring of provider network compliance and corrective actions when providers fail to meet network access requirements. In addition, AH should implement formal monitoring of the number, mix, and geographic locations of its individual specialty provider network to demonstrate the provider network meets the needs of its members. Lastly, AH should ensure that it demonstrates, through committee meeting minutes or related documentation, that it included results of appointment compliance in its evaluation of provider network capacity.	AH did not sufficiently address the recommendation. AH demonstrated a process to monitor the numbers and types (in terms of training, experience, and specialization) of network providers required to furnish the contracted Medicaid services. However, AH continued to lack sufficient mechanisms to ensure ongoing monitoring of network provider compliance with the state-established network access standards and corrective actions when providers failed to meet the requirements. Note: Standard I—Assurance of Adequate Capacity and Availability of Services was comprehensively reviewed during the CY 2024 CMR cycle, and recommendations addressing all findings related to this standard are included in the CCO’s individual Results and Conclusions section.
Standard III—Coordination and Continuity of Care	
AH should revise its policies and procedures to align with federal and State requirements. AH should also demonstrate notification to members at all levels of the person formally designated as primarily responsible for coordinating the services accessed by the member. Finally, AH should demonstrate implementation of appropriate assessments, reassessments, and revision of treatment plans according to federal and State requirements.	AH sufficiently addressed the recommendation.
Standard IV—Coverage and Authorization of Services	
AH should revise its policies and procedures to align with federal and State requirements. AH should demonstrate adherence to federal and State requirements for authorization of services and required content and time frames for providing NOABDs.	AH did not sufficiently address the recommendation. AH and its subcontractors continued to have processes that did not fully align with federal and State requirements for authorization of services and required content and time frames for providing NOABDs. AH’s subcontractors did not have policies and procedures in place for continuing authorization requests. Also, AH and its subcontractors could not demonstrate processes for consistent application of criteria. The CCO also continued to

CY 2023 Recommendation	CY 2024 Assessment
	have processes that did not align with federal requirements, including a reconsideration process after an NOABD has been issued. AH also utilized individuals who do not have the appropriate expertise in treating the member's needs to issue denial decisions. The CCO was unable to demonstrate the appropriate outreach attempts, use of extensions, or ongoing tracking of the timeliness of decisions. Additionally, AH did not have a process to ensure all NOABDs included the appropriate content, readability, and enclosures. AH should ensure its processes align with federal and State requirements for authorization of services and required content and time frames for providing NOABDs.
Standard V—Provider Selection	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard VI—Subcontractual Relationships and Delegation	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard VII—Member Rights and Protections	
AH should revise its policies and procedures and member- and provider-facing materials to align with federal and State requirements.	AH sufficiently addressed the recommendation.
Standard VIII—Confidentiality	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard IX—Enrollment and Disenrollment	
This recommendation was initially given during the CY 2022 EQR. AH should ensure its documents used to train enrollment and disenrollment staff align with federal and State requirements.	AH sufficiently addressed the recommendation.
Standard X—Grievance and Appeal Systems	
AH should revise its policies and procedures to align with federal and State requirements. Additionally, AH should demonstrate adherence to requirements for appropriate decision-makers; time frames for acknowledging and responding to grievances and/or appeals; readability of notices;	AH sufficiently addressed the recommendation.

CY 2023 Recommendation	CY 2024 Assessment
and implementation of federal and State requirements within communications to members, providers, and subcontractors. AH should also demonstrate maintaining one level of appeal, being the final adjudicator on appeals, and adherence to federal and State appeal extension requirements.	
Standard XI—Practice Guidelines	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard XII—Quality Assessment and Performance Improvement	
This recommendation was initially given during the CY 2022 EQR. AH should ensure appropriate oversight of its QAPI program, including implementing a QI committee that meets the State’s requirements.	AH sufficiently addressed the recommendation.
Standard XIII—Health Information Systems, including ISCA	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Standard XIV—Member Information	
AH should revise its policies, procedures, and member-facing materials to align with federal and State requirements.	AH did not sufficiently address the recommendation. Although AH has revised some of its member-facing materials, the CCO failed to demonstrate a process to outreach to providers to obtain missing information from the provider directory. AH was also missing the required information about network providers from the provider directory. AH should revise its processes and provider directory to align with federal and State requirements.
Standard XVI—Emergency and Poststabilization Services	
AH should revise the applicable plan documents to define “emergency and poststabilization services” and communicate the appropriate requirements.	AH sufficiently addressed the recommendation.
Performance Improvement Projects	
Statewide Mental Health Service Access Monitoring PIP	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.

CY 2023 Recommendation	CY 2024 Assessment
Statewide Substance Use Disorder PIP	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Performance Measure Validation	
AH took several steps in 2022 to improve performance on the <i>Initiation of SUD Treatment</i> and <i>Engagement of SUD Treatment</i> measure indicators. AH used internal claims-based dashboards to visualize utilization of SUD treatment services and identify gaps in the provider network. Additionally, AH participated in the statewide <i>Substance Use Disorder PIP</i> introduced by OHA in 2022 and supported peer support specialists with the work of reaching members in rural and remote communities who are ready to receive SUD treatment. AH should continue implementing these efforts to raise its rates on these measure indicators for members 18 years and older to the level of the benchmarks set by OHA.	AH sufficiently addressed the recommendation. AH addressed the recommendations provided by HSAG and continued its efforts to improve performance in this measure, which included enhancing internal claims-based dashboards to visualize utilization of SUD treatment services, continued participation in the statewide <i>Substance Use Disorder PIP</i> , supported work by peer support specialists to engage members that are ready to receive SUD treatment regardless of their geographic location and assist in navigating SUD treatment options, and collaboration with key partners. AH should continue implementing these efforts to raise its rate on this measure for members 18 years and older to the level of the benchmarks set by OHA.
Validation of Network Adequacy	
Delivery System Network Evaluation	
AH should ensure that its responses within the <i>DSN Provider Narrative Template</i> describe and demonstrate how information collected for provider panel status, telehealth utilization, and the availability of physical accessibility accommodations is used to inform and support its network adequacy monitoring and decision-making.	AH sufficiently addressed the recommendation. AH hired additional staff to ensure appropriate collection of physical accessibility data and had conducted at least one round of data collection at the time of review. While the process showed room for improvement, AH had dedicated staff and resources to making iterative improvements. AH should continue to iteratively improve on its network adequacy monitoring efforts.
Secret Shopper Survey	
HSAG recommends that AH use the case-level analytic data files to address the data deficiencies identified during the secret shopper survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	AH sufficiently addressed the recommendation. AH reviewed the case-level analytic data files and made appropriate updates to the provider directory data and <i>DSN Provider Capacity Report</i> data. AH should continue to monitor and improve any efforts in maintaining accurate provider data.

CY 2023 Recommendation	CY 2024 Assessment
HSAG recommends that AH confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. AH should use the case-level analytic data files containing data deficiencies identified during the secret shopper survey calls.	AH sufficiently addressed the recommendation. AH reported ongoing efforts to monitor panel status and update provider directory information. AH also reported that it is working with clinics to monitor appointment wait times and submit quarterly reporting. AH also reviewed the case-level analytic data files and made appropriate updates to the provider directory data and <i>DSN Provider Capacity Report</i> data. AH should continue to monitor and provide education to offices regarding wait time standards.
Revealed Telephone Survey	
HSAG recommends that AH use the case-level analytic data files to address the data deficiencies identified during the revealed telephone survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, program information, and translation/interpreter services offered).	AH sufficiently addressed the recommendation. AH reviewed the case-level analytic data files and made appropriate updates to the provider directory data and <i>DSN Provider Capacity Report</i> data. AH should continue to monitor and improve any efforts in maintaining accurate provider data.
HSAG recommends that AH confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. AH should use the case-level analytic data files containing data deficiencies identified during the revealed telephone survey calls and work with BH outpatient offices to identify the root cause for delays in appointment availability.	AH sufficiently addressed the recommendation. AH reviewed the case-level analytic data files and made appropriate updates to the provider directory data and <i>DSN Provider Capacity Report</i> data. AH reported ongoing efforts to monitor panel status and update provider directory information. AH also reported that it is working with clinics to monitor appointment wait times and submit quarterly reporting. AH should continue to monitor and provide education to offices regarding wait time standards.
Encounter Data Validation	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Mental Health Parity Evaluation	
AH should review its implementation of concurrent and retrospective review NQTLs for OP MH/SUD services to ensure that the additional limitation based on the benefit does not impede the member's ability to access OP care more so than M/S.	AH sufficiently addressed the recommendation.

CY 2023 Recommendation	CY 2024 Assessment
AH should identify processes, strategies, evidentiary standards, and other factors used in formulary design and application for prescription drugs.	AH sufficiently addressed the recommendation.

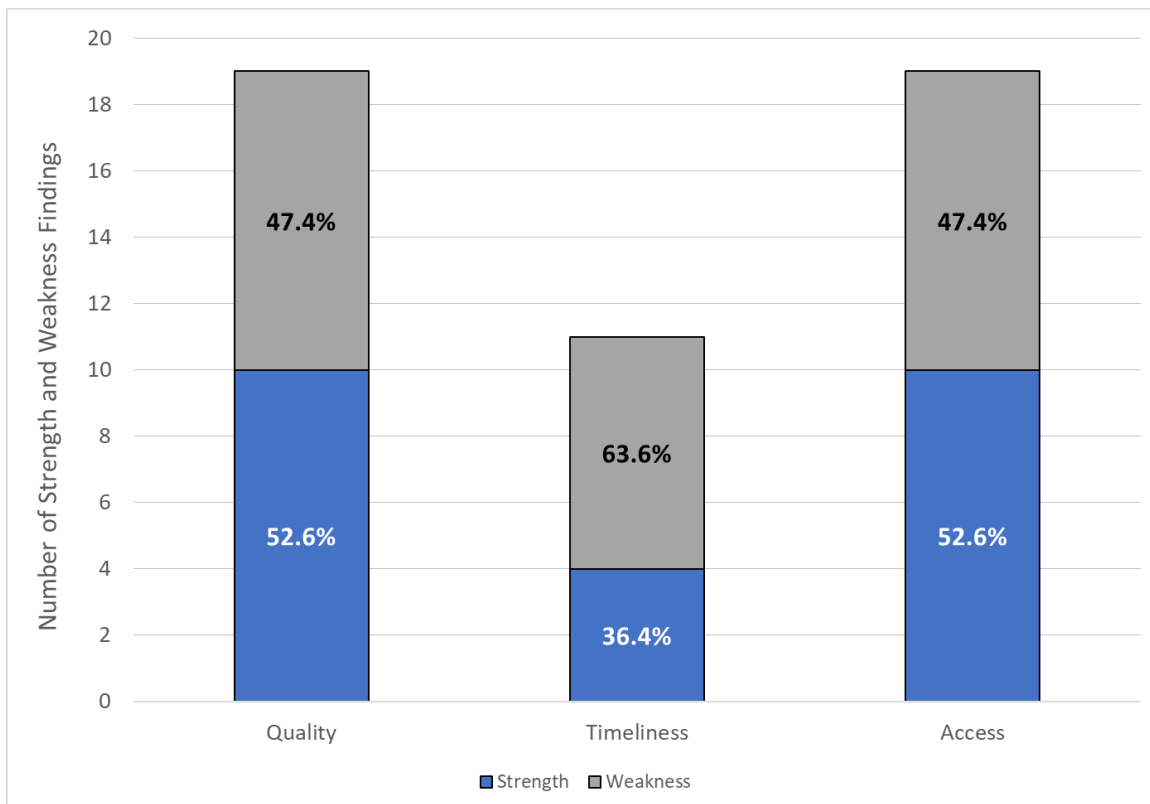
*Standard I—Availability of Services and Standard II—Assurances of Adequate Capacity and Services were combined, and all elements required by 42 CFR §438.206 and §438.207 were assessed under the combined Standard I—Assurance of Adequate Capacity and Availability of Services during the CY 2024 CMR activity.

AllCare CCO, Inc.

Results and Conclusions

HSAG assessed the strengths and weaknesses of each CCO with respect to the quality, timeliness, and accessibility of health care services. Figure 5-3 illustrates the number of strengths exhibited by AllCare relative to the number of weaknesses identified during the CY 2024 EQR activities across the three domains. The greater the proportion of weaknesses, the greater opportunities for improvement.

Figure 5-3—AllCare Overall Number of Findings (Strengths and Weaknesses) by Domain



Detailed results from the EQR’s substantive findings are summarized in Table 5-3 for each activity. This table highlights the extent to which AllCare furnishes high quality, timely, and appropriate access to health care services, and recommendations for how AllCare can best address issues identified for each activity.⁴⁸

⁴⁸ See Section 4—Comparative Statewide Results for detailed, CCO-specific scores associated with EQR activity.

Table 5-3—AllCare Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s) ⁴⁹
Compliance Monitoring Review		
	Strength: AllCare demonstrated best practices with the diverse and robust nature of its health equity training curriculum.	 
	Strength: AllCare demonstrated best practices by employing dedicated staff to assist members with physical and mental disabilities with navigating care.	 
	Strength: AllCare demonstrated best practices in including lesbian, gay, bi-sexual, transgender, queer, intersex, and asexual and disabled population representation on the Community Advisory Council (CAC).	 
	Strength: AllCare achieved full compliance for the <i>Practice Guidelines</i> standard, demonstrating that the CCO had established policies and procedures, along with the appropriate structure, to ensure that clinical practice guidelines were adopted, reviewed, updated, and disseminated. These guidelines took into account the needs of members and were based on evidence or on a consensus among providers in the relevant field. Additionally, decision-making was aligned with these guidelines.	 
	Weakness: AllCare received a score of 71.1 percent in the <i>Assurance of Adequate Capacity and Availability of Services</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements, the inability to demonstrate sufficient implementation of established processes, and deficiencies within its monitoring activities impacting the CCO’s ability to ensure timely access to care and services. Why the weakness exists: AllCare lacked a methodology for monitoring and maintaining its provider network for the federal and State required components. Additionally, the policies and procedures implemented did not fully align with State-established time and distance and appointment standards, reporting requirements, and provision of access, accommodations, and equipment for members with physical and mental disabilities. Also, the CCO failed to demonstrate monitoring the provider network against State-established time and distance and appointment standards, and taking corrective action when providers failed to meet appointment standards. Finally, the CCO failed to communicate the appropriate access to care and service requirements in its member and provider communications.	  

⁴⁹  = Quality,  = Timeliness,  = Access

Strength/ Weakness	Description	Domain(s) ⁴⁹
	Recommendations: AllCare should develop and implement a methodology for monitoring and maintaining its provider network for the federal and State-required components. Additionally, the CCO should revise its policies and procedures to align with State-established requirements for timely access to care and services and reporting and demonstrate implementation. The CCO should also demonstrate corrective action when providers fail to meet appointment standards. Finally, the CCO should revise its provider and member communications to include the appropriate access to care and service requirements.	
	Weakness: AllCare received a score of 75.0 percent in the <i>Provider Selection</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements and the inability to demonstrate sufficient implementation of established processes impacting the CCO's ability to meet federal and State requirements for selecting, retaining, and credentialing network providers. Why the weakness exists: AllCare lacked policies and procedures for selecting and retaining network providers. Additionally, the CCO did not follow its policy and procedure for organizational credentialing. The CCO also did not have a mechanism to ensure its provider selection processes did not inadvertently discriminate against providers. Recommendations: AllCare should develop written policies and procedures for selecting and retaining providers and adhere to its policy and procedure for organizational credentialing. The CCO should ensure its provider selection processes do not inadvertently discriminate against providers.	
	Weakness: AllCare received a score of 62.5 percent in the <i>Subcontractual Relationships and Delegation</i> standard due to insufficient documentation to support operations and ensure compliance with federal requirements for written agreements between the CCO and its subcontractors. Why the weakness exists: AllCare contracts with its subcontractors failed to include federally required language for written agreements with subcontractors. Recommendations: AllCare should revise its written agreements to align with federally required language for written agreements with subcontractors.	

Strength/ Weakness	Description	Domain(s) ⁴⁹
Performance Improvement Projects		
Statewide Mental Health Service Access Monitoring PIP		
	Strength: AllCare successfully continued the Implementation stage for the PIP, receiving a <i>Met</i> score for 100 percent of applicable evaluation elements in the PIP Validation Tool. In the Implementation stage, AllCare accurately reported baseline and RY 2 performance indicator data, identified and analyzed barriers to improving MH service access, carried out interventions to address those barriers, and refined interventions based on intervention evaluation results.	
	Strength: AllCare's RY 2 performance indicator results demonstrated sustained improvement in MH service access compared to baseline indicator results.	
Statewide Substance Use Disorder PIP		
	Strength: AllCare accurately reported baseline and RY 1 performance indicator data; identified and analyzed barriers for initiation, engagement, and treatment of alcohol and other drug use disorders; and began to carry out interventions to address those barriers.	
	Weakness: AllCare received a <i>Moderate Confidence</i> rating for overall confidence that the <i>Substance Use Disorder</i> PIP achieved significant improvement. Why the weakness exists: AllCare's RY 1 improvement noted for Indicator 2 (<i>Percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation</i>) results over BY was not statistically significant. Recommendations: AllCare should revisit root cause analyses identifying barriers to improving to determine which barriers to improvement were not effectively addressed. AllCare should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to further improve percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.	
Performance Measure Validation		
	Strength: AllCare's MY 2023 performance on the <i>Members Receiving Preventive Dental or Oral Health Services—Ages 1 to 5 Years</i> measure indicator demonstrated ongoing improvement, since MY 2021, increasing 4.1 percentage points since MY 2022. In addition, the CCO's MY 2023 rate for this age group exceeded the statewide aggregate and the benchmark set by OHA for MY 2023 by more than 5 percentage points (14.4 percentage points). The <i>Members Receiving Preventive</i>	

Strength/ Weakness	Description	Domain(s) ⁴⁹
	<i>Dental or Oral Health Services—Ages 6 to 14 Years</i> measure indicator exceeded the OHA benchmark by 5.1 percentage points.	
	Weakness: Though improvement was noted between MY 2022 and MY 2023, AllCare’s MY 2023 rate on the <i>Child and Adolescent Well-Care Visits—Ages 3 to 6 Years</i> measure indicator fell below the benchmark set by OHA for MY 2023 by 5 percentage points or more (6.5 percentage points). Why the weakness exists: In response to prior year recommendations, AllCare noted high staff turnover rates in provider offices leading to new staff training on utilization of gap lists and quality reports for member outreach. Recommendations: AllCare took several steps in MY 2023 to improve performance on this measure, increasing its performance rate in the measurement year by more than 6 percentage points. AllCare reported providing member gap lists and quality reports to provider offices to bring awareness and increase performance. Additionally, AllCare utilized a member incentive program encouraging parents/guardians to seek well-care visits for their children. AllCare appointed a team of provider engagement specialists to provide additional support to provider offices regarding quality measures, reporting, and general issue resolution. The provider engagement specialist team’s key goals were to boost network participation, enhance provider satisfaction, and reduce the administrative burden. AllCare should continue implementing these efforts to continue raising its rate on this measure to the level of the benchmarks set by OHA.	
	Weakness: Though improvement was noted between MY 2022 and MY 2023, AllCare’s MY 2023 rates on the <i>Initiation and Engagement of SUD Treatment</i> measure indicators for members ages 18 years and older fell below the statewide aggregate and the benchmark set by OHA for MY 2023. Though not incentivized, for members ages 13 to 17 years, AllCare’s performance declined 13.5 percentage points for the <i>Engagement of SUD Treatment</i> measure indicator, falling 14.7 percentage points below the statewide aggregate. Why the weakness exists: AllCare noted gaps in the quality, timeliness, and accessibility of SUD treatment services. Previously discussed gaps included: (1) the need for real-time hospital event notification to ensure members diagnosed with SUD are contacted by BH providers while in the hospital; and (2) the need for increased outreach to members diagnosed with SUD that have housing challenges and/or have not yet received BH services. Recommendations: AllCare reported continuing the strategies outlined in 2022 to improve measure performance for members ages 18 years and older. AllCare’s BH Clinical Transitions team continued sending real-time hospital event notifications to contracted BH providers to	

Strength/ Weakness	Description	Domain(s) ⁴⁹
	encourage outreach to members in the hospital. AllCare established working agreements with community-based organizations to leverage their peer specialists for outreach to members who are unhoused or lack housing security. AllCare should continue implementing these efforts to continue raising its rates on the <i>Initiation and Engagement of SUD Treatment</i> measure indicators for members ages 18 years and older to the level of the benchmarks set by OHA.	
Validation of Network Adequacy		
Network Adequacy Validation Audit		
	Strength: In addition to using standard processes to maintain member data such as researching 834 file processing errors daily and reconciliation enrollment against the monthly audit file and discrepancy report, AllCare implemented processes to report demographic changes for members within its service area via OHA's CCO Data Submission Tool. Additionally, AllCare's systems were able to capture member self-reported changes.	
	Strength: AllCare implemented a drive time and distance dashboard in June 2024 which tracked network adequacy percentages by provider type and tier month to month.	
Delivery System Network Evaluation		
	Weakness: AllCare's DSN Provider Narrative compliance scores overall (82.7 percent), and for the <i>Member Needs and Population Management</i> (75.0 percent) and <i>DSN Monitoring and Analysis</i> (80.0 percent) domains were less than 90 percent and the statewide CCO aggregate rates. This deficiency was also found in the CY 2020, CY 2021, CY 2022, and CY 2023 external quality reviews. Why the weakness exists: AllCare was not able to describe or demonstrate compliance with several key DSN monitoring and analysis requirements or describe and demonstrate use of collected data to inform network adequacy monitoring and decision making for certain services and populations. Recommendations: AllCare should ensure that all <i>DSN Provider Narrative Template</i> responses provide sufficient information to demonstrate that collected data are used to inform network adequacy monitoring and decision making.	
	Weakness: AllCare's provider network showed potential barriers to access to care for ALIM, PT, and SLP specialists. Why the weakness exists: ALIM, PT, and particularly SLP specialists showed low rates of active engagement in providing care to members. Recommendations: AllCare should evaluate and address the low rates of providers with active status.	

Strength/ Weakness	Description	Domain(s) ⁴⁹
	Weakness: AllCare did not meet the time and distance standards for PCD, M-ONC, and SLP providers serving adult members; for PCD, SUD, M-ONC, NEUR, SLP, and RHEU providers serving pediatric members; and for Rx and MTD facilities. Why the weakness exists: AllCare did not meet the adult (PCD, M-ONC, and SLP), pediatric (PCD, SUD, M-ONC, NEUR, SLP, and RHEU), and facility (Rx and MTD) network adequacy standards since fewer than 95 percent of its members were within acceptable travel times or distances for these provider types. Additionally, 0.0 percent of AllCare's pediatric members had access to SLP and RHEU providers since AllCare's provider network had not contracted with providers in these specialties. While AllCare had approved exceptions for PCD and RHEU providers, the CCO had not engaged in the exception request process with OHA for SUD, M-ONC, NEUR, or SLP providers. It is expected that the CCO have at least one provider of all monitored types within its network, regardless of compliance with time and distance standard compliance, rather than rely on single case agreements or similar methods. Recommendations: AllCare should ensure that it takes the necessary steps to maintain an adequate network that can provide all covered and necessary care. The CCO should work to contract with at least one provider of each missing type that can supply such services as part of the CCO's network, even if that provider is not within the service region. Such providers should still be meaningfully accessible through regional transportation (e.g., driving to a nearby population center). The CCO should engage with OHA on potential solutions for these needs, including engagement in OHA's time and distance exception request process for noncompliant provider types and populations.	
Revealed Telephone Survey		
	Strength: Among the total sampled cases, 95.0 percent of OP SUD locations were reached.	
	Strength: Among the cases accepting the CCO, 100 percent of OP SUD cases offered translation or interpreter services.	
	Strength: Of the PCP cases that offered an appointment for existing patients, 90.3 percent of routine visits and 96.6 percent of urgent visits were compliant with the wait time standards, respectively.	
	Strength: Of the OP SUD cases that offered an appointment, 100 percent of urgent visits and pregnant OP SUD visits were compliant with the wait time standards.	
	Weakness: Overall, 85.8 percent of the total PCP and OP SUD sampled cases were reached. Among the cases reached, 87.2 percent confirmed the correct location, 70.6 percent offered the requested	

Strength/ Weakness	Description	Domain(s) ⁴⁹
	services, 66.1 percent accepted OHP Medicaid, and 45.0 percent accepted AllCare. Also, 86.1 percent of PCP cases offered translation or interpreter services. Why the weakness exists: In addition to limitations related to the revealed survey approach, inaccuracies found in AllCare's provider data may have contributed to the low response rate and accuracy results. Recommendations: AllCare should use the case-level analytic data files to address the data deficiencies identified during the survey calls (e.g., incorrect or disconnected telephone numbers; incorrect location; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
	Weakness: Among the total PCP and OP SUD cases reached, 34.9 percent accepted new patients. In addition, appointment availability was only offered for less than 35.0 percent of PCP cases and 70.0 percent of OP SUD cases. Of the PCP appointments that were offered for new patients, 57.1 percent of routine visits and 62.5 percent of urgent visits were compliant with the wait time standards. Also, of the OP SUD appointments that were offered, 30.8 percent of routine visits and 83.3 percent of opioid use disorder treatment visits were compliant with the wait time standards. Why the weakness exists: In addition to limitations related to the revealed survey approach, inaccuracies found in AllCare's provider data and insufficient provider panel capacity may have contributed to low access and availability rates (i.e., new patient acceptance, appointment availability, and wait times). Also, internal office staffing structures and procedures may have contributed to the long wait times. Recommendations: AllCare should confirm appointment availability with providers, including panel capacity to accept new patients. Further, AllCare should use the case-level analytic data files to address data deficiencies identified during the survey calls.	
Encounter Data Validation		
Since EDV results were not available for inclusion in the 2024 EQR technical report, the strengths and weaknesses for each CCO could not be assessed. The findings will be incorporated in next year's EQR technical report.		
Mental Health Parity Evaluation		
	Weakness: AllCare showed a substantial difference in the percentage of paid, IP out-of-network MH/SUD claims compared to IP M/S claims. Although the difference in the percentage of paid claims may be legitimate, it may also highlight procedural or network differences, indicating potential barriers for members accessing MH/SUD services. Why the weakness exists: IP out-of-network MH/SUD claims were paid less frequently than M/S claims.	

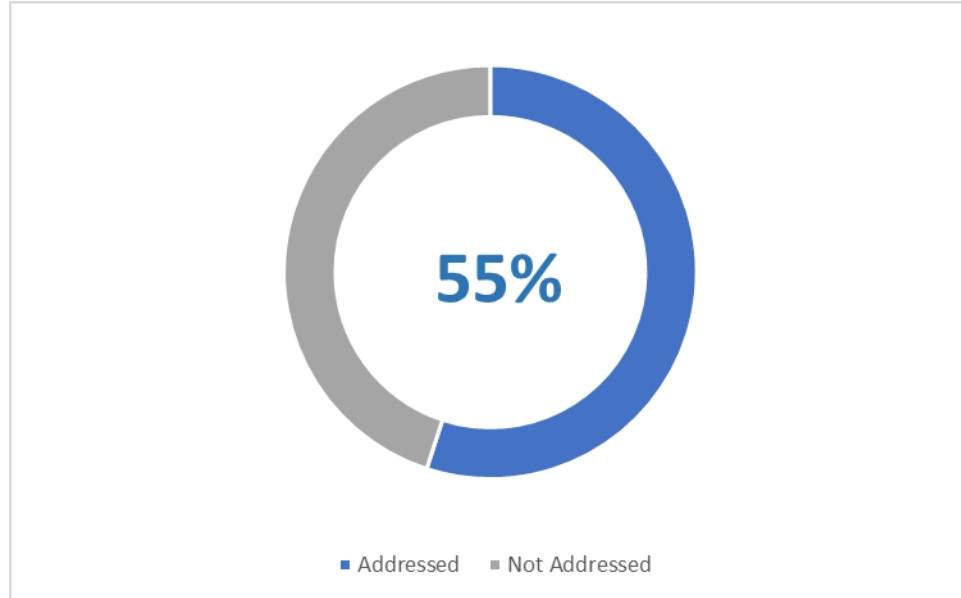
Strength/ Weakness	Description	Domain(s) ⁴⁹
	Recommendations: AllCare should review out-of-network claim denials to understand factors affecting the lower percentage of paid IP MH/SUD claims compared to IP M/S claims. The CCO should assess whether any barriers exist for members accessing MH/SUD services, including the need to seek services outside of the CCO's network (e.g., appointment availability).	

Follow-Up on Prior Year Recommendations

HSAG evaluated AllCare's approach to addressing the recommendations related to findings issued during CY 2023 and unresolved findings from CY 2020, CY 2021, and CY 2022 while conducting the CY 2024 EQR activities. The CCOs not addressing recommendations are at risk of being out of compliance with their contracts.

Figure 5-4 illustrates the degree in which the CCO sufficiently addressed the recommendations for QI made by HSAG during the CY 2023 EQR.

Figure 5-4—Percentage of CY 2023 EQR Recommendations Addressed by AllCare



AllCare-specific CY 2023 recommendations and follow-up CY 2024 assessments are summarized in Table 5-4.

Table 5-4—Assessment of AllCare’s Approach to Addressing Previous Annual Recommendations

CY 2023 Recommendation	CY 2024 Assessment
Compliance Monitoring Review	
Standard I—Assurance of Adequate Capacity and Availability of Services*	
This recommendation was initially given during the CY 2021 EQR. AllCare should revise policies and procedures, member and provider communications, and auditing tools to include complete and accurate network access information. In addition, AllCare should ensure processes include ongoing monitoring of provider network compliance and corrective actions when providers fail to meet network access requirements. The CCO should also provide and document oversight of subcontractors to ensure compliance with monitoring and corrective action requirements.	AllCare did not sufficiently address the recommendation. AllCare did not demonstrate its provider and member materials include the correct BH and specialty BH access standards. Additionally, AllCare did not demonstrate collecting the appropriate data to monitor providers’ compliance with the State-required appointment standards and corrective action when providers failed to meet the requirements. Note: Standard I—Assurance of Adequate Capacity and Availability of Services was comprehensively reviewed during the CY 2024 CMR cycle, and recommendations addressing all findings related to this standard are included in the CCO’s individual Results and Conclusions section.
Standard III—Coordination and Continuity of Care	
AllCare should revise its policies and procedures to align with State requirements. AllCare should also demonstrate implementation of appropriate assessments, reassessments, and revision of treatment plans according to federal and State requirements.	AllCare sufficiently addressed the recommendation.
Standard IV—Coverage and Authorization of Services	
AllCare should revise its policies and procedures to align with federal and State requirements. AllCare should also demonstrate implementation of appropriate service offerings and consistent application of medical necessity criteria according to federal and State requirements. AllCare should also demonstrate adherence to federal and State required time frames for NOABDs.	AllCare did not sufficiently address the recommendation. AllCare did not demonstrate an enhanced process to ensure that decision-makers who deny an authorization request have the appropriate expertise in treating the member’s needs. The CCO also did not demonstrate monitoring its subcontractors’ compliance with time frames for authorizations. AllCare should develop processes to ensure alignment with federal and State requirements. AllCare should also demonstrate adherence to federal and State required time frames for authorization decisions.
Standard V—Provider Selection	
This standard was not assessed during the 2023 CMR.	Not applicable.

CY 2023 Recommendation	CY 2024 Assessment
Standard VI—Subcontractual Relationships and Delegation	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard VII—Member Rights and Protections	
AllCare should revise its policies and procedures and member- and provider-facing materials to align with federal and State requirements.	AllCare did not sufficiently address the recommendation. AllCare’s policies and procedures did not align with federal and State requirements for advance directives. AllCare should revise its policies and procedures to align with federal and State requirements for advance directives.
Standard VIII—Confidentiality	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Standard IX—Enrollment and Disenrollment	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Standard X—Grievance and Appeal Systems	
AllCare should revise its policies and procedures to align with federal and State requirements. AllCare should also demonstrate implementation of federal and State requirements within staff messaging. AllCare should also demonstrate adherence to federal and State requirements for decision-makers on clinically related grievances, time frames for acknowledging receipt of grievances, and the readability of notices. AllCare should also demonstrate implementation of federal and State requirements within communications to members, providers, and subcontractors.	AllCare did not sufficiently address the recommendation. Although AllCare revised its policies and procedures, the CCO did not demonstrate enhanced processes to ensure adherence to federal and State time frames for acknowledgement and resolution of grievances and appropriate decision-makers on clinically related grievances. AllCare should demonstrate enhanced processes to ensure adherence to federal and State requirements for decision-makers on clinically related grievances, and time frames for acknowledging receipt of and resolution of grievances.
Standard XI—Practice Guidelines	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard XII—Quality Assessment and Performance Improvement	
This recommendation was initially given during the CY 2022 EQR. AllCare’s QAPI program remained out of compliance with federal and State requirements for a QAPI program, including lack of mechanisms to access the	AllCare sufficiently addressed the recommendation.

CY 2023 Recommendation	CY 2024 Assessment
quality and appropriateness of members with SHCN. AllCare also failed to demonstrate a QI committee that met the State requirements, including approval of the annual quality strategy. AllCare should revise its QAPI program structure to align with federal and State requirements for a QAPI program. AllCare should also demonstrate appropriate oversight of its QAPI program.	
Standard XIII—Health Information Systems, including ISCA	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Standard XIV—Member Information	
AllCare should revise its policies, procedures, and member-facing materials to align with federal and State requirements. AllCare should also demonstrate monitoring for timeliness of notification to members of significant information changes and providing proper notification to members of the availability of member information.	AllCare did not sufficiently address the recommendation. AllCare did not demonstrate the appropriate updates to align with federal and State requirements for provider directories. AllCare also did not demonstrate the appropriate time frame of notification to members of the availability of the member handbook and provider directory. AllCare should revise its processes to align with federal and State requirements. AllCare should also demonstrate the appropriate time frame of notification to members of the availability of member information.
Standard XVI—Emergency and Poststabilization Services	
AllCare should demonstrate evidence of processes to ensure payment of emergency and poststabilization services.	AllCare sufficiently addressed the recommendation.
Performance Improvement Projects	
Statewide Mental Health Service Access Monitoring PIP	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Statewide Substance Use Disorder PIP	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Performance Measure Validation	
AllCare should conduct root cause analyses to identify specific factors affecting performance on the <i>Child and Adolescent Well-Care Visits—Ages 3 to 6 Years</i> measure indicator. Once identified,	AllCare sufficiently addressed the recommendation. AllCare addressed the recommendations provided by HSAG and continued its efforts to improve performance in

CY 2023 Recommendation	CY 2024 Assessment
targeted interventions should be developed, implemented, and evaluated to ensure effective improvement strategies are adopted to increase performance over time. Additionally, AllCare should continue to monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches to ensuring the quality, timeliness, and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	this measure, which included providing member gap lists and quality reports to provider offices to bring awareness and increase performance; utilizing a member incentive program encouraging parents/guardians to seek well-care visits for their child(ren); and appointing a team of provider engagement specialists to provide additional support to provider offices regarding quality measures, reporting, and general issue resolution. AllCare should continue implementing these efforts to continue raising its rates on this measure to the level of the benchmarks set by OHA.
AllCare took several steps in 2022 to improve performance on the <i>Initiation of SUD Treatment</i> and <i>Engagement of SUD Treatment</i> measure indicators for members ages 18 years and older. AllCare’s BH Clinical Transitions team sent real-time hospital event notifications to contract BH providers to encourage outreach to members in the hospital. AllCare established working agreements with community-based organizations to leverage their peer specialists for outreach to members who are homeless or have housing challenges. Lastly, AllCare reimbursed BH providers for outreach to members in the pre-engagement or pre-contemplation stages of SUD treatment, as allowed by OHA. AllCare should continue implementing these efforts to raise its rates on these measure indicators for members 18 years and older to the level of the benchmarks set by OHA.	AllCare sufficiently addressed the recommendation. AllCare addressed recommendations provided by HSAG and continued its efforts to improve performance in this measure, which included the BH Clinical Transitions team sending real-time hospital event notifications to contracted BH providers to encourage outreach to members in the hospital and continued establishing working agreements with community-based organizations to leverage their peer specialists for outreach to members who are unhoused or lack housing security. AllCare should continue implementing these efforts to continue raising its rates on the <i>Initiation and Engagement of SUD Treatment</i> measure indicators for members 18 years and older to the level of the benchmarks set by OHA.
Validation of Network Adequacy	
Delivery System Network Evaluation	
This recommendation was initially given during the CY 2020 EQR. AllCare should ensure that all <i>DSN Provider Narrative Template</i> responses are directly relevant to the element being answered and provide sufficient information to demonstrate that collected data are used to inform network adequacy monitoring and decision-making.	AllCare sufficiently addressed the recommendation. While results from the CCO’s 2024 DSN Provider Narrative may have similar scores to the 2023 DSN Provider Narrative in some respects, the overall quality of submitted documentation and implementation of targeted efforts clearly demonstrated the CCO’s intentionality in addressing prior issues. AllCare should continue its efforts to improve the quality of its network adequacy monitoring and DSN submissions.

CY 2023 Recommendation	CY 2024 Assessment
AllCare should ensure it is collecting and reporting provider data accurately and provide an explanation addressing both noncompliance with State time and distance standards as well as the low rates of providers accepting new patients.	AllCare sufficiently addressed the recommendation. AllCare provided documentation and narrative responses addressing time and distance compliance as well as accurate and timely provider data collection and reporting via new information technology infrastructure investments and staffing. AllCare should continue to monitor its time and distance compliance.
Secret Shopper Survey	
HSAG recommends that AllCare confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. AllCare should use the case-level analytic data files containing data deficiencies identified during the secret shopper survey calls.	AllCare did not sufficiently address the recommendation. AllCare did not confirm appointment availability and scheduling procedures with providers or address the data deficiencies identified in the survey as the CCO is currently looking to contract with a third-party vendor. AllCare should continue to monitor and improve any efforts in maintaining accurate provider data and confirm appointment availability and scheduling procedures with providers.
Revealed Telephone Survey	
HSAG recommends that AllCare use the case-level analytic data files to address the data deficiencies identified during the revealed telephone survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, program information, and translation/interpreter services offered).	AllCare did not sufficiently address the recommendation. AllCare did not address the data deficiencies identified in the survey as the CCO is currently looking to contract with a third-party vendor. AllCare should continue to monitor and improve any efforts in maintaining accurate provider data (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information). At a minimum, the CCO should use the case-level analytic data files to address deficiencies identified during the revealed telephone survey calls.
HSAG recommends that AllCare confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. AllCare should use the case-level analytic data files containing data deficiencies identified during the revealed telephone survey calls and work with BH outpatient offices to identify the root cause for delays in appointment availability.	AllCare did not sufficiently address the recommendation. AllCare did not confirm appointment availability and scheduling procedures with providers as the CCO is currently looking to contract with a third-party vendor. AllCare should continue to monitor and improve any efforts in maintaining accurate provider data and confirm appointment availability and scheduling procedures with providers.

CY 2023 Recommendation	CY 2024 Assessment
Encounter Data Validation	
This recommendation was initially given during the CY 2022 EQR. AllCare should consider providing more specific details on the frequency and scope of the provider audits, as well as any plans for continuous monitoring and improvement based on the audit findings to fully address the recommendation. Additionally, AllCare should mention any specific educational topics covered in the training opportunities offered to providers.	AllCare sufficiently addressed the recommendation.
HSAG recommends that AllCare and Capitol Dental/Ayin consider implementing measures to ensure proper handling of data during system migrations. This could involve refining data extraction protocols and conducting thorough data validation checks post-migration to mitigate the risk of high omission rates. Additionally, establishing a comprehensive communication plan between AllCare and its subcontractor, Capitol Dental/Ayin, during such changes could help in preventing oversights and ensuring data accuracy.	AllCare did not sufficiently address the recommendation. AllCare and Ayin have partially addressed the recommendation by identifying the issue and committing to a solution with a consolidated system. However, the response lacked details on refined protocols, validation processes, or communication plans to ensure such errors do not recur. Implementing these measures would fully address the recommendation.
Mental Health Parity Evaluation	
AllCare should ensure that submitted descriptions and supplemental documentation are inclusive of all treatment limitations used by the CCO to manage MH/SUD benefits and to demonstrate parity with the treatment limitations applied to M/S benefits. Responses should address the writing prompt questions in the tool related to the CCO's rationale for the NQTL; the procedures, processes, and requirements used to apply the NQTL; the frequency and strictness of the NQTL; and the evidentiary standards to support the rationale for how frequently and strictly the NQTL is applied. In addition, AllCare should ensure that individuals completing the <i>MHP Treatment Limitation Review Tool</i> attend the MHP technical assistance webinar and that they request additional assistance, as needed, to ensure their understanding of the requirements.	AllCare sufficiently addressed the recommendation.

CY 2023 Recommendation	CY 2024 Assessment
AllCare should identify processes, strategies, evidentiary standards, and other factors used in formulary design and application for pharmacy management NQTLs.	AllCare sufficiently addressed the recommendation.
AllCare should review out-of-network claim denials to understand factors affecting the lower percentage of paid MH/SUD IP claims compared to M/S IP claims. AllCare should assess whether any barriers exist for members accessing MH/SUD services, including the need to seek services outside of the CCO's network (e.g., appointment availability).	AllCare sufficiently addressed the recommendation. AllCare reported completing a review of CCO out-of-network claims denials and assessed barriers for MH/SUD IP services. The CCO determined there are no access issues as members are able to access all MH/SUD IP and hospital services statewide. AllCare reported that, while members are able to access out-of-network facilities, the IP facilities and hospital staff were not informing the CCO of admissions leading to denials. AllCare also reported increasing its education and communication with out-of-network facilities. However, AllCare received a weakness related to M/S and MH/SUD IP claims denial differences during the CY 2024 MHP Evaluation, and HSAG recommends continued efforts to educate out-of-network facilities to inform the CCO of admissions. This will be assessed again during the CY 2025 MHP Evaluation.

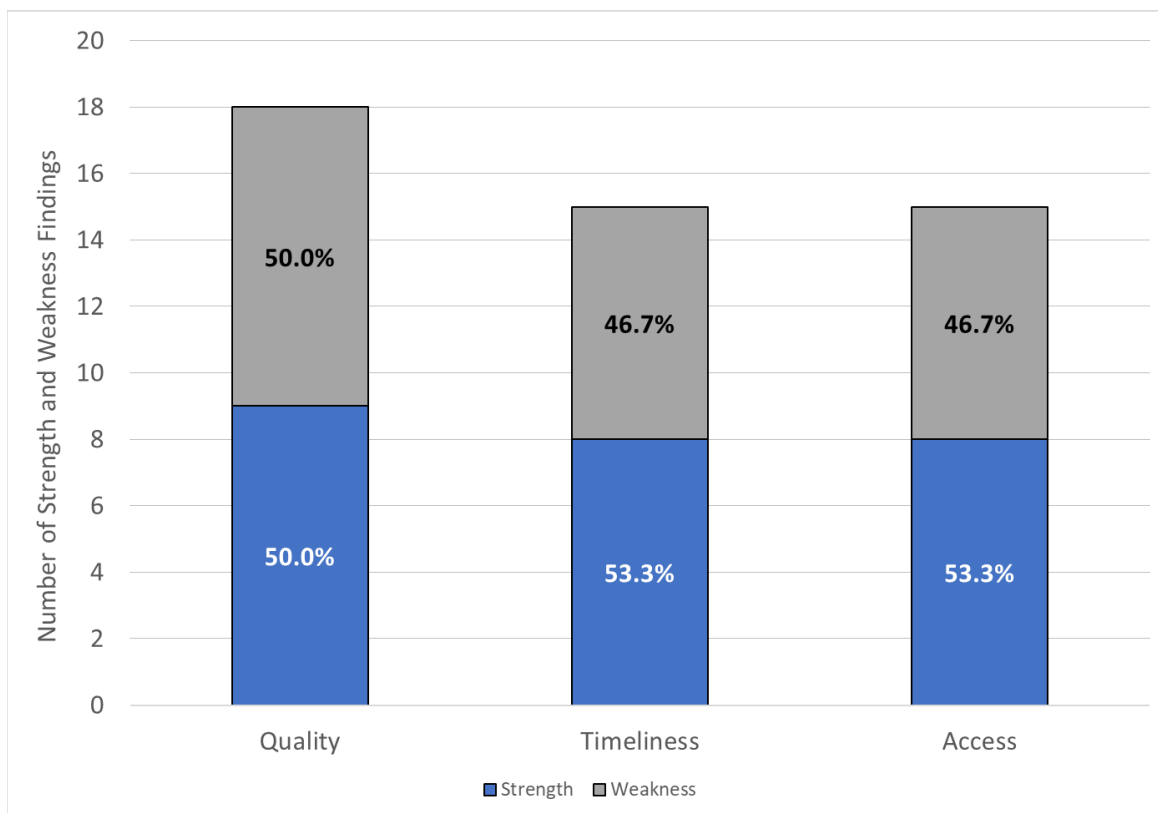
*Standard I—Availability of Services and Standard II—Assurances of Adequate Capacity and Services were combined, and all elements required by 42 CFR §438.206 and §438.207 were assessed under the combined Standard I—Assurance of Adequate Capacity and Availability of Services during the CY 2024 CMR activity.

Cascade Health Alliance, LLC

Results and Conclusions

HSAG assessed the strengths and weaknesses of each CCO with respect to the quality, timeliness, and accessibility of health care services. Figure 5-5 illustrates the number of strengths exhibited by CHA relative to the number of weaknesses identified during the CY 2024 EQR activities across the three domains. The greater the proportion of weaknesses, the greater opportunities for improvement.

Figure 5-5—CHA Overall Number of Findings (Strengths and Weaknesses) by Domain



Detailed results from the EQR’s substantive findings are summarized in Table 5-5 for each activity. This table highlights the extent to which CHA furnishes high quality, timely, and appropriate access to health care services, and recommendations for how CHA can best address issues identified for each activity.⁵⁰

⁵⁰ See Section 4—Comparative Statewide Results for detailed, CCO-specific scores associated with EQR activity.

Table 5-5—CHA Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s) ⁵¹
Compliance Monitoring Review		
	Strength: CHA demonstrated best practices by monitoring hours of operation through its secret shopper survey.	  
	Strength: CHA demonstrated best practices by employing a methodology that included assessing all network providers for wait time to appointments and an established procedure for conducting follow-up outreach to providers to fill in gaps in the survey responses.	  
	Strength: CHA demonstrated best practices by including a specific element for making determinations based upon appropriate practice guidelines in the CCO's interrater reliability tool.	 
	Strength: CHA demonstrated best practices by having the medical director review all member education materials that are clinical in nature to ensure alignment with the CCO's clinical practice guidelines.	 
	Weakness: CHA received a score of 71.1 percent in the <i>Assurance of Adequate Capacity and Availability of Services</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements, inability to demonstrate sufficient implementation of established processes, and deficiencies within its monitoring activities impacting the CCO's ability to ensure timely access to care and services. Why the weakness exists: CHA lacked a comprehensive process for monitoring and maintaining its provider network for the federal and State-required components. Additionally, the policies and procedures implemented did not fully align with State-established time and distance standards, timely access to care and service appointment standards, reporting requirements, and provision of access, accommodations, and equipment for members with physical and mental disabilities. Although the CCO demonstrated best practices with surveying all providers within its network, the CCO failed to demonstrate the collection of data to monitor all appointment standards. The CCO also failed to take corrective action when providers failed to meet appointment standards. Finally, the CCO failed to include the appropriate access to care and service requirements in its policies, procedures, and member and provider communications.	  

⁵¹  = Quality,  = Timeliness,  = Access

Strength/ Weakness	Description	Domain(s) ⁵¹
	Recommendations: CHA should develop and implement a process for monitoring and maintaining its provider network for the federal and State-required components. Additionally, the CCO should revise its policies and procedures to align with State-established requirements for its provider network and reporting and demonstrate implementation. The CCO should also demonstrate the implementation of corrective action when providers fail to meet standards. Finally, the CCO should revise its policies, procedures, and member and provider communications to include the appropriate access to care and service requirements.	
	Weakness: CHA received a score of 58.3 percent in the <i>Provider Selection</i> standard due to insufficient documentation to support operations and ensure compliance, the inability to demonstrate sufficient implementation of established processes, and failure to conduct appropriate monitoring, impacting the CCO’s ability to meet federal and State requirements for selecting, retaining, credentialing, and recredentialing network providers. Why the weakness exists: CHA lacked policies and procedures for selecting and retaining network providers. Additionally, the policies and procedures implemented did not fully align with State requirements for credentialing and recredentialing providers and included conflicting information on notification time frames for denial notifications. Additionally, the CCO failed to adhere to the State-established time frame for recredentialing and lacked ongoing monitoring of recredentialing timeliness. The CCO also did not have a mechanism to ensure its provider selection processes did not inadvertently discriminate against providers. Recommendations: CHA should develop written policies and procedures for selecting and retaining providers. Additionally, the CCO should ensure its credentialing and recredentialing policies and procedures align with State requirements. The CCO should also demonstrate adherence to the State’s required recredentialing time frame and conduct ongoing monitoring to ensure compliance. Finally, the CCO should ensure its provider selection processes do not inadvertently discriminate against providers.	
	Weakness: CHA received a score of 62.5 percent in the <i>Subcontractual Relationships and Delegation</i> standard due to insufficient documentation to support operations and ensure compliance with federal requirements for written agreements between the CCO and its subcontractors. Why the weakness exists: CHA’s contracts with the subcontractors failed to include federally required language for written agreements with subcontractors. Additionally, the CCO	

Strength/ Weakness	Description	Domain(s) ⁵¹
	failed to demonstrate that it conducts the appropriate oversight and monitoring of its subcontractors. Recommendations: CHA should revise its written agreements to align with federally required language for written agreements with subcontractors. The CCO should also ensure that it conducts appropriate oversight and monitoring of its subcontractors.	
—	Weakness: CHA received a score of 83.3 percent in the <i>Practice Guidelines</i> standard due to the inability to demonstrate sufficient implementation of established processes, impacting the CCO's ability to disseminate the appropriate clinical practice guidelines. Why the weakness exists: CHA failed to comply with its procedures for disseminating practice guidelines to its members. Recommendations: CHA should ensure compliance with its procedures for disseminating practice guidelines to its members.	 
Performance Improvement Projects		
Statewide Mental Health Service Access Monitoring PIP		
+	Strength: CHA successfully continued the Implementation stage for the PIP, receiving a <i>Met</i> score for 100 percent of applicable evaluation elements in the PIP Validation Tool. In the Implementation stage, CHA accurately reported baseline and RY 2 performance indicator data, identified and analyzed barriers to improving MH service access, carried out interventions to address those barriers, and refined interventions based on intervention evaluation results.	
+	Strength: CHA's RY 2 performance indicator results demonstrated statistically significant improvement in MH service access compared to baseline indicator results.	 
Statewide Substance Use Disorder PIP		
+	Strength: CHA accurately reported baseline and RY 1 performance indicator data; identified and analyzed barriers for initiation, engagement, and treatment of alcohol and other drug use disorders; and began to carry out interventions to address those barriers.	
—	Weakness: CHA received a <i>Low Confidence</i> rating for overall confidence that the <i>Substance Use Disorder</i> PIP achieved significant improvement. Why the weakness exists: CHA's improvement in Indicator 1 (<i>Percentage of new SUD episodes that result in treatment and initiation within 14 days</i>) result from baseline to RY 1 was not statistically significant. In addition, the CCO's performance for Indicator 2 (<i>Percentage of new SUD episodes that have evidence of</i>	  

Strength/ Weakness	Description	Domain(s) ⁵¹
	<i>treatment engagement within 34 days of initiation</i>) declined from BY to RY 1. Recommendations: CHA should revisit root cause analyses identifying barriers to improving initiation, engagement, and treatment of alcohol and other drug use disorders to determine which barriers to improvement were not effectively addressed. CHA should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to further improve the percentage of new SUD episodes that result in treatment and initiation within 14 days and the percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation indicator results.	
Performance Measure Validation		
	Strength: CHA's MY 2023 performance on the <i>Child and Adolescent Well-Care Visits—Ages 3 to 6 Years</i> measure improved by more than 5 percentage points compared to MY 2022 (9.6 percentage points).	
	Strength: CHA's MY 2023 rate for the <i>Initiation of SUD Treatment</i> measure indicator for members ages 13 to 17 years exceeded the statewide aggregate by more than 5 percentage points. For members ages 18 years and older, CHA's MY 2023 rate for the <i>Initiation of SUD Treatment</i> measure indicator continued to improve, exceeding both the statewide aggregate and the benchmark set by OHA for MY 2023.	
	Strength: CHA's MY 2023 performance on the <i>Members Receiving Preventive Dental or Oral Health Services</i> measure demonstrated ongoing improvement, exceeding the benchmark set by OHA for MY 2023 by 5 percentage points or more for both members ages 1 to 5 years and members ages 6 to 14 years.	
	Weakness: CHA's MY 2023 performance on the <i>Engagement of SUD Treatment</i> measure indicator declined by more than 5 percentage points (8.0 percentage points) since MY 2022 among members ages 13 to 17 years, falling below the statewide aggregate. Why the weakness exists: Although CHA's eligible population from this measure decreased from MY 2022 to MY 2023, numerator counts also declined, resulting in the decreased rate. The statewide aggregate for this measure increased from MY 2022, indicating overall statewide improvement, to which CHA was unable to match for 2023. Recommendations: CHA took several steps in MY 2023 to improve performance on this measure. CHA established validation mechanisms in the Business Intelligence (BI) and Quality	

Strength/ Weakness	Description	Domain(s) ⁵¹
	Management (QM) departments. CHA developed internal processes for QM deliverables. The quality training coordinator conducted monthly check-ins with providers to foster engagement and identify access to care gaps, as well as provide training sessions focused on metrics and clinic-level interactions. Tracking mechanisms were developed to document provider interactions and educational activities while implementing a more consistent process to maintain data integrity. CHA monitored progress during various monthly meetings, including Metrics and Quality Improvement Committee meetings. Dashboards and individual performance discussions took place with providers. CHA should continue implementing these efforts to continue raising its rates on this measure to the level of the benchmarks set by OHA.	
	Weakness: CHA's MY 2023 performance on the <i>Oral Evaluation for Adults With Diabetes</i> measure placed below the statewide aggregate and the benchmark set by OHA for MY 2023 by 5 percentage points or more; 6.7 percentage points below the statewide aggregate and 6.3 percentage points below benchmark. Why the weakness exists: CHA's MY 2023 performance on this measure indicator was not at the level of CCOs statewide (i.e., CHA's rate was below the statewide aggregate rate) and did not meet the performance threshold set by OHA. Recommendations: CHA should conduct root cause analyses to identify specific factors affecting performance. Once identified, targeted interventions should be developed, implemented, and evaluated to ensure effective improvement strategies are adopted to increase performance over time. Additionally, CHA should continue to monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches to ensuring the quality, timeliness, and accessibility of health care services (e.g., mobile clinics).	
Validation of Network Adequacy		
Network Adequacy Validation Audit		
	Strength: To maintain accuracy and continuity of knowledge, CHA maintained a policy and procedure document for the network adequacy time and distance calculation process.	

Strength/ Weakness	Description	Domain(s) ⁵¹
Delivery System Network Evaluation		
	Weakness: CHA's provider data indicated that several potential barriers to care existed, including no DME, GST, MTD, NEPH, or OT providers within the network, and low percentages of contracted PCDs and SUD providers located within the service region. Why the weakness exists: Less than 60 percent of PCDs and less than 70 percent of SUD providers were located within the service region. The CCO stated that it did not have any DME, GST, MTD, NEPH, or OT providers available for contracting within or near its service region. However, it is expected that the CCO would have at least one provider of all monitored types within its network, regardless of time and distance standards compliance, rather than rely on single case agreements or similar methods. Additionally, CHA did not meet time and distance access adult, pediatric, and facility network adequacy standards for 12 individual and facility provider types across all tiers. Further, CHA had not engaged in OHA's time and distance exception request process for any noncompliant provider types. Recommendations: CHA should continue to explore and implement strategies to address the providers absent from the network and region, including but not limited to strategies described within its <i>DSN Provider Narrative Template</i> submission, such as rotating specialty provider practices and recruiting efforts. Additionally, CHA should work to contract with at least one provider or facility of each missing type that can supply such services as part of the CCO's network, even if that provider is not within the service region. Such providers should still be meaningfully accessible through regional transportation (e.g., driving to a nearby population center). The CCO should engage with OHA on potential solutions for these needs, including engagement in OHA's time and distance exception request process for noncompliant provider types and populations.	
Revealed Telephone Survey		
	Strength: Of the PCP cases that accepted the CCO, 100 percent offered translation or interpreter services.	
	Weakness: Overall, 77.8 percent of the total PCP and OP SUD sampled cases were reached. Among the PCP and OP SUD cases reached, 78.6 percent confirmed the correct location and 57.1 percent offered the requested services. Of note, since CHA had no OP SUD cases that provided the requested services, insurance and access and availability information were not confirmed. In addition,	

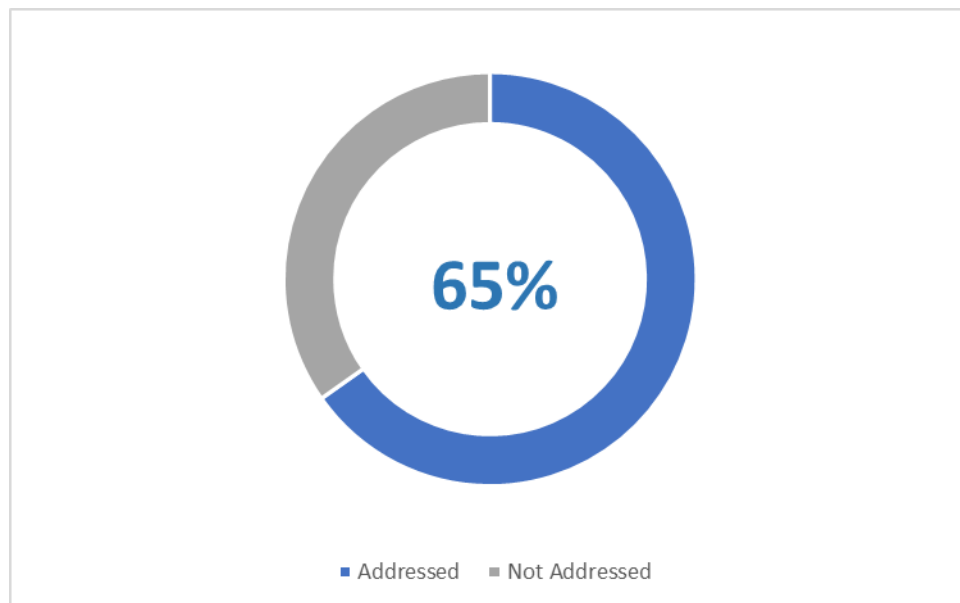
Strength/ Weakness	Description	Domain(s) ⁵¹
	among the PCP cases reached, 77.8 percent accepted OHP and CHA. Why the weakness exists: In addition to limitations related to the revealed survey approach, inaccuracies found in CHA’s provider data may have contributed to the low response rate and accuracy results. Recommendations: CHA should use the case-level analytic data files to address the data deficiencies identified during the survey calls (e.g., incorrect or disconnected telephone numbers; incorrect location; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
	Weakness: Among the PCP cases reached, 55.6 percent accepted new patients. In addition, appointment availability was only offered for less than 67.0 percent of PCP cases. OP SUD appointment availability was not assessed due to the CCO having no SUD cases in the sample that provided OP services. Of the PCP appointments that were offered, 50.0 percent of new patient routine visits, 66.7 percent of existing patient routine visits, and 83.3 percent of existing patient urgent visits were compliant with the wait time standards. Why the weakness exists: In addition to limitations related to the revealed survey approach, inaccuracies found in CHA’s provider data and insufficient provider panel capacity may have contributed to low access and availability rates (i.e., new patient acceptance, appointment availability, and wait times). Also, internal office staffing structures and procedures may have contributed to the long wait times. Recommendations: CHA should confirm appointment availability with providers, including panel capacity to accept new patients. Further, CHA should use the case-level analytic data files to address data deficiencies identified during the survey calls.	  
Encounter Data Validation		
Since EDV results were not available for inclusion in the 2024 EQR technical report, the strengths and weaknesses for each CCO could not be assessed. The findings will be incorporated in next year’s EQR technical report.		
Mental Health Parity Evaluation		
The CCO met performance expectations. No significant strengths or weaknesses were noted during the review.		

Follow-Up on Prior Year Recommendations

HSAG evaluated CHA’s approach to addressing the recommendations related to findings issued during CY 2023 and unresolved findings from CY 2020, CY 2021, and CY 2022 while conducting the CY 2024 EQR activities. The CCOs not addressing recommendations are at risk of being out of compliance with their contracts.

Figure 5-6 illustrates the degree in which the CCO sufficiently addressed the recommendations for QI made by HSAG during the CY 2023 EQR.

Figure 5-6—Percentage of CY 2023 EQR Recommendations Addressed by CHA



CHA-specific CY 2023 recommendations and follow-up CY 2024 assessments are summarized in Table 5-6.

Table 5-6—Assessment of CHA’s Approach to Addressing Previous Annual Recommendations

CY 2023 Recommendation	CY 2024 Assessment
Compliance Monitoring Review	
<i>Standard I—Assurance of Adequate Capacity and Availability of Services*</i>	
This recommendation was initially given during the CY 2021 EQR. CHA should revise policies, procedures, and other documents to include complete and accurate network access information. In addition, CHA should ensure processes include ongoing monitoring of provider network compliance and corrective actions when	CHA did not sufficiently address the recommendation. CHA did not demonstrate monitoring its provider network in accordance with state-established requirements, including monitoring the appropriate provider types and specialty providers by individual specialty, and ensuring the sufficiency of its provider network to

CY 2023 Recommendation	CY 2024 Assessment
providers fail to meet network access requirements. Lastly, CHA should develop a documented process for monitoring provider capacity that includes monitoring specialty providers individually by specialty type, and ensure its network evaluation incorporates key data collected from its monitoring processes and is sufficient in evaluating the needs of its membership.	provide adequate access to all services covered under the contract for all members. CHA also did not demonstrate collecting the appropriate data to access compliance with appointment access standards outline by the State. The CCO also did not demonstrate corrective action when providers failed to meet compliance. Note: Standard I—Assurance of Adequate Capacity and Availability of Services was comprehensively reviewed during the CY 2024 CMR cycle, and recommendations addressing all findings related to this standard are included in the CCO’s individual Results and Conclusions section.
Standard III—Coordination and Continuity of Care	
CHA should revise its policies and procedures to align with State requirements. CHA should also demonstrate implementation of appropriate initial health risk screenings, assessments, and reassessments according to federal and State requirements.	CHA did not sufficiently address the recommendation. Although CHA demonstrated revising its policies and procedures to meet some federal and State requirements, the CCO did not demonstrate a process for ongoing health risk assessment (HRA) completion monitoring. CHA should develop and implement a process to monitor HRA completion on an ongoing basis.
Standard IV—Coverage and Authorization of Services	
CHA should revise its policies and procedures to align with federal and State requirements. CHA should demonstrate adherence to federal and State requirements for authorization of services and required content and time frames for providing NOABDs.	CHA sufficiently addressed the recommendation.
Standard V—Provider Selection	
This recommendation was initially given during the CY 2021 EQR. CHA should implement an effective credentialing program that includes recredentialing of providers no less than every three years. The CCO should also ensure proper training of staff and participating providers and their staff as required by the CCO Contract.	CHA did not sufficiently address the recommendation. CHA continued to recredential providers outside of the three-year recredentialing time frame required by the State. Note: Standard V—Provider Selection was comprehensively reviewed during the CY 2024 CMR cycle, and recommendations addressing all findings related to this standard are included in the CCO’s individual Results and Conclusions section.
Standard VI—Subcontractual Relationships and Delegation	
This standard was not assessed during the 2023 CMR.	Not applicable.

CY 2023 Recommendation	CY 2024 Assessment
Standard VII—Member Rights and Protections	
CHA should revise its policies and procedures and member- and provider-facing materials to align with federal and State requirements.	CHA sufficiently addressed the recommendation.
Standard VIII—Confidentiality	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Standard IX—Enrollment and Disenrollment	
This recommendation was initially given during the CY 2022 EQR. CHA should revise its training provided to staff to align with federal and State requirements. CHA should also demonstrate oversight and monitoring of disenrollment reasons to ensure compliance with the regulatory requirements.	CHA sufficiently addressed the recommendation.
Standard X—Grievance and Appeal Systems	
CHA should revise its policies and procedures to align with federal and State requirements. CHA should also demonstrate adherence to federal and State requirements for time frames for acknowledging and responding to grievances and appeals, and the readability and required content of notices. CHA should also demonstrate implementation of federal and State requirements within communications to members, providers, and subcontractors.	CHA did not sufficiently address the recommendation. Although CHA revised its policies to include some of the requirements, the policy continued to omit the required components. CHA should revise its policies and procedures to align with federal and State requirements for grievance and appeal records.
Standard XI—Practice Guidelines	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Standard XII—Quality Assessment and Performance Improvement	
This recommendation was initially given during the CY 2022 EQR. CHA should revise its QAPI program structure to align with federal and State requirements for a QAPI program. CHA should also identify a defined process or mechanism to evaluate the LTSS population and/or relevant subpopulations for the appropriate care. CHA should also demonstrate appropriate oversight of its QAPI program.	CHA sufficiently addressed the recommendation.

CY 2023 Recommendation	CY 2024 Assessment
Standard XIII—Health Information Systems, including ISCA	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Standard XIV—Member Information	
CHA should revise its policies, procedures, and member-facing materials to align with federal and State requirements.	CHA did not sufficiently address the recommendation. CHA did not demonstrate the appropriate information regarding whether the CCO’s structure, operations, and physician incentive plans were readily available to provide to members. The CCO also had not implemented the appropriate requirements for its provider handbook. Additionally, CHA did not demonstrate that it provides member information in the preferred method for its members. CHA should revise its processes and member-facing materials to align with federal and State requirements.
Standard XVI—Emergency and Poststabilization Services	
CHA should revise the applicable plan documents to define “emergency and poststabilization services” and communicate the appropriate requirements.	CHA sufficiently addressed the recommendation.
Performance Improvement Projects	
Statewide Mental Health Service Access Monitoring PIP	
CHA should revisit root cause analyses identifying barriers to improving access to MH services to determine which barriers to improvement were not effectively addressed. CHA should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to improve indicator results.	CHA sufficiently addressed the recommendation.
CHA should complete the Clinical and Programmatic Improvement Table to demonstrate significant clinical or programmatic improvement in processes and outcomes.	Not applicable. The PIP documentation requirements changed for the most recent validation cycle, and documenting clinical and programmatic improvement was no longer required or assessed.
Statewide Substance Use Disorder PIP	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.

CY 2023 Recommendation	CY 2024 Assessment
Performance Measure Validation	
This recommendation was initially given during the CY 2021 EQR. CHA should continue to monitor key performance measure rates in alignment with its QAPI goals and objectives. CHA should conduct root cause analyses to identify factors affecting performance specifically for the <i>Child and Adolescent Well-Care Visits—Ages 3 to 6 Years</i> measure indicator and develop, implement, and evaluate targeted interventions to ensure improvement strategies are adopted. Additionally, CHA should monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches for ensuring the timeliness and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	CHA sufficiently addressed the recommendation. CHA addressed the recommendations provided by HSAG and continued its efforts to improve performance in this measure, which included establishing validation mechanisms in the BI and QM departments, developing internal processes for QM deliverables, conducting monthly check-ins with providers to foster engagement and identify access to care gaps, and providing training sessions focused on metrics and clinic-level interactions. Tracking mechanisms were developed to document provider interactions and educational activities while implementing a more consistent process to maintain data integrity. CHA monitored progress during various monthly meetings, including Metrics and Quality Improvement Committee meetings. Dashboards and individual performance discussions took place with providers. At the member level, CHA provided incentive gift cards to encourage participation in well-care visits and other health-related activities. CHA should continue implementing these efforts to continue raising its rates on this measure to the level of the benchmarks set by OHA.
Validation of Network Adequacy	
Delivery System Network Evaluation	
CHA should ensure that all <i>DSN Provider Narrative Template</i> responses provide sufficient information to demonstrate that collected data are used to inform network adequacy monitoring and decision-making and should provide sufficient and relevant explanation for planned network interventions.	CHA sufficiently addressed the recommendation. CHA provided supporting documentation and narrative descriptions of multiple strategies for addressing previous recommendations, including but not limited to staffing updates, data management improvements, additional executive oversight, and general process improvements. CHA should continue to assess and improve its network adequacy monitoring program.
CHA should investigate the nature of its low new patient acceptance among PCPs and PCDs as well as the lack of NEPH and OT specialty providers,	CHA sufficiently addressed the recommendation. CHA conducted a root cause analysis of its low member acceptance rates and found that its contracted PCPs and PCDs had little to no capacity to take on additional members.

CY 2023 Recommendation	CY 2024 Assessment
and plan/enact interventions to address these potential barriers as appropriate.	CHA described successful efforts to bring new providers into the service region. CHA confirmed that there were a lack of NEPH and OT specialists in its region to contract with and described ongoing efforts to locate and contract with specialty providers on a permanent or rotating basis. CHA also implemented a stopgap measure to relax PA requirements for such providers. CHA should continue to assess its network's capacity to meet the needs of its members and provide services in alignment with the full range of OHP benefits.
Secret Shopper Survey	
This recommendation was initially given during the CY 2021 EQR. HSAG recommends that CHA use the case-level analytic data files to address the data deficiencies identified during the secret shopper survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	CHA sufficiently addressed the recommendation. CHA reported that it implemented initiatives such as a custom software program to monitor and validate provider data. CHA should continue to monitor and improve any efforts in maintaining accurate provider data (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).
HSAG recommends that CHA confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. CHA should use the case-level analytic data files containing data deficiencies identified during the secret shopper survey calls.	CHA sufficiently addressed the recommendation. CHA reported that it implemented initiatives, such as a custom software program to monitor and validate provider data. CHA should continue to monitor and improve any efforts in maintaining accurate provider data and compliance with wait time standards.
Revealed Telephone Survey	
HSAG recommends that CHA use the case-level analytic data files to address the data deficiencies identified during the revealed telephone survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, program information, and translation/interpreter services offered).	CHA sufficiently addressed the recommendation. CHA reported that it conducted routine outreach and monitoring activities to provider offices to confirm provider data. CHA should continue to monitor and improve any efforts in maintaining accurate provider data (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).

CY 2023 Recommendation	CY 2024 Assessment
HSAG recommends that CHA confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. CHA should use the case-level analytic data files containing data deficiencies identified during the revealed telephone survey calls and work with BH outpatient offices to identify the root cause for delays in appointment availability.	CHA sufficiently addressed the recommendation. CHA reported that it conducted routine outreach and monitoring activities to provider offices to confirm provider data and appointment availability. CHA should continue to monitor and improve any efforts in maintaining accurate provider data and compliance with wait time standards.
Encounter Data Validation	
This recommendation was initially given during the CY 2021 EQR. HSAG recommends that CHA implement standard quality controls to ensure accurate data extracts. Through the development of standard data extraction procedures and quality control, the number of errors associated with extracted data could be reduced. Additionally, while no other weaknesses were identified, HSAG recommends that CHA continually monitor its encounter submissions to OHA to ensure complete, accurate, and timely encounter data submissions.	CHA did not sufficiently address the recommendation. Based on the response, it appears that CHA has not fully addressed the recommendation. While CHA indicated a general commitment to using feedback for improvements, the lack of specific actions, implemented initiatives, or evidence of performance improvements suggests the recommendation has not been fully addressed. Further clarification and concrete steps are needed to demonstrate compliance with the recommendation.
This recommendation was initially given during the CY 2022 EQR. CHA should investigate the root cause for the omissions and consider performing periodic medical record reviews (MRRs) of submitted claims to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews would then be provided to providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.	CHA did not sufficiently address the recommendation. CHA did not provide a response or supporting documentation to address the recommendation.
HSAG recommends CHA align its data submission practices, adhering closely to the specified layout, ensuring a more seamless integration into the analytical process. This adjustment will facilitate accurate and efficient data handling during subsequent phases of analysis and evaluation.	CHA did not sufficiently address the recommendation. CHA did not provide a response or supporting documentation to address the recommendation.

CY 2023 Recommendation	CY 2024 Assessment
Mental Health Parity Evaluation	
This recommendation was initially given during the CY 2022 EQR. CHA should update its administrative systems, or work with delegate Rx benefit managers, to capture the necessary data elements to allow the reporting of Rx PA data by benefit type. CHA should implement these changes in order to support future MHP reporting requirements.	CHA sufficiently addressed the recommendation.
CHA should review out-of-network claim denials to understand factors affecting the lower percentage of paid MH/SUD IP claims compared to M/S IP claims. CHA should assess whether any barriers exist for members accessing MH/SUD services, including the need to seek services outside the CCO's network (e.g., appointment availability).	CHA sufficiently addressed the recommendation.

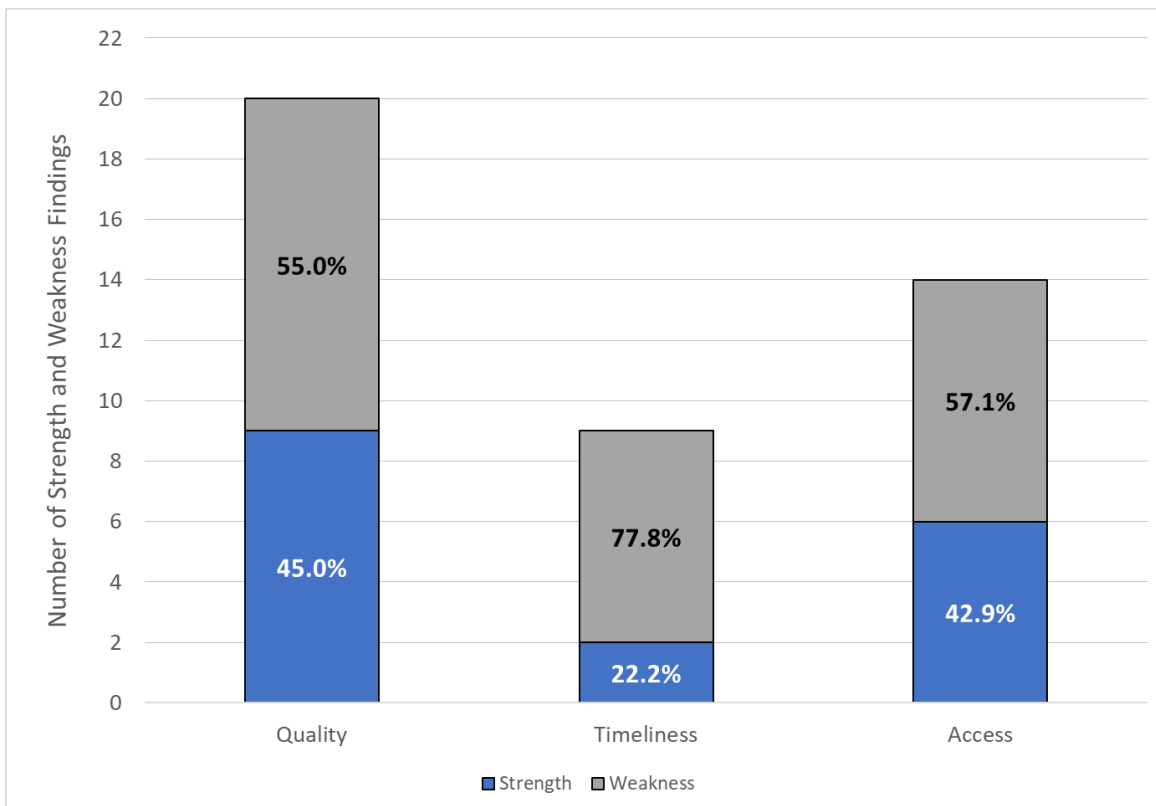
*Standard I—Availability of Services and Standard II—Assurances of Adequate Capacity and Services were combined, and all elements required by 42 CFR §438.206 and §438.207 were assessed under the combined Standard I—Assurance of Adequate Capacity and Availability of Services during the CY 2024 CMR activity.

Columbia Pacific CCO, LLC

Results and Conclusions

HSAG assessed the strengths and weaknesses of each CCO with respect to the quality, timeliness, and accessibility of health care services. Figure 5-7 illustrates the number of strengths exhibited by CPCCO relative to the number of weaknesses identified during the CY 2024 EQR activities across the three domains. The greater the proportion of weaknesses, the greater opportunities for improvement.

Figure 5-7—CPCCO Overall Number of Findings (Strengths and Weaknesses) by Domain



Detailed results from the EQR’s substantive findings are summarized in Table 5-7 for each activity. This table highlights the extent to which CPCCO furnishes high quality, timely, and appropriate access to health care services, and recommendations for how CPCCO can best address issues identified for each activity.⁵²

⁵² See Section 4—Comparative Statewide Results for detailed, CCO-specific scores associated with EQR activity.

Table 5-7—CPCCO Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s) ⁵³
Compliance Monitoring Review		
	Strength: CPCCO demonstrated best practices by establishing a step-by-step procedure for customer service to follow to ensure the appropriate department is notified of access issues reported by members.	 
	Strength: CPCCO demonstrated best practices by incorporating justice into its Equity, Diversity, and Inclusion strategic plan.	 
	Strength: CPCCO demonstrated best practices with its provider satisfaction survey, which includes questions about claims, authorizations, and appeals processes and the providers' views on using the provider portal as part of its provider retention efforts.	
	Weakness: CPCCO received a score of 76.3 percent in the <i>Assurance of Adequate Capacity and Availability of Services</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements, inability to demonstrate sufficient implementation of established processes, and deficiencies within its monitoring activities impacting the CCO's ability to ensure timely access to care and services. Why the weakness exists: CPCCO lacked a methodology for monitoring and maintaining its provider network for the federal and State-required components. Additionally, the policies and procedures implemented did not fully align with State-established time and distance standards, reporting requirements, and provision of access, accommodations, and equipment for members with physical and mental disabilities. Also, the CCO failed to demonstrate mechanisms for monitoring provider compliance with State-established time and distance and appointment standards, and evidence of taking corrective action when providers fail to meet appointment standards. Recommendations: CPCCO should develop and implement a methodology for monitoring and maintaining its provider network for the federal and State-required components. Additionally, the CCO should revise its policies and procedures to align with federal and State requirements for its timely access to care and services and reporting and demonstrate implementation. The CCO should also demonstrate the implementation of corrective action when providers fail to meet appointment standards.	  

⁵³  = Quality,  = Timeliness,  = Access

Strength/ Weakness	Description	Domain(s) ⁵³
—	Weakness: CPCCO received a score of 75.0 percent in the <i>Provider Selection</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements, the inability to demonstrate sufficient implementation of established processes, and deficiencies within its monitoring activities impacting the CCO’s ability to meet federal and State requirements for selecting, retaining, credentialing, and recredentialing network providers. Why the weakness exists: CPCCO did not demonstrate policies and procedures for the selecting and retaining providers. Additionally, the CCO did not adhere to State requirements for credentialing and recredentialing providers or its policy and procedure for credentialing and recredentialing, including collecting and reviewing the appropriate credentialing documentation and recredentialing time frames. The CCO also did not demonstrate comprehensive oversight of its subcontractors to ensure compliance with credentialing and recredentialing requirements. Finally, the CCO did not establish a mechanism for ensuring providers are not inadvertently discriminated against with its credentialing processes. Recommendations: CPCCO should establish policies and procedures for selecting and retaining providers. Additionally, the CCO should ensure that its subcontractors adhere to its credentialing and recredentialing policies and procedures and collect the appropriate credentialing documentation. The CCO should also implement a mechanism for ensuring providers are not inadvertently discriminated against with its credentialing processes.	 
—	Weakness: CPCCO received a score of 87.5 percent in the <i>Subcontractual Relationships and Delegation</i> standard due to insufficient documentation to support operations and ensure compliance with federal requirements for written agreements between the CCO and its subcontractors. Why the weakness exists: CPCCO’s contracts with the subcontractors failed to include federally required language for written agreements with subcontractors. Recommendations: CPCCO should revise its written agreements to align with federally required language for written agreements with subcontractors.	
—	Weakness: CPCCO received a score of 83.3 percent in the <i>Practice Guidelines</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements impacting the CCO’s ability to adopt the appropriate clinical practice guidelines.	 

Strength/ Weakness	Description	Domain(s) ⁵³
	Why the weakness exists: CPCCO's policy and procedures did not fully align with the federal and State requirements for adopting the appropriate clinical practice guidelines. Recommendations: CPCCO should revise its policy and procedures to fully align with the federal and State requirements for adopting the appropriate clinical practice guidelines.	
Performance Improvement Projects		
Statewide Mental Health Service Access Monitoring PIP		
	Strength: CPCCO successfully continued the Implementation stage for the PIP, receiving a <i>Met</i> score for 100 percent of applicable evaluation elements in the PIP Validation Tool. In the Implementation stage, CPCCO accurately reported baseline and RY 2 performance indicator data, identified and analyzed barriers to improving MH service access, carried out interventions to address those barriers, and refined interventions based on intervention evaluation results.	
	Strength: CPCCO's RY 2 performance indicator results demonstrated sustained improvement in MH service access compared to baseline indicator results.	
Statewide Substance Use Disorder PIP		
	Strength: CPCCO accurately reported baseline and RY 1 performance indicator data; identified and analyzed barriers for initiation, engagement, and treatment of alcohol and other drug use disorders; and began to carry out interventions to address those barriers.	
	Weakness: CPCCO received a <i>Low Confidence</i> rating for overall confidence that the <i>Substance Use Disorder</i> PIP achieved significant improvement. Why the weakness exists: CPCCO's performance for Indicator 1 (<i>Percentage of new SUD episodes that result in treatment and initiation within 14 days</i>) declined from BY to RY 1. In addition, the CCO's improvement in Indicator 2 (<i>Percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation</i>) result from baseline to RY 1 was not statistically significant. Recommendations: CPCCO should revisit root cause analyses identifying barriers to improving to determine which barriers to improvement were not effectively addressed. CPCCO should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to further improve the percentage of new SUD episodes that result in treatment and initiation within 14 days and the percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation indicator results.	

Strength/ Weakness	Description	Domain(s) ⁵³
Performance Measure Validation		
	Strength: CPCCO'S MY 2023 performance on the <i>Oral Evaluation for Adults With Diabetes</i> measure demonstrated ongoing improvement since MY 2021.	
	Weakness: CPCCO's MY 2023 rates on the <i>Child and Adolescent Well-Care Visits</i> measure for members ages 3 to 6 years fell below the benchmark set by OHA for MY 2023 and the statewide aggregate by 5 percentage points or more. Why the weakness exists: CPCCO performance rates for the measure held steady, only improving by 0.4 percentage points between MY 2022 and MY 2023, with members in the age range remaining consistent. The statewide aggregate for the measure continued to increase as did the benchmark set forth by OHA. Recommendations: CPCCO should conduct root cause analyses to identify specific factors affecting performance on this measure and develop, implement, and evaluate targeted interventions to ensure improvement strategies are adopted. Additionally, CPCCO should monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches for ensuring the timeliness and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	
	Weakness: CPCCO's MY 2023 rates on the <i>Initiation and Engagement of SUD Treatment</i> measure indicators for members ages 18 years and older fell below the benchmarks set by OHA for MY 2023. Additionally, CPCCO's MY 2023 rates on the <i>Initiation and Engagement of SUD Treatment</i> measure indicators for members ages 13 to 17 years declined more than 5 percentage points from MY 2022 (16.3 percentage point decrease in the initiation of SUD treatment and 17.9 percentage point decrease in the engagement of SUD treatment) with both metrics falling below the statewide aggregate. Why the weakness exists: In 2023, CPCCO noted several barriers to implementing performance improvement initiatives, including staffing shortages in its provider network and systemic barriers limiting access to care. Additionally, in response to previous findings, CPCCO noted barriers regarding 42 CFR, identifying SUD diagnosis episodes in a timely manner (within 14 and 34 days), and educating the network on workflow processes. Recommendations: CPCCO reported continuing use of its SUD subject matter expert workgroup and use of the annual CPCCO SUD Summit to engage internal and external network partners. CPCCO reported focusing on more in-depth analysis surrounding the <i>Initiation and Engagement of SUD Treatment</i> metric to identify new opportunities for improvement. CPCCO should continue implementing	

Strength/ Weakness	Description	Domain(s) ⁵³
	these efforts to raise its rates on this measure to the level of the benchmarks set by OHA. Additionally, CPCCO should continue to place effort in identifying improved data sharing strategies (such as Point Click Care) to improve data sharing practices and identify more SUD diagnoses in a timely manner.	
Validation of Network Adequacy		
Network Adequacy Validation Audit		
	Strength: CPCCO maintained detailed process documentation for analyst creation of the network adequacy report, ensuring business continuity of the network adequacy reporting process.	
Delivery System Network Evaluation		
	Weakness: CPCCO demonstrated a moderate level of compliance with network monitoring requirements. Why the weakness exists: CPCCO was not able to demonstrate how it collects and uses data on wait time to appointment availability, hours of operation, telehealth capacity and utilization, availability of culturally and linguistically appropriate care, or availability of physical accessibility accommodations to inform network adequacy monitoring and decision making. Recommendations: CPCCO should demonstrate how it collects and uses DSN data to inform network adequacy monitoring and decision making.	
	Weakness: CPCCO showed data quality issues within its provider data, including but not limited to service area activity and status of accepting new patients. This issue was also identified during the CY 2021, CY 2022, and CY 2023 DSN Evaluations. The issue was not addressed or responded to by CPCCO. Why the weakness exists: The percentage of providers operating within the service area was approximately 10 percent or less for most providers, including PCPs. With the exception of PCPs, PCDs, and ALIM, less than 1 percent of all provider types were accepting new patients. Recommendations: CPCCO should seek technical assistance with OHA to determine the nature of the provider capacity data issues and correct them.	
	Weakness: CPCCO did not meet the State time and distance standard for MTD facilities. Why the weakness exists: CPCCO did not meet the facility network adequacy standards for MTD facilities since fewer than 95 percent of its members were within acceptable travel times or distances of MTD	

Strength/ Weakness	Description	Domain(s) ⁵³
	facilities. Additionally, CPCCO had not engaged in OHA's time and distance exception request process for this provider type. Recommendations: CPCCO should engage in OHA's time and distance exception request process for all instances of noncompliance.	
Revealed Telephone Survey		
	Strength: Among the total PCP and OP SUD cases reached, 92.2 percent confirmed the correct location.	
	Strength: Of the PCP appointments that were offered for existing patients, 90.5 percent of routine visits and 97.3 percent of urgent visits were compliant with the wait time standards.	
	Weakness: Overall, 89.5 percent of the total PCP and OP SUD sampled cases were reached. Among the cases reached, 80.9 percent offered the requested services, 76.5 percent accepted OHP Medicaid, and 33.5 percent accepted CPCCO. Also, 76.6 percent of cases offered translation or interpreter services. Why the weakness exists: In addition to limitations related to the revealed survey approach, inaccuracies found in CPCCO's provider data may have contributed to the low response rate and accuracy results. Recommendations: CPCCO should use the case-level analytic data files to address the data deficiencies identified during the survey calls (e.g., incorrect or disconnected telephone numbers; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
	Weakness: Among the cases reached, only 27.8 percent accepted new patients. In addition, appointment availability was only offered for less than 26.0 percent of PCP cases and 46.0 percent of OP SUD cases. Of the new patient appointments that were offered, 70.0 percent of routine visits and 83.3 percent of urgent visits were compliant with the wait time standards. Among the OP SUD appointments that were offered, compliance rates ranged from 25.0 percent (urgent visits) to 53.6 percent (routine visits). Why the weakness exists: In addition to limitations related to the revealed survey approach, inaccuracies found in CPCCO's provider data and insufficient provider panel capacity may have contributed to low access and availability rates (i.e., new patient acceptance, appointment availability, and wait times). Also, internal office staffing structures and procedures may have contributed to the long wait times. Recommendations: CPCCO should confirm appointment availability with providers, including panel capacity to accept new patients. Further, CPCCO should use the case-level analytic data files to address data deficiencies identified during the survey calls.	

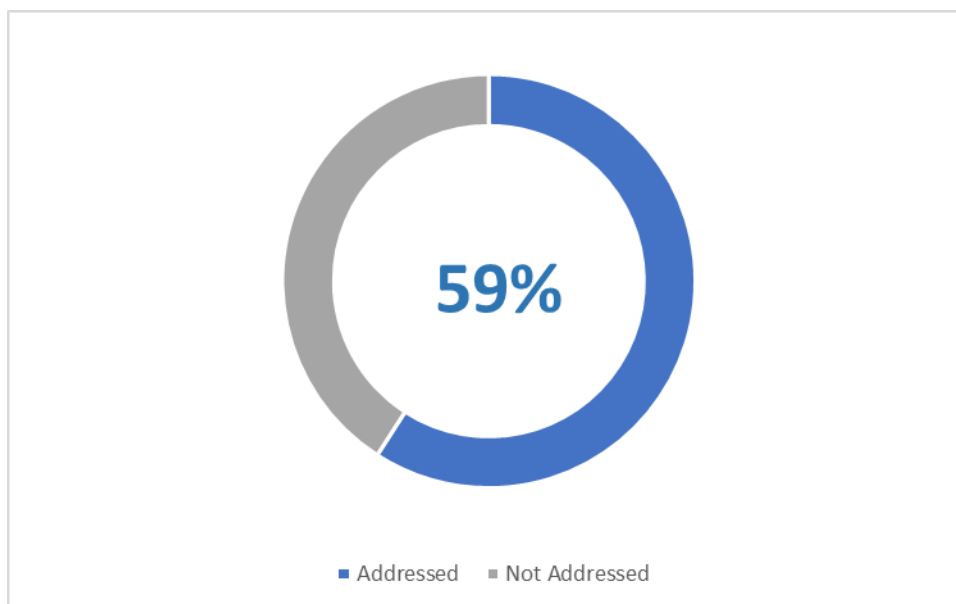
Strength/ Weakness	Description	Domain(s) ⁵³
Encounter Data Validation		
Since EDV results were not available for inclusion in the 2024 EQR technical report, the strengths and weaknesses for each CCO could not be assessed. The findings will be incorporated in next year's EQR technical report.		
Mental Health Parity Evaluation		
	Weakness: CPCCO was unable to prepare, extract, and submit accurate IP claims data for analysis of parity. Claims cannot be evaluated if relevant data is not reported. Why the weakness exists: CPCCO identified a data quality issue related to their IP claims summary count submission. The CCO confirmed it included institutional claims from a CMS COBA contractor which should have been excluded from the analysis. These claims were rebilled and paid by the CCO and included as in-network professional MH/SUD claims. Recommendations: CPCCO should review its internal processes for the collection and submission of MHP-related data to ensure complete and accurate claims data are submitted in support of this activity, including data quality control procedures.	

Follow-Up on Prior Year Recommendations

HSAG evaluated CPCCO's approach to addressing the recommendations related to findings issued during CY 2023 and unresolved findings from CY 2020, CY 2021, and CY 2022 while conducting the CY 2024 EQR activities. The CCOs not addressing recommendations are at risk of being out of compliance with their contracts.

Figure 5-8 illustrates the degree in which the CCO sufficiently addressed the recommendations for QI made by HSAG during the CY 2023 EQR.

Figure 5-8—Percentage of CY 2023 EQR Recommendations Addressed by CPCCO



CPCCO-specific CY 2023 recommendations and follow-up CY 2024 assessments are summarized in Table 5-8.

Table 5-8—Assessment of CPCCO’s Approach to Addressing Previous Annual Recommendations

CY 2023 Recommendation	CY 2024 Assessment
Compliance Monitoring Review	
<i>Standard I—Assurance of Adequate Capacity and Availability of Services*</i>	
This recommendation was initially given during the CY 2021 EQR. CPCCO should develop thorough, documented processes that address all required elements of network evaluation. The CCO should be able to demonstrate evidence of monitoring its provider network and corrective action when providers fail to meet the standards. In addition, CPCCO should develop a documented process for monitoring provider capacity that includes monitoring specialty providers individually by specialty type and ensuring its network evaluation incorporates key data collected from its monitoring processes.	CPCCO did not sufficiently address the recommendation. CPCCO did not demonstrate monitoring its provider in accordance with the state-established requirements, including thresholds. The CCO also did not demonstrate an established methodology for collecting the appropriate information to assess the sufficiency of the provider network to administer covered services. CPCCO also did not demonstrate consistent monitoring of the provider network against all state-established network access standards or taking corrective action when providers failed to meet compliance. Note: Standard I—Assurance of Adequate Capacity and Availability of Services was comprehensively reviewed during the CY 2024 CMR cycle, and recommendations addressing all findings related

CY 2023 Recommendation	CY 2024 Assessment
	to this standard are included in the CCO's individual Results and Conclusions section.
Standard III—Coordination and Continuity of Care	
CPCCO should revise its policies and procedures to align with federal and State requirements.	CPCCO sufficiently addressed the recommendation.
Standard IV—Coverage and Authorization of Services	
CPCCO should revise its policies and procedures to align with federal and State requirements. CPCCO should demonstrate adherence to federal and State requirements for authorization of services and required content and time frames for providing NOABDs.	CPCCO did not sufficiently address the recommendation. CPCCO did not demonstrate that its subcontractors have in place and follow written policies and procedures for processing requests for initial and continuing authorization of services that were compliant with federal and State requirements or processes for ensuring consistent application of review criteria. Additionally, CPCCO did not demonstrate a process for eliminating the reconsideration process after issuing a denial, nor did the CCO demonstrate an enhanced process for ensuring appropriate decision-makers for authorizations and notices are issued for all denial decisions. CPCCO should revise its processes to align with federal and State requirements. CPCCO should demonstrate adherence to federal and State requirements for authorization of services and providing NOABDs.
Standard V—Provider Selection	
This recommendation was initially given during the CY 2021 EQR. CPCCO should develop and conduct state-required training and document completion of provider and CCO staff training.	Not applicable. The recommendation was tied to a state-specific element that was removed from HSAG's review.
Standard VI—Subcontractual Relationships and Delegation	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Standard VII—Member Rights and Protections	
CPCCO should revise its policies and procedures and member- and provider-facing materials to align with federal and State requirements.	CPCCO did not sufficiently address the recommendation. CPCCO did not demonstrate the appropriate information on member rights and advance directives were sufficiently communicated in the provider manual, nondiscrimination statement, and member handbook. CPCCO should revise its policies and

CY 2023 Recommendation	CY 2024 Assessment
	procedures and member- and provider-facing materials to align with federal and State requirements.
Standard VIII—Confidentiality	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard IX—Enrollment and Disenrollment	
This recommendation was initially given during the CY 2022 EQR. CPCCO should ensure that it communicates to members all the reasons why members can disenroll from the CCO. Utilizing the model member handbook would ensure the CCO captures the requirements.	CPCCO sufficiently addressed the recommendation.
Standard X—Grievance and Appeal Systems	
CPCCO should revise its policies and procedures to align with federal and State requirements. Additionally, CPCCO should demonstrate adherence to federal and State requirements for time frames for acknowledging and responding to grievances and appeals; readability of notices; and implementation of federal and State requirements within communications to members, providers, and subcontractors. CPCCO should also demonstrate maintaining one level of appeal.	CPCCO did not sufficiently address the recommendation. CPCCO did not demonstrate its processes and training materials were revised to align with federal and State requirements for one level of appeal following an adverse benefit determination. CPCCO also could not demonstrate a process to ensure providers and subcontractors are notified of changes within five business days after OHA’s approval of updates to procedures and time frames. CPCCO should revise its processes to align with federal and State requirements. Additionally, CPCCO should ensure all provider and subcontractor communications are revised to align with all federal and State requirements. CPCCO should also demonstrate maintaining one level of appeal.
Standard XI—Practice Guidelines	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Standard XII—Quality Assessment and Performance Improvement	
This recommendation was initially given during the CY 2022 EQR. CPCCO should ensure appropriate oversight of its QAPI program, including implementing a QI committee that meets the State’s requirements.	CPCCO did not sufficiently address the recommendation. CPCCO did not demonstrate the appropriate oversight of its QAPI program, including a QI committee that aligns with State requirements, and mechanisms to assess the quality and appropriateness of care furnished to members with SHCN and using LTSS. CPCCO

CY 2023 Recommendation	CY 2024 Assessment
	should ensure appropriate oversight of its QAPI program, including implementing a QI committee that meets the State’s requirements and mechanisms to assess the quality and appropriateness of care provided to members with SHCN and utilizing LTSS.
Standard XIII—Health Information Systems, including ISCA	
This recommendation was initially given during the CY 2022 EQR. CPCCO should develop and implement processes to monitor its BH providers’ compliance with Measures and Outcomes Tracking System (MOTS) reporting requirements.	Not applicable. The recommendation was tied to a state-specific element that was removed from HSAG’s review.
Standard XIV—Member Information	
CPCCO should revise its policies, procedures, and member-facing materials to align with federal and State requirements. Additionally, CPCCO should track and monitor the timely provision of required member information.	CPCCO did not sufficiently address the recommendation. CPCCO’s policies and procedures were still out of alignment with federal and State requirements for readability and being readily accessible. Additionally, the CCO did not demonstrate the appropriate revisions were made to the provider directory and electronic documentation. CPCCO also did not ensure the appropriate information on physician incentive plans would be provided to members, if requested. CPCCO should revise its policies, procedures, and member-facing materials to align with federal and State requirements. Additionally, CPCCO should track and monitor the timely provision of required member information.
Standard XVI—Emergency and Poststabilization Services	
CPCCO should revise the applicable plan documents to define “poststabilization services” and communicate the appropriate requirements.	CPCCO sufficiently addressed the recommendation.
Performance Improvement Projects	
Statewide Mental Health Service Access Monitoring PIP	
This recommendation was initially given during the CY 2022 EQR. CPCCO should include a statement in the narrative interpretation of RY 1 results that addresses whether any factors were identified that may impact the validity or comparability of RY 1 results to the baseline results. The CCO should state if no factors were	CPCCO sufficiently addressed the recommendation.

CY 2023 Recommendation	CY 2024 Assessment
identified. If factors were identified, the CCO should describe resolutions of those factors in the narrative interpretation of results.	
CPCCO should revisit root cause analyses identifying barriers to improving access to MH services to determine which barriers to improvement were not effectively addressed. CPCCO should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to further improve indicator results.	CPCCO sufficiently addressed the recommendation.
CPCCO should complete the Clinical and Programmatic Improvement Table to demonstrate significant clinical or programmatic improvement in processes and outcomes.	Not applicable. The PIP documentation requirements changed for the most recent validation cycle, and documenting clinical and programmatic improvement was no longer required or assessed.
Statewide Substance Use Disorder PIP	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Performance Measure Validation	
CPCCO should continue ongoing monitoring and monthly SUD subject matter expert group meetings and develop interventions to raise its rates on the <i>Initiation of SUD Treatment</i> and <i>Engagement of SUD Treatment</i> measure indicators for members ages 18 years and older to the level of the benchmarks set by OHA.	CPCCO sufficiently addressed the recommendation. CPCCO addressed the recommendations provided by HSAG and continued its efforts to improve performance in this measure, which included continuing use of its SUD subject matter expert workgroup and use of the annual CPCCO SUD Summit to engage internal and external network partners. CPCCO reported focusing on more in-depth analysis surrounding the <i>Initiation and Engagement of SUD Treatment</i> metric to identify new opportunities for improvement. CPCCO should continue implementing these efforts to raise its rates on this measure to the level of the benchmarks set by OHA.
Validation of Network Adequacy	
Delivery System Network Evaluation	
This recommendation was initially given during the CY 2021 EQR. CPCCO should work with OHA to determine the root cause of the low count for in-network providers and work to correct any deficiency.	CPCCO did not sufficiently address the recommendation. Although CPCCO described process improvements to its network data management including dedicated staffing, the Q1 <i>DSN Provider Capacity Report</i> from OHA (used

CY 2023 Recommendation	CY 2024 Assessment
	for all CCOs in the 2024 DSN Evaluation) showed similar issues to those identified in 2021–2023, with very low percentages of providers indicated as operating in the service area and accepting new patients. The most likely reason for this is enterprise-wide reporting for CPCCO and affiliated providers via the parent group CareOregon, but it should be possible for the CCO to restrict its reporting to those providers that are meaningfully accessible within the service region (with the caveat that any reporting methodology shall be determined and approved by the State). Additionally, CPCCO did not describe seeking technical assistance or otherwise coordinating with OHA.
CPCCO should ensure that all future reporting utilizes the state-established specialty provider taxonomies current to the review period and should demonstrate how it collects and uses DSN data to inform network adequacy monitoring and decision-making.	CPCCO sufficiently addressed the recommendation. While results from the CCO’s 2024 DSN Provider Narrative may have similar scores to the 2023 DSN Provider Narrative in some respects, the overall quality of submitted documentation, implementation of OHA’s required taxonomies in monitoring, and evidence of ongoing change management sufficiently demonstrated the CCO’s intentionality in addressing prior issues. CPCCO should continue its efforts to improve the quality of its network adequacy monitoring and DSN submissions.
Secret Shopper Survey	
HSAG recommends that CPCCO use the case-level analytic data files to address the data deficiencies identified during the secret shopper survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	CPCCO sufficiently addressed the recommendation. In addition to routine outreach and monitoring activities to confirm provider data, CPCCO reported implementing an enhanced tracking tool to monitor and identify any data discrepancies. CPCCO should continue to monitor and improve any efforts in maintaining accurate provider data (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).
HSAG recommends that CPCCO confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. CPCCO should use the case-level analytic data files containing	CPCCO sufficiently addressed the recommendation. In addition to routine outreach and monitoring activities to confirm provider data, appointment availability, and scheduling procedures, CPCCO reported implementing an

CY 2023 Recommendation	CY 2024 Assessment
data deficiencies identified during the secret shopper survey calls.	enhanced tracking tool to monitor and identify any data discrepancies. CPCCO should continue to monitor and improve any efforts in maintaining accurate provider data and compliance with wait time standards.
Revealed Telephone Survey	
HSAG recommends that CPCCO use the case-level analytic data files to address the data deficiencies identified during the revealed telephone survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, program information, and translation/interpreter services offered).	CPCCO sufficiently addressed the recommendation. In addition to routine outreach and monitoring activities to confirm provider data, CPCCO reported implementing an enhanced tracking tool to monitor and identify any data discrepancies. CPCCO should continue to monitor and improve any efforts in maintaining accurate provider data (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).
HSAG recommends that CPCCO confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. CPCCO should use the case-level analytic data files containing data deficiencies identified during the revealed telephone survey calls and work with BH outpatient offices to identify the root cause for delays in appointment availability.	CPCCO sufficiently addressed the recommendation. In addition to routine outreach and monitoring activities to confirm provider data, appointment availability, and scheduling procedures, CPCCO reported implementing an enhanced tracking tool to monitor and identify any data discrepancies. CPCCO should continue to monitor and improve any efforts in maintaining accurate provider data and compliance with wait time standards.
Encounter Data Validation	
HSAG recommends that CPCCO proactively inform HSAG about special scenarios like the one observed with Willamette Dental Group (WDG), where the <i>Adjudication Date</i> was not populated due to WDG's capitated nature that it does not receive, process, or adjudicate claims.	CPCCO sufficiently addressed the recommendation.
While encounter submission to OHA did not require the inclusion of the <i>Rendering Provider NPI</i> value if it matched the <i>Billing Provider NPI</i> value, the data request for the EDV comparative analysis had different requirements. To address this, HSAG recommends that CPCCO and its subcontractor(s) ensure that values for both <i>Billing Provider NPI</i> and <i>Rendering Provider NPI</i> are included in the data submission, irrespective	CPCCO sufficiently addressed the recommendation.

CY 2023 Recommendation	CY 2024 Assessment
of their equivalence. This adjustment will enhance the accuracy and completeness of the comparative analysis data. Additionally, it will provide HSAG with the means to verify and ensure the accuracy of the Medicaid Management Information System’s (MMIS’) process of populating the <i>Rendering Provider NPI</i> with the <i>Billing Provider NPI</i> .	
Mental Health Parity Evaluation	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.

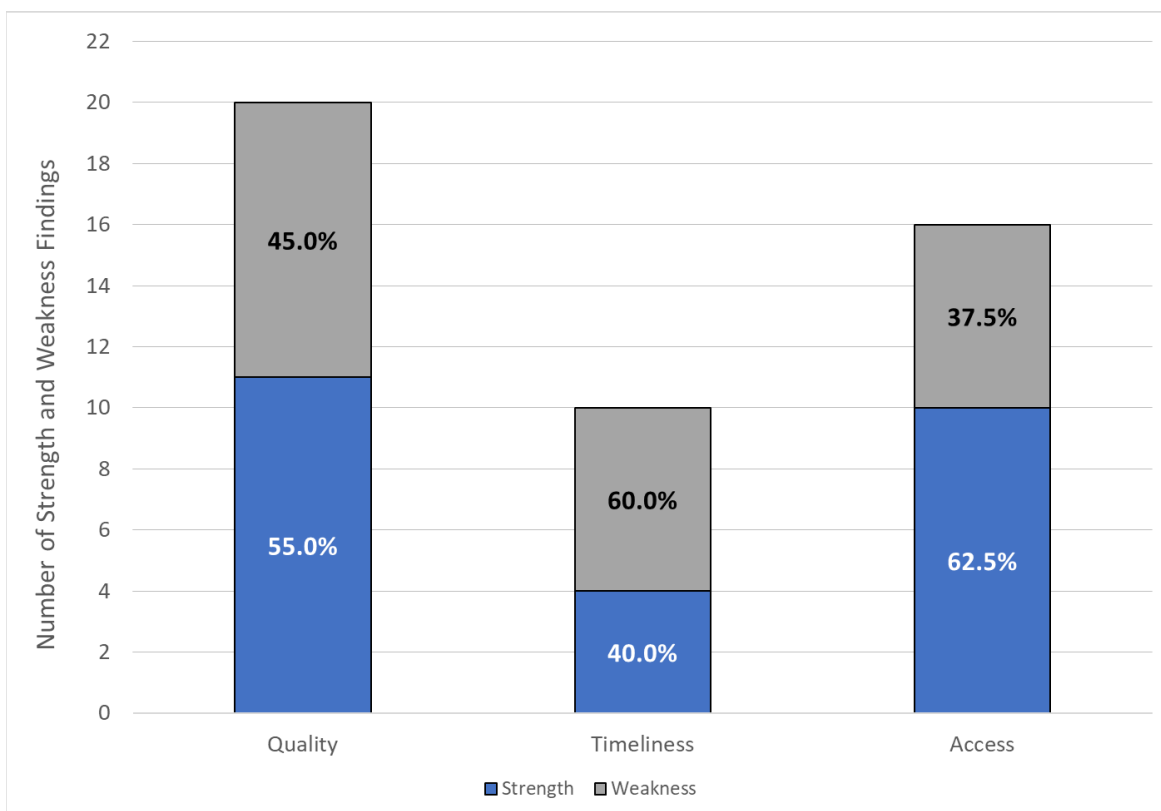
*Standard I—Availability of Services and Standard II—Assurances of Adequate Capacity and Services were combined, and all elements required by 42 CFR §438.206 and §438.207 were assessed under the combined Standard I—Assurance of Adequate Capacity and Availability of Services during the CY 2024 CMR activity.

Eastern Oregon CCO, LLC

Results and Conclusions

HSAG assessed the strengths and weaknesses of each CCO with respect to the quality, timeliness, and accessibility of health care services. Figure 5-9 illustrates the number of strengths exhibited by EOCCO relative to the number of weaknesses identified during the CY 2024 EQR activities across the three domains. The greater the proportion of weaknesses, the greater opportunities for improvement.

Figure 5-9—EOCCO Overall Number of Findings (Strengths and Weaknesses) by Domain



Detailed results from the EQR’s substantive findings are summarized in Table 5-9 for each activity. This table highlights the extent to which EOCCO furnishes high quality, timely, and appropriate access to health care services, and recommendations for how EOCCO can best address issues identified for each activity.⁵⁴

⁵⁴ See Section 4—Comparative Statewide Results for detailed, CCO-specific scores associated with EQR activity.

Table 5-9—EOCCO Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s) ⁵⁵
Compliance Monitoring Review		
	Strength: EOCCO’s subcontractor, Greater Oregon Behavioral Health, Inc., demonstrated best practices by conducting a comprehensive analysis comparing the characteristics of its provider network to the CCO’s membership receiving BH services and assessing opportunities for improvement.	 
	Strength: EOCCO demonstrated best practices by including an affirmation statement in the provider agreements prohibiting the restriction of family planning methods.	 
	Strength: EOCCO demonstrated best practices by performing survey calls assessing hours of operation to ensure equal access for its members.	 
	Strength: EOCCO demonstrated best practices through its annual delegation reviews that assess compliance with targeted elements annually, aligning with the CMR compliance reviews.	
	Weakness: EOCCO received a score of 89.5 percent in the <i>Assurance of Adequate Capacity and Availability of Services</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements and deficiencies within its monitoring activities impacting the CCO’s ability to ensure timely access to care and services. Why the weakness exists: EOCCO lacked a comprehensive methodology for monitoring and maintaining its provider network for the federal and State-required components. Additionally, the CCO’s internal training documentation and provider communications did not fully align with State-established appointment standards. The CCO also failed to demonstrate the appropriate monitoring of the provider network against State-established appointment standards and evidence of taking corrective action when providers failed to meet appointment standards. Recommendations: EOCCO should develop and implement a methodology for monitoring and maintaining its provider network for the federal and State-required components. Additionally, the CCO should demonstrate corrective action when providers fail to meet appointment standards. The CCO should also revise its provider and internal training materials to fully align with the State-established appointment standards.	  

⁵⁵  = Quality,  = Timeliness,  = Access

Strength/ Weakness	Description	Domain(s) ⁵⁵
	Weakness: EOCCO received a score of 83.3 percent in the <i>Provider Selection</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements and the inability to demonstrate sufficient implementation of established processes impacting the CCO's ability to meet federal and State requirements for selecting, retaining, and recredentialing network providers. Why the weakness exists: EOCCO lacked policies and procedures for selecting and retaining network providers. Additionally, the CCO did not adhere to its policy and procedures or State requirements for recredentialing providers, including recredentialing within the appropriate time frame. Recommendations: EOCCO should develop written policies and procedures for selecting and retaining providers and adhere to its policy and procedure and State requirements for recredentialing.	
	Weakness: EOCCO received a score of 87.5 percent in the <i>Subcontractual Relationships and Delegation</i> standard due to insufficient documentation to support operations and ensure compliance with federal requirements for written agreements between the CCO and its subcontractors. Why the weakness exists: EOCCO's contracts with the subcontractors failed to include federally required language for written agreements with subcontractors. Recommendations: EOCCO should revise its written agreements to align with federally required language for written agreements with subcontractors.	
	Weakness: EOCCO received a score of 16.7 percent in the <i>Practice Guidelines</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements impacting the CCO's ability to adopt, review, update, and disseminate the appropriate clinical practice guidelines and ensure decision-making was aligned with the guidelines. Why the weakness exists: EOCCO could not demonstrate a process that aligned with the federal and State requirements for adopting, reviewing, updating, and disseminating the appropriate clinical practice guidelines and ensuring decision-making was aligned with the guidelines. Recommendations: EOCCO should develop and implement a process that aligns with the federal and State requirements for adopting, reviewing, updating, and disseminating the appropriate clinical practice guidelines and ensuring decision-making is aligned with the guidelines.	

Strength/ Weakness	Description	Domain(s) ⁵⁵
Performance Improvement Projects		
Statewide Mental Health Service Access Monitoring PIP		
	Strength: EOCCO successfully continued the Implementation stage for the PIP, receiving a <i>Met</i> score for 100 percent of applicable evaluation elements in the PIP Validation Tool. In the Implementation stage, EOCCO accurately reported baseline and RY 2 performance indicator data, identified and analyzed barriers to improving MH service access, carried out interventions to address those barriers, and refined interventions based on intervention evaluation results.	
	Strength: EOCCO's RY 2 performance indicator results demonstrated statistically significant improvement in MH service access compared to baseline indicator results.	
Statewide Substance Use Disorder PIP		
	Strength: EOCCO accurately reported baseline and RY 1 performance indicator data; identified and analyzed barriers for initiation, engagement, and treatment of alcohol and other drug use disorders; and began to carry out interventions to address those barriers.	
	Weakness: EOCCO received a <i>No Confidence</i> rating for overall confidence that the <i>Substance Use Disorder</i> PIP achieved significant improvement. Why the weakness exists: EOCCO demonstrated a decline in performance from baseline to RY 1 for both Indicator 1 (<i>Percentage of new SUD episodes that result in treatment and initiation within 14 days</i>) and Indicator 2 (<i>Percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation</i>) results. Recommendations: EOCCO should revisit root cause analyses identifying barriers to improving initiation, engagement, and treatment of alcohol and other drug use disorders to determine which barriers to improvement were not effectively addressed. EOCCO should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to further improve the percentage of new SUD episodes that result in treatment and initiation within 14 days and the percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation indicator results.	
Performance Measure Validation		
	Strength: EOCCO's MY 2023 performance on the <i>Child and Adolescent Well-Care Visits—Ages 3 to 6 Years</i> measure indicator demonstrated ongoing improvement since MY 2021, performing above the statewide aggregate for MY 2023.	

Strength/ Weakness	Description	Domain(s) ⁵⁵
	Strength: EOCCO's MY 2023 performance on the <i>Members Receiving Preventive Dental or Oral Health Services—Ages 1 to 5 Years and Ages 6 to 14 Years</i> measure indicators demonstrated ongoing improvement since MY 2021. EOCCO's performance for members ages 1 to 5 years receiving preventive dental or oral health services improved by more than 5 percentage points compared to MY 2022 (12.5 percentage points). In addition, EOCCO's MY 2023 rates in both age groups exceeded the statewide aggregate. EOCCO's MY 2023 rates in both age groups exceeded the benchmark set by OHA for MY 2023 by 5 percentage points or more.	
	Strength: EOCCO's MY 2023 performance on the <i>Oral Evaluation for Adults With Diabetes</i> measure demonstrated ongoing improvement since MY 2021. Additionally, EOCCO's MY 2023 performance exceeded both the statewide aggregate and the benchmark set by OHA for MY 2023.	
	Weakness: EOCCO's MY 2023 performance on the <i>Initiation of SUD Treatment</i> measure indicator for members ages 18 years and older fell below the benchmark set by OHA for MY 2023 by 5 percentage points or more (6.3 percentage points). Why the weakness exists: In response to EQR recommendations, EOCCO reported identifying through its learning collaboratives that an initial SUD diagnosis is often changed during the engagement service resulting in a <i>Not Met</i> score for the specific member. Recommendations: EOCCO began a learning collaborative that included all providers providing SUD services related to initiation, engagement, or treatment of SUDs for members. The goal of the collaborative was to provide a metric overview, receive feedback related to barriers, and increase communication among providers. Additionally, EOCCO engaged an SUD coordinator to assist in the coordination of engagement and treatment services once an initiation service was provided. EOCCO should continue implementing these efforts to raise its rates on this measure to the level of the benchmarks set by OHA.	
Validation of Network Adequacy		
Network Adequacy Validation Audit		
	Strength: EOCCO had established robust processes for maintaining member and provider information by conducting routine internal auditing activities to ensure accuracy and completeness of member and provider records.	

Strength/ Weakness	Description	Domain(s) ⁵⁵
Delivery System Network Evaluation		
	Strength: EOCCO described working with small, independent Rx facilities within its service region to secure critical access pharmacy designations. Such pharmacies receive higher reimbursement rates, helping to ensure they remain open and provide member access to critical services.	 
	Strength: As part of its commitment to providing culturally appropriate care and in response to increased utilization, EOCCO expanded its traditional health worker (THW) program, sponsoring existing workforce development and new workforce training, and closely monitoring THW utilization data via regular analysis and reporting.	 
	Weakness: EOCCO's provider data results suggested potential data issues regarding adult and pediatric populations served, service area, and accepting new patient status. Why the weakness exists: EOCCO reported nearly all its providers as serving strictly either adult or pediatric populations, with few providers documented as serving both. Additionally, EOCCO reported very low rates of providers operating within the service area or accepting new patients, with most providers accepting no new patients. Recommendations: EOCCO should seek technical assistance with OHA to determine the nature of the provider capacity data issues and correct them.	
	Weakness: EOCCO did not meet the time and distance standards for NEUR, PT, R-ONC, SLP, and ALIM providers serving adult members; for all pediatric provider types except for PCPs, PCDs, and CRD providers serving pediatric members; and MTD facilities. Why the weakness exists: EOCCO did not meet the adult (NEUR, PT, R-ONC, SLP, and ALIM), pediatric (MH, SUD, M-ONC, NEUR, OPH, OPT, OT, POD, PSYC, PT, R-ONC, SLP, ALIM, DERM, END, GST, HEM, NEPH, OTO, PUL, RHEU, and URO), and facility (MTD) network adequacy standards since fewer than 95 percent of its members were within acceptable travel times or distances for these provider types. Additionally, 0.0 percent of EOCCO's pediatric members had access to OPT, OT, POD, PT, R-ONC, and LSP providers since EOCCO's provider network had not contracted with providers in these specialties. Finally, while EOCCO had engaged in OHA's time and distance exception request process for some noncompliant provider types, most remained unaddressed. It is expected that the CCO have at least one provider of all monitored types within its network, regardless of time and distance standard compliance, rather than rely on single case agreements or similar methods.	

Strength/ Weakness	Description	Domain(s) ⁵⁵
	Recommendations: EOCCO should ensure that it takes the necessary steps to maintain an adequate network that can provide all covered and necessary care. The CCO should work to contract with at least one provider of each missing type that can supply such services as part of the CCO's network, even if that provider is not within the service region. Such providers should still be meaningfully accessible through regional transportation (e.g., driving to a nearby population center). The CCO should engage with OHA on potential solutions for these needs, including engagement in OHA's time and distance exception request process for noncompliant provider types and populations.	
Revealed Telephone Survey		
	Strength: Of the PCP cases that offered an appointment, 100 percent of urgent appointments for existing patients were compliant with the wait time standard.	
	Weakness: Overall, 73.4 percent of the total PCP and OP SUD sampled cases were reached. Among the cases reached, 86.5 percent confirmed the correct location, 68.9 percent offered the requested services, 61.7 percent accepted OHP Medicaid, and 43.0 percent accepted EOCCO. Also, 83.1 percent of cases offered translation or interpreter services. Why the weakness exists: In addition to limitations related to the revealed survey approach, inaccuracies found in EOCCO's provider data may have contributed to the low response rate and accuracy results. Recommendations: EOCCO should use the case-level analytic data files to address the data deficiencies identified during the survey calls (e.g., incorrect or disconnected telephone numbers; incorrect location; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
	Weakness: Among the total PCP and OP SUD cases reached, only 39.4 percent accepted new patients. In addition, appointment availability was only offered for less than 32.0 percent of PCP cases and 29.0 percent of OP SUD cases. Of the PCP appointments that were offered, 53.7 percent of new patient routine visits, 48.1 percent of new patient urgent visits, and 78.7 percent of existing patient routine visits were compliant with the wait time standards. Also, of the OP SUD appointments that were offered, all compliance rates were low, ranging from 7.7 percent (opioid use disorder visits) to 46.2 percent (routine visits). Why the weakness exists: In addition to limitations related to the revealed survey approach, inaccuracies found in EOCCO's provider data and insufficient provider panel capacity may have contributed to low access and availability rates (i.e., new patient acceptance, appointment availability, and wait times). Also, internal office staffing structures and procedures may have contributed to the long wait times.	

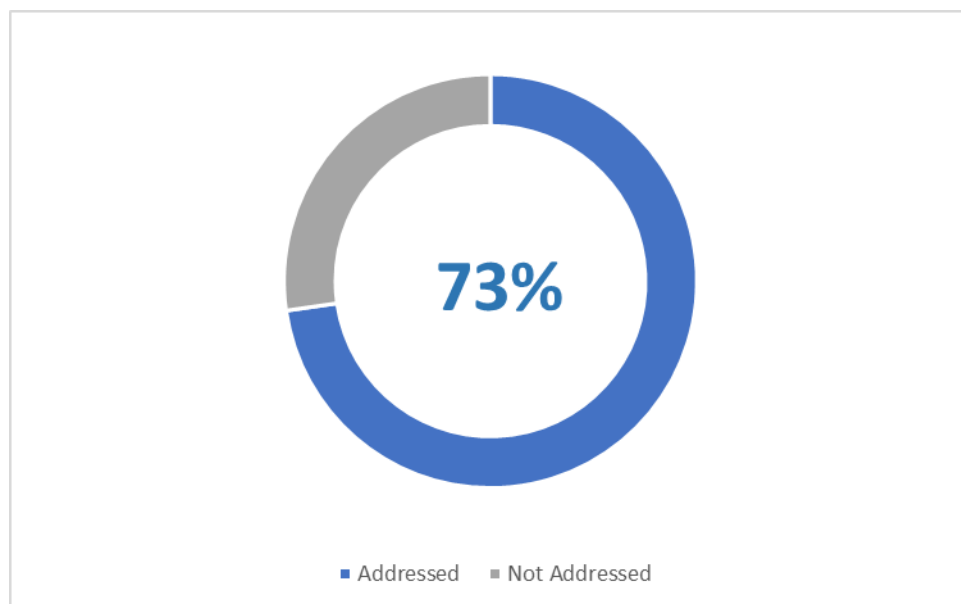
Strength/ Weakness	Description	Domain(s) ⁵⁵
	Recommendations: EOCCO should confirm appointment availability with providers, including panel capacity to accept new patients. Further, EOCCO should use the case-level analytic data files to address data deficiencies identified during the survey calls.	
Encounter Data Validation		
Since EDV results were not available for inclusion in the 2024 EQR technical report, the strengths and weaknesses for each CCO could not be assessed. The findings will be incorporated in next year's EQR technical report.		
Mental Health Parity Evaluation		
The CCO met performance expectations. No significant strengths or weaknesses were noted during the review.		

Follow-Up on Prior Year Recommendations

HSAG evaluated EOCCO's approach to addressing the recommendations related to findings issued during CY 2023 and unresolved findings from CY 2020, CY 2021, and CY 2022 while conducting the CY 2024 EQR activities. The CCOs not addressing recommendations are at risk of being out of compliance with their contracts.

Figure 5-10 illustrates the degree in which the CCO sufficiently addressed the recommendations for QI made by HSAG during the CY 2023 EQR.

Figure 5-10—Percentage of CY 2023 EQR Recommendations Addressed by EOCCO



EOCCO-specific CY 2023 recommendations and follow-up CY 2024 assessments are summarized in Table 5-10.

Table 5-10—Assessment of EOCCO’s Approach to Addressing Previous Annual Recommendations

CY 2023 Recommendation	CY 2024 Assessment
Compliance Monitoring Review	
Standard I—Assurance of Adequate Capacity and Availability of Services*	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Standard III—Coordination and Continuity of Care	
EOCCO should revise its policies and procedures to align with State requirements. EOCCO should also demonstrate implementation of appropriate assessments, reassessments, and revision of treatment plans according to federal and State requirements. EOCCO should also implement mechanisms to ensure the appropriate maintenance of medical records in accordance with professional standards.	EOCCO did not sufficiently address the recommendation. Although the CCO revised its policies and procedures to align with federal and State requirements and began implementation, the CCO could not demonstrate implementation of a process to ensure each provider furnishing services to members maintain and share member health records in accordance with professional standards. EOCCO should implement mechanisms to ensure the appropriate maintenance of medical records in accordance with professional standards.
Standard IV—Coverage and Authorization of Services	
EOCCO should revise its policies and procedures to align with federal and State requirements. EOCCO should demonstrate adherence to federal and State requirements for authorization requests and required content, readability, and time frames for providing NOABDs. EOCCO should also demonstrate proper outreach to retrieve the information needed to process service authorization requests.	EOCCO sufficiently addressed the recommendation.
Standard V—Provider Selection	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard VI—Subcontractual Relationships and Delegation	
This standard was not assessed during the 2023 CMR.	Not applicable.

CY 2023 Recommendation	CY 2024 Assessment
Standard VII—Member Rights and Protections	
EOCCO should revise its policies and procedures and provider-facing materials to align with federal and State requirements.	EOCCO sufficiently addressed the recommendation.
Standard VIII—Confidentiality	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard IX—Enrollment and Disenrollment	
This recommendation was initially given during the CY 2022 EQR. EOCCO should ensure its policies and procedures align with federal and State requirements.	EOCCO sufficiently addressed the recommendation.
Standard X—Grievance and Appeal Systems	
EOCCO should revise its policies and procedures to align with federal and State requirements. EOCCO should also adhere to federal and State requirements for the required content for grievance resolution notices, maintenance of an expedited process, time frames for acknowledging appeals, and extension requirements. EOCCO should also demonstrate implementation of federal and State requirements within communications to providers and subcontractors.	EOCCO sufficiently addressed the recommendation.
Standard XI—Practice Guidelines	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Standard XII—Quality Assessment and Performance Improvement	
This recommendation was initially given during the CY 2022 EQR. EOCCO should revise its QAPI program structure to align with federal and State requirements for a QAPI program. EOCCO should identify a defined process or mechanism to evaluate the population and/or relevant subpopulations for the appropriate care. EOCCO should describe the data used and how these data will be used to assess the population. EOCCO should also demonstrate appropriate oversight of its QAPI program.	EOCCO did not sufficiently address the recommendation. Although EOCCO revised its QAPI program structure to meet the requirements for QI committees, the CCO did not demonstrate mechanisms to assess the quality and appropriateness of care furnished to members using LTSS. EOCCO should revise its QAPI program structure to include mechanisms to assess the quality and appropriateness of care furnished to members using LTSS.

CY 2023 Recommendation	CY 2024 Assessment
Standard XIII—Health Information Systems, including ISCA	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard XIV—Member Information	
This recommendation was initially given during the CY 2020 EQR. EOCCO should revise its policies, procedures, and member-facing materials to align with federal and State requirements. EOCCO should also notify members of the availability of member information and track and monitor the timely provision of required member information. Lastly, EOCCO should ensure the provider directory includes the State and federal requirements for the information listed for each provider.	EOCCO did not sufficiently address the recommendation. EOCCO developed a policy for ensuring that member materials align with federal requirements for materials to be readily accessible; however, the CCO could not demonstrate full implementation of the policy. Additionally, the CCO’s printable formulary was not in the appropriate font size and the provider directory did not meet federal and State requirements. HSAG recommends that EOCCO demonstrate implementation of its process and improvement plan to ensure alignment with federal and State requirements for member information.
Standard XVI—Emergency and Poststabilization Services	
EOCCO should revise its policies and procedures to align with federal and State requirements. EOCCO should also revise its provider materials to define “emergency and poststabilization services” and communicate the appropriate requirements.	EOCCO sufficiently addressed the recommendation.
Performance Improvement Projects	
Statewide Mental Health Service Access Monitoring PIP	
EOCCO should revisit root cause analyses identifying barriers to improving access to MH services to determine which barriers to improvement were not effectively addressed. EOCCO should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to improve indicator results.	EOCCO sufficiently addressed the recommendation.
Statewide Substance Use Disorder PIP	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.

CY 2023 Recommendation	CY 2024 Assessment
Performance Measure Validation	
EOCCO should continue efforts started in CY 2022 to raise its performance measurement rate for the <i>Initiation of SUD Treatment</i> measure indicator, specifically for members 18 years and older, to the level of the benchmarks set by OHA.	EOCCO sufficiently addressed the recommendation. EOCCO addressed the recommendations provided by HSAG and continued its efforts to improve performance in this measure, which included implementation of a learning collaborative that included all providers providing SUD services related to initiation, engagement, or treatment of SUDs for members. The goal of the collaborative was to provide a metric overview, receive feedback related to barriers, and increase communication among providers. Additionally, EOCCO engaged an SUD coordinator to assist in the coordination of engagement and treatment services once an initiation service was provided. EOCCO should continue implementing these efforts to raise its rates on this measure to the level of the benchmarks set by OHA.
Validation of Network Adequacy	
Delivery System Network Evaluation	
This recommendation was initially given during the CY 2022 EQR. EOCCO should adhere to state-approved DSN data requirements and seek technical assistance from OHA, as needed. Specifically, the CCO should seek to understand and correct provider capacity data issues related to adult and pediatric populations served, service area, and accepting new patients' status.	EOCCO did not sufficiently address the recommendation. EOCCO described process improvements to its network data management, including dedicated staffing, and demonstrated improvements in accuracy of PCP reporting for accepting patient status, operating in service area status, and age of demographic served. However, while these issues appeared resolved for PCPs, issues with other non-PCP data values and reporting persisted, as evidenced by EOCCO's data lookup procedures, Q1 <i>DSN Provider Capacity Report</i> results, and other documentation. EOCCO should adhere to state-approved DSN data requirements and seek technical assistance from OHA, if needed.
EOCCO should ensure that it describes or demonstrates how collected information is used to inform network adequacy monitoring and decision-making. EOCCO should ensure that all network adequacy interventions include plans for assessing their efficacy. EOCCO should address all findings from prior DSN evaluations.	EOCCO sufficiently addressed the recommendation.

CY 2023 Recommendation	CY 2024 Assessment
Secret Shopper Survey	
This recommendation was initially given during the CY 2021 EQR. HSAG recommends that EOCCO use the case-level analytic data files to address the data deficiencies identified during the secret shopper survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	EOCCO sufficiently addressed the recommendation. EOCCO reported that it implemented initiatives such as a tool that tracks and monitors provider data. EOCCO should continue to monitor and improve any efforts in maintaining accurate provider data (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).
HSAG recommends that EOCCO confirm appointment availability with providers, including panel capacity to accept new patients. EOCCO should use the case-level analytic data files containing data deficiencies identified during the secret shopper survey calls.	EOCCO sufficiently addressed the recommendation. EOCCO reported that it conducted routine outreach and monitoring activities to confirm provider appointment availability and capacity. EOCCO should continue to monitor and improve any efforts in maintaining accurate provider data and compliance with wait time standards.
Revealed Telephone Survey	
HSAG recommends that EOCCO use the case-level analytic data files to address the data deficiencies identified during the revealed telephone survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	EOCCO sufficiently addressed the recommendation. EOCCO reported that it implemented initiatives such as a tool that tracks and monitors provider data. EOCCO should continue to monitor and improve any efforts in maintaining accurate provider data (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).
HSAG recommends that EOCCO confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. EOCCO should use the case-level analytic data files containing data deficiencies identified during the revealed telephone survey calls and work with BH outpatient offices to identify the root cause for delays in appointment availability.	EOCCO sufficiently addressed the recommendation. EOCCO reported creating a new staff position to routinely engage with providers and assess appointment availability. EOCCO should continue to monitor and improve any efforts in maintaining accurate provider data and compliance with wait time standards.
Encounter Data Validation	
This recommendation was initially given during the CY 2022 EQR. EOCCO should provide additional information on any enhanced	EOCCO did not sufficiently address the recommendation. EOCCO has partially addressed the recommendation. While the

CY 2023 Recommendation	CY 2024 Assessment
measures, contractual amendments, or strategies implemented to strengthen provider accountability in responding to medical record requests. Additionally, outlining steps taken to address nonresponsive providers and any improvements made to the process would demonstrate a proactive approach to meeting the recommendation.	outlined communication enhancements and collaborations are positive steps, the response lacks specifics regarding contractual amendments, measures to address nonresponsive providers, or demonstrated improvements. To fully address the recommendation, EOCCO should implement and detail these additional measures.
This recommendation was initially given during the CY 2022 EQR. EOCCO should investigate the root cause for the omissions and consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews should then be provided to providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.	EOCCO did not sufficiently address the recommendation. EOCCO has partially addressed the recommendation. While the response outlines efforts to identify issues and improve communication and education, it does not explicitly include conducting periodic MRRs or providing findings to providers as recommended. Additional steps to implement and document MRRs and utilize its findings for targeted provider training would fully address the recommendation.
While encounter submission to OHA did not require the inclusion of the <i>Rendering Provider NPI</i> value if it matched the <i>Billing Provider NPI</i> value, the data request for the EDV comparative analysis had different requirements. To address this, HSAG recommends that EOCCO and its subcontractor(s) ensure that values for both <i>Billing Provider NPI</i> and <i>Rendering Provider NPI</i> are included in the data submission, irrespective of their equivalence. This adjustment will enhance the accuracy and completeness of the comparative analysis data. Additionally, it will provide HSAG with the means to verify and ensure the accuracy of the MMIS' process of populating the <i>Rendering Provider NPI</i> with the <i>Billing Provider NPI</i> .	EOCCO sufficiently addressed the recommendation. EOCCO's existing processes and commitment to include the necessary data in future submissions, combined with plans for quality checks, demonstrate compliance with HSAG's guidance. However, demonstrating these updates in future EDV submissions will confirm their implementation.
Mental Health Parity Evaluation	
EOCCO should review its implementation of concurrent review for OP MH/SUD services to ensure that the additional limitation based on the benefit does not impede the member's ability to access OP care more so than M/S.	EOCCO sufficiently addressed the recommendation.

CY 2023 Recommendation	CY 2024 Assessment
EOCCO should identify processes, strategies, evidentiary standards, and other factors used in step therapy assignment for prescription drugs.	EOCCO sufficiently addressed the recommendation.
EOCCO should identify processes, strategies, evidentiary standards, and other factors used in formulary tiering.	EOCCO sufficiently addressed the recommendation.

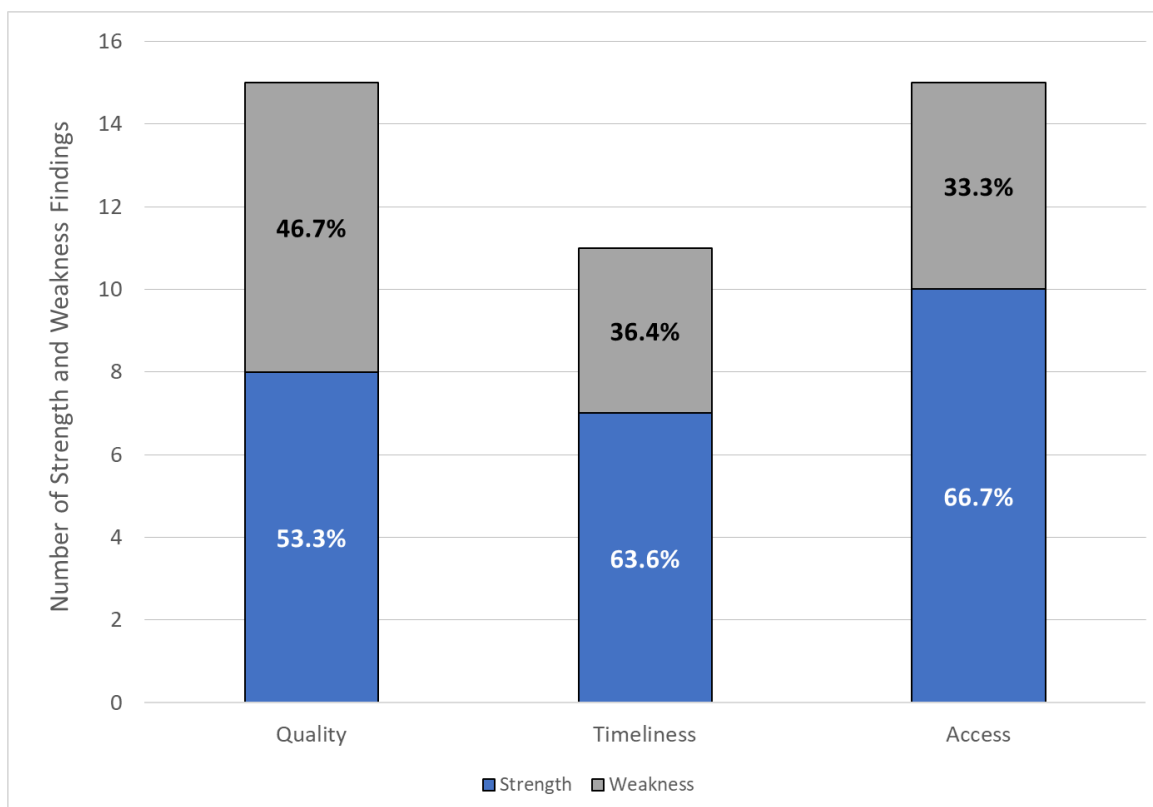
*Standard I—Availability of Services and Standard II—Assurances of Adequate Capacity and Services were combined, and all elements required by 42 CFR §438.206 and §438.207 were assessed under the combined Standard I—Assurance of Adequate Capacity and Availability of Services during the CY 2024 CMR activity.

Health Share of Oregon

Results and Conclusions

HSAG assessed the strengths and weaknesses of each CCO with respect to the quality, timeliness, and accessibility of health care services. Figure 5-11 illustrates the number of strengths exhibited by HSO relative to the number of weaknesses identified during the CY 2024 EQR activities across the three domains. The greater the proportion of weaknesses, the greater opportunities for improvement.

Figure 5-11—HSO Overall Number of Findings (Strengths and Weaknesses) by Domain



Detailed results from the EQR’s substantive findings are summarized in Table 5-11 for each activity. This table highlights the extent to which HSO furnishes high quality, timely, and appropriate access to health care services, and recommendations for how HSO can best address issues identified for each activity.⁵⁶

⁵⁶ See Section 4—Comparative Statewide Results for detailed, CCO-specific scores associated with EQR activity.

Table 5-11—HSO Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s) ⁵⁷
Compliance Monitoring Review		
	Weakness: HSO received a score of 55.3 percent in the <i>Assurance of Adequate Capacity and Availability of Services</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements, the inability to demonstrate sufficient implementation of established processes, and deficiencies within its monitoring activities impacting the CCO's ability to ensure timely access to care and services. Why the weakness exists: HSO lacked a methodology for monitoring and maintaining its provider network for the federal and State-required components. Additionally, the policies and procedures implemented did not fully align with State-established time and distance standards, family planning requirements, reporting requirements, provision of culturally, linguistically, and trauma-informed services, and provision of access, accommodations, and equipment for members with physical and mental disabilities. Also, the CCO failed to demonstrate the appropriate mechanisms for monitoring, or provide evidence of monitoring access to family planning providers, State-established time and distance standards, provider compliance with appointment standards, and corrective action when providers fail to meet appointment standards. Finally, the CCO failed to communicate the appropriate access to care and service requirements in its provider communications. Recommendations: HSO should develop and implement a methodology for monitoring and maintaining its provider network for the federal and State-required components. Additionally, the CCO should revise its policies and procedures to align with federal and State requirements for timely access to care and services and reporting and demonstrate implementation. The CCO should also demonstrate the implementation of corrective action when providers fail to meet appointment standards. Finally, the CCO should revise its provider communications to include the appropriate access to care and service requirements.	  
	Weakness: HSO received a score of 58.3 percent in the <i>Provider Selection</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements and failure to conduct appropriate monitoring activities impacting the	 

⁵⁷  = Quality,  = Timeliness,  = Access

Strength/ Weakness	Description	Domain(s) ⁵⁷
	CCO's ability to meet federal and State requirements for selecting, retaining, credentialing, and recredentialing network providers. Why the weakness exists: HSO and its subcontractors lacked policies and procedures for selecting and retaining network providers. Additionally, the CCO did not have a mechanism to ensure its subcontractors' provider selection processes did not inadvertently discriminate against providers. The CCO also did not demonstrate the appropriate ongoing monitoring of its subcontractors to ensure compliance with federal and State requirements for credentialing, recredentialing, denial of participation in its network notifications, and providers excluded from participation in federal health care programs. Recommendations: HSO and its subcontractors should develop written policies and procedures for selecting and retaining providers. Additionally, the CCO should ensure its subcontractors' provider selection processes do not inadvertently discriminate against providers. The CCO should also conduct the appropriate ongoing monitoring of its subcontractors to ensure compliance with federal and State requirements for credentialing, recredentialing, denial of participation in its network notification, and providers excluded from participation in federal health care programs.	
	Weakness: HSO received a score of 75.0 percent in the <i>Subcontractual Relationships and Delegation</i> standard due to insufficient documentation to support operations and ensure compliance with federal requirements for written agreements between the CCO and its subcontractors and failure to conduct appropriate monitoring activities impacting the CCO's ability to adhere to federal requirements and the CCO's contractual requirements with the State. Why the weakness exists: HSO failed to demonstrate that it conducts the appropriate oversight and monitoring of its subcontractors and holds them accountable for contractual requirements. Additionally, the CCO's contracts with its subcontractors failed to include federally required language for written agreements with subcontractors. Recommendations: HSO should hold its subcontractors accountable for contractual obligations and conduct the appropriate oversight and monitoring of its subcontractors. The CCO should also revise its written agreements to align with federally required language for written agreements with subcontractors.	
	Weakness: HSO received a score of 33.3 percent in the <i>Practice Guidelines</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements and failure to conduct appropriate monitoring activities impacting the CCO's ability to adopt, review, update, and disseminate the appropriate	

Strength/ Weakness	Description	Domain(s) ⁵⁷
	clinical practice guidelines and ensure decision-making was aligned with the guidelines. Why the weakness exists: HSO could not demonstrate a process that aligned with the federal and State requirements for adopting, reviewing, updating, and disseminating the appropriate clinical practice guidelines and ensuring decision-making was aligned with the guidelines. The CCO also could not demonstrate comprehensive monitoring of its subcontractors for compliance with federal and State requirements for clinical practice guidelines. Recommendations: HSO should develop and implement a process that aligns with the federal and State requirements for adopting, reviewing, updating, and disseminating the appropriate clinical practice guidelines and ensuring decision-making is aligned with the guidelines. The CCO should also demonstrate comprehensive monitoring of its subcontractors for compliance with federal and State requirements for clinical practice guidelines.	
Performance Improvement Projects		
Statewide Mental Health Service Access Monitoring PIP		
	Strength: HSO successfully continued the Implementation stage for the PIP, receiving a <i>Met</i> score for 100 percent of applicable evaluation elements in the PIP Validation Tool. In the Implementation stage, HSO accurately reported baseline and RY 2 performance indicator data, identified and analyzed barriers to improving MH service access, carried out interventions to address those barriers, and refined interventions based on intervention evaluation results.	
	Strength: HSO's RY 2 performance indicator results demonstrated sustained improvement in MH service access compared to baseline indicator results.	
Statewide Substance Use Disorder PIP		
	Strength: HSO successfully initiated the Implementation stage for the PIP, receiving a <i>Met</i> score for 100 percent of applicable evaluation elements in the PIP Validation Tool. In the Implementation stage, HSO accurately reported baseline and RY 1 performance indicator data; identified and analyzed barriers for initiation, engagement, and treatment of alcohol and other drug use disorders; and began to carry out interventions to address those barriers.	
	Strength: HSO's RY 1 performance indicator results demonstrated statistically significant improvement for initiation, engagement, and treatment of alcohol and other drug use disorders compared to baseline indicator results.	

Strength/ Weakness	Description	Domain(s) ⁵⁷
Performance Measure Validation		
	Strength: HSO's MY 2023 performance on the <i>Initiation and Engagement of SUD Treatment</i> measure indicators demonstrated ongoing improvement for members ages 18 years and older since MY 2022. In addition, the CCO's MY 2023 rate for both the initiation and engagement measure indicators exceeded the statewide aggregate and the benchmark set by OHA for MY 2023.	
	Strength: HSO's MY 2023 performance on the <i>Members Receiving Preventive Dental or Oral Health Services—Ages 1 to 5 Years and Ages 6 to 14 Years</i> measure indicators demonstrated ongoing improvement since MY 2021. In addition, the CCO's MY 2023 rate for the <i>Ages 1 to 5 Years</i> measure indicator exceeded the benchmark set by OHA for MY 2023, with the performance for ages 1 to 5 years increasing by more than 5 percentage points (6.1 percentage points).	
	Strength: HSO's MY 2023 performance on the <i>Oral Evaluation for Adults With Diabetes</i> measure indicators demonstrated improvement from MY 2022. In addition, the CCO's MY 2023 rate exceeded the statewide aggregate and the benchmark set by OHA for MY 2023.	
Validation of Network Adequacy		
Network Adequacy Validation Audit		
	Strength: HSO had a well-documented process for creating network adequacy reports within the ArcGIS application utilizing the State provided files.	
Delivery System Network Evaluation		
	Weakness: HSO showed potential issues within its provider data, including but not limited to service area activity and status of accepting new patients. Why the weakness exists: HSO reported moderate rates of providers operating within its service area and moderate to very low rates (i.e., 10 percent or less) of providers accepting new patients. Recommendations: HSO should seek technical assistance with OHA to determine the nature of the provider capacity data issues and correct them.	
Revealed Telephone Survey		
	Strength: Of the total PCP and OP SUD cases reached, 91.8 percent confirmed the correct location.	
	Strength: Of the PCP cases that offered an appointment for existing patients, 95.5 percent of urgent appointments were compliant with the wait time standard.	

Strength/ Weakness	Description	Domain(s) ⁵⁷
	Strength: Of the OP SUD cases that offered an appointment, 90.0 percent of routine appointments were compliant with the wait time standard.	
	Strength: Of the PCP and OP SUD cases that accepted the CCO, 96.8 percent offered translation or interpreter services.	
	Weakness: Overall, 85.6 percent of the total PCP and OP SUD sampled cases were reached. Among the cases reached, 74.9 percent offered the requested services, 66.3 percent accepted OHP Medicaid, and 49.4 percent accepted HSO. Why the weakness exists: In addition to limitations related to the revealed survey approach, inaccuracies found in HSO's provider data may have contributed to the low response rate and accuracy results. Recommendations: HSO should use the case-level analytic data files to address the data deficiencies identified during the survey calls (e.g., incorrect or disconnected telephone numbers; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
	Weakness: Among the total PCP and OP SUD cases reached, 41.6 percent accepted new patients. In addition, appointment availability was only offered for less than 50.0 percent of PCP cases and 20.0 percent of OP SUD cases. Of the PCP appointments that were offered, 60.3 percent (new patient routine visits), 76.1 percent (new patient urgent visits), and 83.0 percent (existing patient routine visits) were compliant with the wait time standards. Also, of the OP SUD appointments that were offered, 11.1 percent of urgent visits, 40.0 percent of opioid use disorder visits, and 72.7 percent of pregnant OP SUD visits were compliant with the wait time standards. Why the weakness exists: In addition to limitations related to the revealed survey approach, inaccuracies found in HSO's provider data and insufficient provider panel capacity may have contributed to low access and availability rates (i.e., new patient acceptance, appointment availability, and wait times). Also, internal office staffing structures and procedures may have contributed to the long wait times. Recommendations: HSO should confirm appointment availability with providers, including panel capacity to accept new patients. Further, HSO should use the case-level analytic data files to address data deficiencies identified during the survey calls.	
Encounter Data Validation		
Since EDV results were not available for inclusion in the 2024 EQR technical report, the strengths and weaknesses for each CCO could not be assessed. The findings will be incorporated in next year's EQR technical report.		

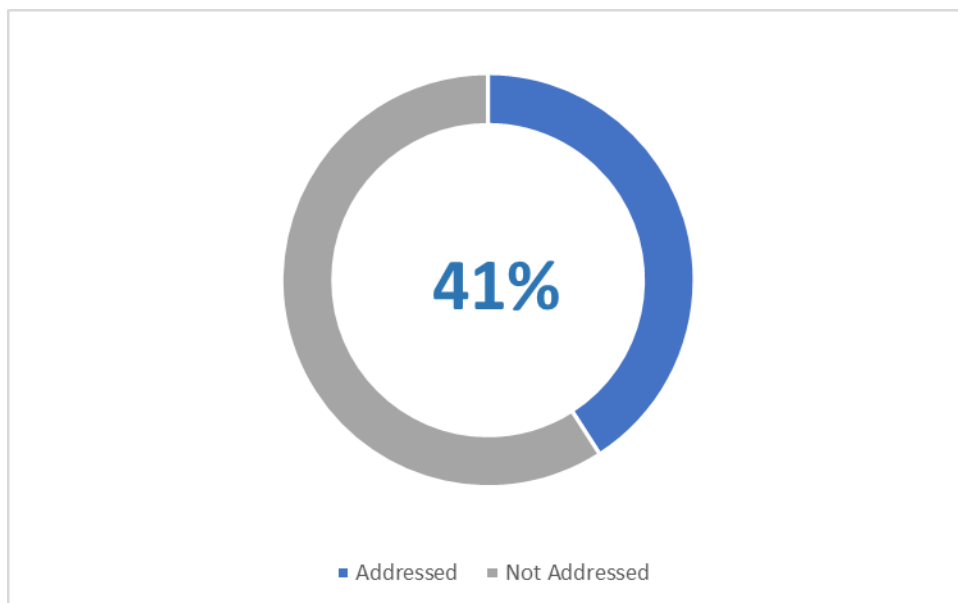
Strength/ Weakness	Description	Domain(s) ⁵⁷
Mental Health Parity Evaluation		
—	Weakness: HSO was partially compliant with the Pharmacy Management–formulary design NQTL requirement. Why the weakness exists: HSO did not provide documentation related to its rationale for the assignment of the NQTL (i.e., prescription drug formulary), procedures used for the development of the formulary (e.g., individuals involved in formulary development, professional guidelines used, and how often the formulary is reviewed and updated or by whom), or how frequently or strictly the NQTL is applied (e.g., ability of the provider to request an exception). Recommendations: HSO should provide supporting documentation to identify processes, strategies, evidentiary standards, and other factors that are used in formulary design and the application for prescription drugs.	🔑

Follow-Up on Prior Year Recommendations

HSAG evaluated HSO’s approach to addressing the recommendations related to findings issued during CY 2023 and unresolved findings from CY 2020, CY 2021, and CY 2022 while conducting the CY 2024 EQR activities. The CCOs not addressing recommendations are at risk of being out of compliance with their contracts.

Figure 5-12 illustrates the degree in which the CCO sufficiently addressed the recommendations for QI made by HSAG during the CY 2023 EQR.

Figure 5-12—Percentage of CY 2023 EQR Recommendations Addressed by HSO



HSO-specific CY 2023 recommendations and follow-up CY 2024 assessments are summarized in Table 5-12.

Table 5-12—Assessment of HSO’s Approach to Addressing Previous Annual Recommendations

CY 2023 Recommendation	CY 2024 Assessment
Compliance Monitoring Review	
Standard I—Assurance of Adequate Capacity and Availability of Services*	
This recommendation was initially given during the CY 2021 EQR. HSO should ensure its subcontractors and its own policies and procedures, member- and provider-facing materials, and other monitoring documentation appropriately address the network availability requirements. In addition, HSO should develop a documented process for monitoring provider capacity that includes monitoring specialty providers individually by specialty type and ensuring its network evaluation incorporates key data collected from its monitoring processes.	HSO did not sufficiently address the recommendation. HSO and its subcontractors’ policies and procedures, member- and provider-facing materials, and other monitoring documentation remained out of compliance and did not appropriately address the network availability requirements, including appointment availability time frames, evidence of monitoring network providers’ compliance with state-established standards and corrective action when appropriate, out-of-network service availability requirements, family planning services requirements, and women specialist requirements. Note: Standard I—Assurance of Adequate Capacity and Availability of Services was comprehensively reviewed during the CY 2024 CMR cycle, and recommendations addressing all findings related to this standard are included in the CCO’s individual Results and Conclusions section.
Standard III—Coordination and Continuity of Care	
HSO should revise its policies and procedures to align with federal and State requirements and demonstrate that its subcontractors have and implement the appropriate processes to ensure compliance with the requirements.	HSO did not sufficiently address the recommendation. HSO could not demonstrate enhanced mechanisms to ensure its subcontractors complied with the requirements, including ensuring the appropriate implementation of policies and procedures for the designated person or entity primarily responsible for coordinating care and services assessed by the member, service coordination, sharing results assessments of member needs, health record sharing and maintenance, comprehensive assessments of members with SHCN, and care plan development. HSO should revise its policies and procedures to align with federal and State requirements and demonstrate that its subcontractors have and

CY 2023 Recommendation	CY 2024 Assessment
	implement the appropriate processes to ensure compliance with the requirements.
Standard IV—Coverage and Authorization of Services	
This recommendation was initially given during the CY 2020 EQR. HSO should revise its policies and procedures to align with federal and State requirements. HSO should demonstrate adherence to federal and State requirements for coverage and authorization of services and required content and time frames for providing NOABDs. The CCO should also ensure that its policies specify the procedures and time frames for processing PAs and that its subcontractors consult with the requesting provider for medical services when appropriate.	HSO did not sufficiently address the recommendation. HSO did not demonstrate oversight of its subcontractors and whether the subcontractors met the requirements or enhance any processes to ensure subcontractors follow the appropriate policies and procedures for authorizing services. HSO should ensure oversight and monitoring of its subcontractors to ensure the subcontractors' policies and processes align with the State and federal requirements. The CCO should also ensure that its policies specify the procedures and time frames for processing PAs and that its subcontractors consult with the requesting provider for medical services when appropriate.
Standard V—Provider Selection	
This recommendation was initially given during the CY 2021 EQR. HSO should ensure that its credentialing program meets minimum State requirements. The CCO should also demonstrate completing the appropriate training for subcontractor staff members and network providers.	Not applicable. The recommendation was tied to a state-specific element that was removed from HSAG's review.
Standard VI—Subcontractual Relationships and Delegation	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard VII—Member Rights and Protections	
This recommendation was initially given during the CY 2020 EQR. HSO and/or its subcontractors should revise their policies and procedures and member- and provider-facing materials to align with federal and State requirements.	HSO did not sufficiently address the recommendation. While HSO developed a process to review subcontractor provider manuals to ensure they meet federal and State requirements, the provider manual continued to omit federal and State member rights and protections requirements. Additionally, HSO's policies and procedures did not align with federal and State requirements for advance directives. HSO should ensure its policies and procedures and other member- and provider-facing materials

CY 2023 Recommendation	CY 2024 Assessment
	align with federal and State requirements for member rights and advance directives.
Standard VIII—Confidentiality	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard IX—Enrollment and Disenrollment	
This recommendation was initially given during the CY 2022 EQR. HSO should ensure its policies and procedures fully address the federal and State requirements for the disenrollment of members.	HSO sufficiently addressed the recommendation.
Standard X—Grievance and Appeal Systems	
HSO should revise its policies and procedures to align with federal and State requirements. Additionally, HSO should demonstrate adherence to federal and State requirements for grievances and appeals.	HSO did not sufficiently address the recommendation. Although HSO revised policies and procedures to align with some of the requirements, the CCO did not demonstrate oversight of its subcontractors to ensure compliance with the requirements for provider-facing materials and compliance with federal requirements for grievance and appeal processes. HSO and its subcontractors should revise its policies and procedures to align with federal and State requirements. Additionally, HSO should demonstrate adherence to federal and State requirements for grievances and appeals.
Standard XI—Practice Guidelines	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard XII—Quality Assessment and Performance Improvement	
This recommendation was initially given during the CY 2022 EQR. HSO should revise its QAPI program structure to align with federal and State requirements for a QAPI program. HSO should also demonstrate implementation and appropriate oversight of its QAPI program.	HSO did not sufficiently address the recommendation. Although HSO completed revisions to its QAPI program, the CCO did not implement a QAPI assessment that met federal and State requirements. HSO should ensure that it conducts a QAPI assessment that aligns with federal and State requirements.
Standard XIII—Health Information Systems, including ISCA	
This recommendation was initially given during the CY 2022 EQR. HSO should develop or implement processes to monitor its BH	Not Applicable. The recommendation was tied to a state-specific element that was removed from HSAG’s review.

CY 2023 Recommendation	CY 2024 Assessment
providers' compliance with MOTS reporting requirements.	
Standard XIV—Member Information	
HSO should revise its policies, procedures, and member-facing materials to align with federal and State requirements. Additionally, HSO should track and monitor the timely provision of required member information.	HSO did not sufficiently address the recommendation. HSO did not demonstrate a process to ensure its subcontractors' member-facing materials align with federal and State requirements for the member handbook, provider directories, formularies, information on the CCO structure, operations, physician incentive plans, and electronic communications. HSO also did not have a process for tracking and monitoring the timely provision of required member information. HSO should revise its policies, procedures, and member-facing materials to align with federal and State requirements. Additionally, HSO should track and monitor the timely provision of required member information.
Standard XVI—Emergency and Poststabilization Services	
HSO should revise the applicable plan documents to define “emergency and poststabilization services” and communicate the appropriate requirements. HSO should also ensure that its internal and subcontractors' policies and procedures align with State and federal requirements and demonstrate implementation.	HSO did not sufficiently address the recommendation. Although the CCO revised its processes to include federal and State requirements for emergency and poststabilization services, HSO reported that it has not fully implemented its processes with its subcontractors. HSO should ensure implementation of federal and State requirements for emergency and poststabilization services internally and with subcontractors.
Performance Improvement Projects	
Statewide Mental Health Service Access Monitoring PIP	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Statewide Substance Use Disorder PIP	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Performance Measure Validation	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.

CY 2023 Recommendation	CY 2024 Assessment
Validation of Network Adequacy	
Delivery System Network Evaluation	
HSO should ensure that all future reporting utilizes the state-established specialty provider taxonomies current to the review period and should demonstrate how it collects and uses DSN data to inform network adequacy monitoring and decision-making.	HSO sufficiently addressed the recommendation.
HSO should seek technical assistance with OHA to determine the nature of the provider capacity data issues and correct them.	HSO sufficiently addressed the recommendation. HSO provided narrative responses and supporting documentation which demonstrated it had sought technical assistance with OHA to determine the nature of its provider capacity data issues, initial results of which indicated a likely reporting error. While HSO's CY 2024 data showed similar errors or inconsistencies as in prior years, HSO addressed the recommendation to seek technical assistance from OHA and demonstrated working toward a resolution.
Secret Shopper Survey	
HSAG recommends that HSO use the case-level analytic data files to address the data deficiencies identified during the secret shopper survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	HSO sufficiently addressed the recommendation. HSO reviewed the data deficiencies and made all applicable changes. In addition to outreach and monitoring activities to confirm provider data, HSO reported that it implemented a dashboard and a staff position to monitor and identify any data discrepancies. HSO should continue to monitor and improve any efforts in maintaining accurate provider data (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).
HSAG recommends that HSO confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. HSO should use the case-level analytic data files containing data deficiencies identified during the secret shopper survey calls.	HSO sufficiently addressed the recommendation. HSO reviewed the data deficiencies and made all applicable changes. In addition, HSO reported that it conducted routine outreach and monitoring activities to confirm provider availability within the network. HSO should continue to monitor and improve any efforts in maintaining accurate provider data.

CY 2023 Recommendation	CY 2024 Assessment
Revealed Telephone Survey	
HSAG recommends that HSO use the case-level analytic data files to address the data deficiencies identified during the revealed telephone survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, program information, and translation/interpreter services offered).	HSO sufficiently addressed the recommendation. HSO reviewed the data deficiencies and made all applicable changes. In addition to outreach and monitoring activities to confirm provider data, HSO reported that it implemented a dashboard and a staff position to monitor and identify any data discrepancies. HSO should continue to monitor and improve any efforts in maintaining accurate provider data (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).
HSAG recommends that HSO confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. HSO should use the case-level analytic data files containing data deficiencies identified during the revealed telephone survey calls and work with BH outpatient offices to identify the root cause for delays in appointment availability.	HSO sufficiently addressed the recommendation. HSO reviewed the data deficiencies and made all applicable changes. Also, HSO reported that it conducted routine outreach and monitoring activities to confirm provider availability within the network. HSO should continue to monitor and improve any efforts in maintaining accurate provider data and compliance with wait time standards.
Encounter Data Validation	
This recommendation was initially given during the CY 2021 EQR. HSO should address the recommendation to implement standardized data extraction procedures to reduce the number of errors associated with data extraction.	HSO sufficiently addressed the recommendation.
This recommendation was initially given during the CY 2022 EQR. HSO should investigate the root cause for the omissions and consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews should then be provided to providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.	HSO sufficiently addressed the recommendation.
HSAG recommends that HSO proactively inform HSAG about special scenarios like the one observed with WDG, where the <i>Adjudication</i>	HSO did not sufficiently address the recommendation. HSO has partially addressed the recommendation. While HSO acknowledged the recommendation and incorporating it into

CY 2023 Recommendation	CY 2024 Assessment
<i>Date</i> was not populated due to WDG's capitated nature that it does not receive, process, or adjudicate claims.	audit documentation is a positive step, there is no evidence of proactive communication, or specific actions taken to address such scenarios in practice. To fully address the recommendation, HSO should demonstrate how it will implement and operationalize this guidance in future audits and communications with HSAG.
While encounter submission to OHA did not require the inclusion of the <i>Rendering Provider NPI</i> value if it matched the <i>Billing Provider NPI</i> value, the data request for the EDV comparative analysis had different requirements. To address this, HSAG recommends that HSO and its subcontractor(s) ensure that values for both <i>Billing Provider NPI</i> and <i>Rendering Provider NPI</i> are included in the data submission, irrespective of their equivalence.	HSO did not sufficiently address the recommendation. HSO has partially addressed the recommendation. While noting the recommendation in audit procedures is a step forward, there is no evidence of practical implementation or assurance that the necessary data will be consistently included in future submissions. To fully address the recommendation, HSO should detail how this requirement will be operationalized and verified in future submissions.
Mental Health Parity Evaluation	
HSO should describe or provide supporting documentation for the reported NQTLs for each subcontractor.	HSO did not sufficiently address the recommendation. HSO did not provide supporting documentation for the NQTL of formulary design for each subcontractor in the CY 2024 MHP Evaluation. Therefore, the NQTL of formulary design for prescription drugs was unable to be fully evaluated for parity with MHP requirements. HSO should provide sufficient information (i.e., supporting documentation) for each subcontractor to demonstrate how each subcontractor is applying the formulary design NQTL.

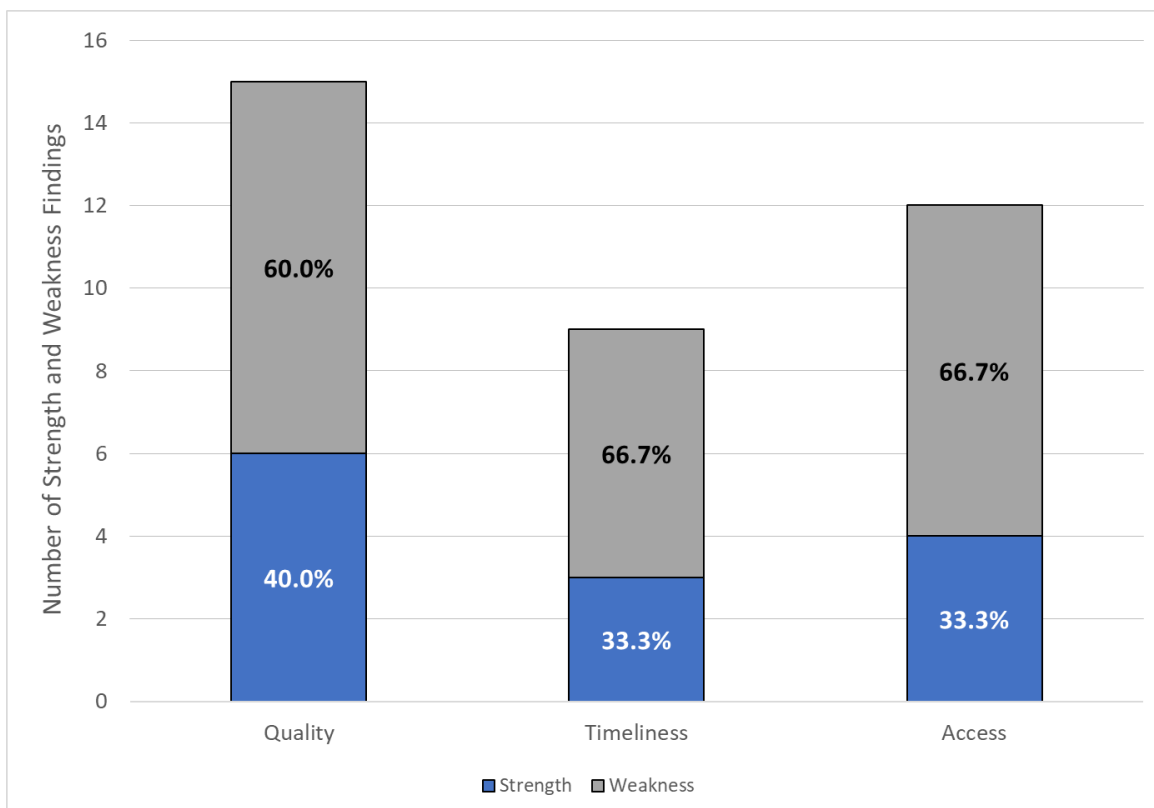
*Standard I—Availability of Services and Standard II—Assurances of Adequate Capacity and Services were combined, and all elements required by 42 CFR §438.206 and §438.207 were assessed under the combined Standard I—Assurance of Adequate Capacity and Availability of Services during the CY 2024 CMR activity.

InterCommunity Health Network

Results and Conclusions

HSAG assessed the strengths and weaknesses of each CCO with respect to the quality, timeliness, and accessibility of health care services. Figure 5-13 illustrates the number of strengths exhibited by IHN relative to the number of weaknesses identified during the CY 2024 EQR activities across the three domains. The greater the proportion of weaknesses, the greater opportunities for improvement.

Figure 5-13—IHN Overall Number of Findings (Strengths and Weaknesses) by Domain



Detailed results from the EQR’s substantive findings are summarized in Table 5-13 for each activity. This table highlights the extent to which IHN furnishes high quality, timely, and appropriate access to health care services, and recommendations for how IHN can best address issues identified for each activity.⁵⁸

⁵⁸ See Section 4—Comparative Statewide Results for detailed, CCO-specific scores associated with EQR activity.

Table 5-13—IHN Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s) ⁵⁹
Compliance Monitoring Review		
	Strength: IHN achieved full compliance with the <i>Practice Guidelines</i> standard demonstrating that the CCO had established policies and procedures, along with the appropriate structure, to ensure that clinical practice guidelines were adopted, reviewed, updated, and disseminated. These guidelines took into account the needs of members and were based on evidence or on a consensus among providers in the relevant field. Additionally, decision-making was aligned with these guidelines.	
	Weakness: IHN received a score of 89.5 percent in the <i>Assurance of Adequate Capacity and Availability of Services</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements and deficiencies in its monitoring activities impacting the CCO’s ability to ensure timely access to care and services. Why the weakness exists: The implemented policies and procedures did not fully align with the federal and State requirements for providing out-of-network care, access, accommodations, and equipment for members with physical and mental disabilities, and reporting. Additionally, the CCO failed to demonstrate the appropriate monitoring of state-established appointment standards. Recommendations: IHN should revise its policies and procedures to align with federal and State requirements for timely access to care and services and reporting and demonstrate implementation.	
	Weakness: IHN received a score of 91.7 percent in the <i>Provider Selection</i> standard due to the inability to demonstrate sufficient implementation of established processes impacting the CCO’s ability to meet federal and State requirements for credentialing network providers. Why the weakness exists: IHN’s subcontractor did not adhere to its policy and procedure or State requirements for credentialing providers, including collecting the appropriate credentialing documentation. Recommendations: IHN should ensure that its subcontractors adhere to its credentialing policy and procedures and are collecting the appropriate credentialing documentation.	
	Weakness: IHN received a score of 75.0 percent in the <i>Subcontractual Relationships and Delegation</i> standard due to insufficient documentation to support operations and ensure compliance with	

⁵⁹  = Quality,  = Timeliness,  = Access

Strength/ Weakness	Description	Domain(s) ⁵⁹
	federal requirements for written agreements between the CCO and its subcontractors. Why the weakness exists: IHN's contracts with the subcontractors failed to include federally required language for written agreements with subcontractors. Recommendations: IHN should revise its written agreements to align with federally required language for written agreements with subcontractors.	
Performance Improvement Projects		
Statewide Mental Health Service Access Monitoring PIP		
	Strength: IHN accurately reported baseline and RY 2 performance indicator data, identified and analyzed barriers to improving MH service access, carried out interventions to address those barriers, and refined interventions based on intervention evaluation results.	
	Weakness: IHN received a <i>Moderate Confidence</i> rating for overall confidence that the <i>Mental Health Service Access Monitoring PIP</i> achieved significant improvement. Why the weakness exists: IHN's indicator results declined from baseline to RY 1 and the improvement from baseline to RY 2 was not statistically significant. Recommendations: IHN should revisit root cause analyses identifying barriers to improving access to MH services to determine which barriers to improvement were not effectively addressed. IHN should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to further improve the percentage of members with a MH service need who received MH services indicator results.	
Statewide Substance Use Disorder PIP		
	Strength: IHN accurately reported baseline and RY 1 performance indicator data; identified and analyzed barriers for initiation, engagement, and treatment of alcohol and other drug use disorders; and began to carry out interventions to address those barriers.	
	Weakness: IHN received a <i>No Confidence</i> rating for overall confidence that the <i>Substance Use Disorder PIP</i> achieved significant improvement. Why the weakness exists: IHN demonstrated a decline in performance from baseline to RY 1 for both Indicator 1 (<i>Percentage of new SUD episodes that result in treatment and initiation within 14 days</i>) and Indicator 2 (<i>Percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation</i>) results. Recommendations: IHN should revisit root cause analyses identifying barriers to improving initiation, engagement, and treatment of alcohol	

Strength/ Weakness	Description	Domain(s) ⁵⁹
	and other drug use disorders to determine which barriers to improvement were not effectively addressed. IHN should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to further improve the percentage of new SUD episodes that result in treatment and initiation within 14 days and the percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation indicator results.	
Performance Measure Validation		
	Strength: IHN's MY 2023 performance on the <i>Members Receiving Preventive Dental or Oral Health Services—Ages 1 to 5 Years and Ages 6 to 14 Years</i> measure indicators demonstrated ongoing improvement since MY 2021. In addition, IHN's MY 2023 rate for the <i>Ages 1 to 5 Years</i> measure indicator exceeded the benchmark set by OHA for MY 2023 by more than 5 percentage points (9.6 percentage points).	
	Weakness: IHN's MY 2023 rate on the <i>Initiation of SUD Treatment</i> measure indicator for members ages 18 years and older declined slightly from MY 2022 (2.0 percentage points) and fell below the benchmark set by OHA for MY 2023. Why the weakness exists: In response to EQR recommendations, IHN reported PCPs facing workflow barriers. Additionally, IHN noted gaps between members being screened for SUD, diagnosed with SUD, and supporting their access to SUD treatment services. Higher utilization and health care cost was noted among members with SUD and co-occurring mental and physical health conditions. Research by IHN determined that clinics without social workers or BH staff did not perform as well as organizations with those resources. Lastly, IHN noted limited understanding of the regional resources BH partners possess for helping IHN members initiate and engage in SUD treatment. Recommendations: IHN implemented the Behavioral Health Home pilot program aiming to unite community partners to provide a comprehensive, person-centered approach for individuals with both physical and MH/BH needs. As a collaborative effort among care givers and IHN, the pilot sought to enhance health outcomes, reduce health care costs, and enhance member engagement for individuals outlined in the target population by integrating BH and primary care. Additionally, IHN implemented interventions focused on educating providers on the <i>Initiation of SUD Treatment</i> metric, SUD treatment services in the community, and how they can support their patients in accessing those services. Provider education included different types of SUD treatment modalities included in the measure, how to access them in the community, and support on patient education regarding treatment	

Strength/ Weakness	Description	Domain(s) ⁵⁹
	options. IHN should continue implementing these efforts to raise its rates on this measure to the level of the benchmarks set by OHA.	
Validation of Network Adequacy		
Network Adequacy Validation Audit		
	Strength: IHN offered providers multiple options to update their demographic and practice data through self-service tools available via IHN's provider website, including ongoing attestations of quarterly data produced via Quest Analytics' BetterDoctor tool.	
Delivery System Network Evaluation		
	Strength: IHN demonstrated innovative strategies in leveraging telehealth data services for population health, hours of operation adjustment, wait time to appointment availability, and urgent care triage.	
	Weakness: IHN showed potential data and/or access issues within its provider and facility data, including active status, service area, and status of accepting new patients. Why the weakness exists: IHN reported moderate rates of providers active within its network and moderate to low rates of providers and facilities operating within its service area. IHN also reported very high rates (i.e., at or close to 100 percent) of providers who were accepting new patients, including PCPs who indicated 0 percent capacity to take on new patients. Recommendations: IHN should seek technical assistance with OHA to determine the nature of the provider capacity data issues and correct them.	
Revealed Telephone Survey		
	Strength: Of the total PCP and OP SUD cases reached, 92.6 percent confirmed the correct location.	
	Strength: Of the total PCP and OP SUD cases that accepted the CCO, 92.2 percent of cases offered translation or interpreter services.	
	Weakness: Overall, 79.4 percent of the total PCP and OP SUD sampled cases were reached. Among the cases reached, 75.6 percent offered the requested services, 43.0 percent accepted OHP Medicaid, and 37.8 percent accepted IHN. Why the weakness exists: In addition to limitations related to the revealed survey approach, inaccuracies found in IHN's provider data may have contributed to the low response rate and accuracy results. Recommendations: IHN should use the case-level analytic data files to address the data deficiencies identified during the survey calls (e.g., incorrect or disconnected telephone numbers; and provider specialty	

Strength/ Weakness	Description	Domain(s) ⁵⁹
	information that does not correspond to the sampled location, plan name, and program information).	
	Weakness: Among the total PCP and OP SUD cases reached, 35.6 percent accepted new patients. In addition, appointment availability was only offered for less than 18.0 percent of PCP cases and 15.0 percent of OP SUD cases. Similarly, compliance rates for PCP and OP SUD appointments were low, ranging from zero percent (new patient urgent PCP visits) to 57.1 percent (routine OP SUD visits). Why the weakness exists: In addition to limitations related to the revealed survey approach, inaccuracies found in IHN's provider data and insufficient provider panel capacity may have contributed to low access and availability rates (i.e., new patient acceptance, appointment availability, and wait times). Also, internal office staffing structures and procedures may have contributed to the long wait times. Recommendations: IHN should confirm appointment availability with providers, including panel capacity to accept new patients. Further, IHN should use the case-level analytic data files to address data deficiencies identified during the survey calls.	
Encounter Data Validation		
Since EDV results were not available for inclusion in the 2024 EQR technical report, the strengths and weaknesses for each CCO could not be assessed. The findings will be incorporated in next year's EQR technical report.		
Mental Health Parity Evaluation		
	Weakness: IHN demonstrated 83.3 percent of MH/SUD IP denial decisions were overturned at the appeal level. Why the weakness exists: Although the total number of appeals was low (i.e., six), the fact that 83.3 percent of the denial decisions were overturned at the appeal level may highlight issues with potentially ineffective PA processes and/or individuals making inappropriate decisions. Recommendations: IHN should review MH/SUD IP appeals to understand the factors affecting the 83.3 percent overturn rate. The CCO should review PA criteria and/or decision-making processes and make appropriate changes to ensure appropriate access to MH/SUD IP services.	

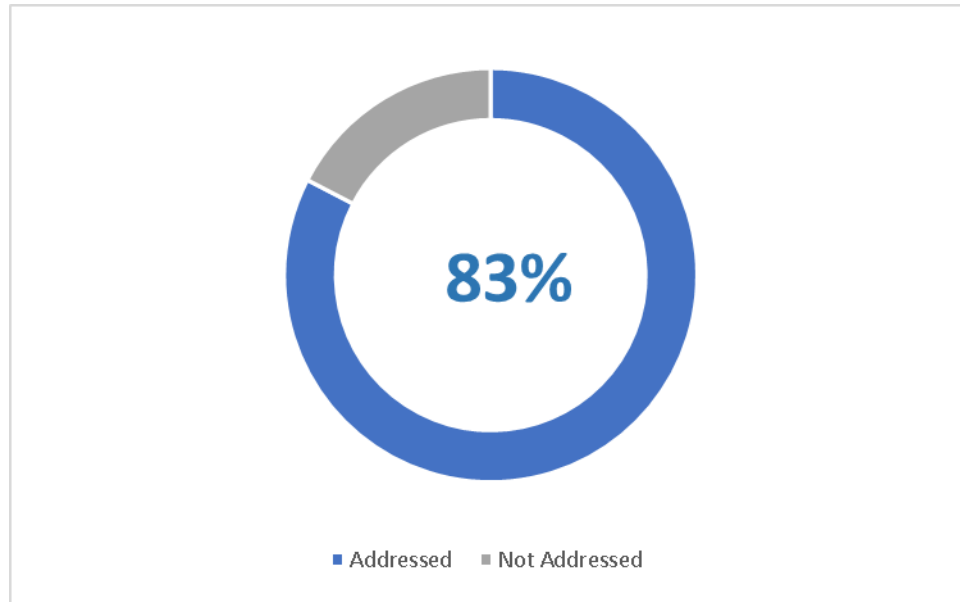
Follow-Up on Prior Year Recommendations

HSAG evaluated IHN's approach to addressing the recommendations related to findings issued during CY 2023 and unresolved findings from CY 2020, CY 2021, and CY 2022 while conducting the

CY 2024 EQR activities. The CCOs not addressing recommendations are at risk of being out of compliance with their contracts.

Figure 5-14 illustrates the degree in which the CCO sufficiently addressed the recommendations for QI made by HSAG during the CY 2023 EQR.

Figure 5-14—Percentage of CY 2023 EQR Recommendations Addressed by IHN



IHN-specific CY 2023 recommendations and follow-up CY 2024 assessments are summarized in Table 5-14.

Table 5-14—Assessment of IHN’s Approach to Addressing Previous Annual Recommendations

CY 2023 Recommendation	CY 2024 Assessment
Compliance Monitoring Review	
<i>Standard I—Assurance of Adequate Capacity and Availability of Services*</i>	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
<i>Standard III—Coordination and Continuity of Care</i>	
IHN should demonstrate implementation of appropriate initial health risk screenings according to federal and State requirements. IHN should also implement mechanisms to ensure the appropriate maintenance of medical records in accordance with professional standards.	IHN sufficiently addressed the recommendation.

CY 2023 Recommendation	CY 2024 Assessment
Standard IV—Coverage and Authorization of Services	
IHN should revise its policies and procedures to align with federal and State requirements. IHN should demonstrate adherence to federal and State requirements for authorization of services and required content for providing NOABDs.	IHN did not sufficiently address the recommendation. IHN did not demonstrate adherence to federal and State requirements for authorization of services and required content for providing NOABDs. Although IHN began implementation of corrective action with its subcontractors, the CCO could not demonstrate full implementation with all subcontractors to meet the federal and State requirements. IHN should demonstrate adherence to federal and State requirements for authorization of services and required content for NOABDs.
Standard V—Provider Selection	
This recommendation was initially given during the CY 2021 EQR. IHN should ensure it has a system to provide the required training to its staff and that participating providers provide clear direction to their subcontractors regarding their delegated responsibilities (i.e., frequency of training, training content, and required participants—dental subcontractor staff and/or dental providers). In addition, participating providers should demonstrate oversight of subcontractors to ensure the training provided on behalf of the CCO is conducted in regulatory alignment.	Not Applicable. The recommendation was tied to a state-specific element that was removed from HSAG’s review.
Standard VI—Subcontractual Relationships and Delegation	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard VII—Member Rights and Protections	
IHN should revise its policies and procedures and provider-facing materials to align with federal and State requirements.	IHN sufficiently addressed the recommendation.
Standard VIII—Confidentiality	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard IX—Enrollment and Disenrollment	
This recommendation was initially given during the CY 2022 EQR. IHN should ensure all	IHN sufficiently addressed the recommendation.

CY 2023 Recommendation	CY 2024 Assessment
documentation communicates the appropriate enrollment nondiscrimination requirements.	
Standard X—Grievance and Appeal Systems	
IHN should revise its policies and procedures to align with federal and State requirements. IHN should demonstrate adherence to federal and State requirements for time frames for acknowledging and responding to grievances and appeals and the readability of notices. IHN should also demonstrate implementation of federal and State requirements within communications to providers and subcontractors.	IHN sufficiently addressed the recommendation.
Standard XI—Practice Guidelines	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard XII—Quality Assessment and Performance Improvement	
This recommendation was initially given during the CY 2022 EQR. IHN should demonstrate appropriate oversight of its QAPI program, including implementing a QI committee that meets State requirements.	IHN sufficiently addressed the recommendation.
Standard XIII—Health Information Systems, including ISCA	
This recommendation was initially given during the CY 2022 EQR. IHN should amend or develop policies and procedures that describe the collection and reporting of required data, as well as oversight processes for monitoring data submissions from its BH providers. IHN should ensure its staff are trained in, knowledgeable of, and implement those defined processes, including the documentation of all oversight activities and follow-up actions taken when issues are identified.	Not Applicable. The recommendation was tied to a state-specific element that was removed from HSAG’s review.
Standard XIV—Member Information	
This recommendation was initially given during the CY 2020 EQR. IHN should ensure that all member-facing materials align with federal and State requirements. IHN should also ensure the provider directory includes the State and federal requirements for the information listed for each provider.	IHN did not sufficiently address the recommendation. Although IHN revised some of its member-facing materials, the CCO did not demonstrate its policy was revised to communicate the appropriate requirements for provider directory information, nor did the CCO

CY 2023 Recommendation	CY 2024 Assessment
	demonstrate implementation of all State and federal requirements.
Standard XVI—Emergency and Poststabilization Services	
IHN should demonstrate evidence of processes to ensure payment of emergency and poststabilization services.	IHN did not sufficiently address the recommendation. Although IHN implemented policy changes to cover poststabilization services, the CCO could not demonstrate that it monitors coverage of emergency services to ensure the proper payment with or without PA, nor that it covers poststabilization services if the CCO and treating physician cannot reach an agreement concerning the member’s care.
Performance Improvement Projects	
Statewide Mental Health Service Access Monitoring PIP	
IHN should ensure that all performance indicator data and interpretation of results are accurately and consistently reported throughout the PIP documentation.	IHN sufficiently addressed the recommendation.
IHN should revisit root cause analyses identifying barriers to improving access to MH services to determine which barriers to improvement were not effectively addressed. IHN should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to improve indicator results.	IHN sufficiently addressed the recommendation.
Statewide Substance Use Disorder PIP	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Performance Measure Validation	
This recommendation was initially given during the CY 2022 EQR. IHN should conduct root cause analyses to identify specific factors affecting performance on the <i>Initiation of SUD Treatment</i> measure indicator and develop, implement, and evaluate targeted interventions to ensure improvement strategies are adopted, specifically for members ages 18 years and older. Additionally, IHN should monitor its provider network to identify gaps in access to care and work with providers to identify alternative	IHN sufficiently addressed the recommendation. IHN addressed the recommendations provided by HSAG and continued its efforts to improve performance in this measure, which included implementing the Behavioral Health Home pilot program aiming to unite community partners to provide a comprehensive, person-centered approach for individuals with both physical and MH/BH needs. As a collaborative effort among care givers and IHN, the pilot sought to enhance health outcomes,

CY 2023 Recommendation	CY 2024 Assessment
approaches for ensuring the timeliness and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	reduce health care costs, and enhance member engagement for individuals outlined in the target population by integrating BH and primary care. Additionally, IHN implemented interventions focused on educating providers on the <i>Initiation of SUD Treatment</i> metric, SUD treatment services in the community, and how they can support their patients in accessing those services. Provider education included different types of SUD treatment modalities included in the measure, how to access them in the community, and support on patient education regarding treatment options. IHN should continue implementing these efforts to raise its rates on this measure to the level of the benchmarks set by OHA.
Validation of Network Adequacy	
Delivery System Network Evaluation	
This recommendation was initially given during the CY 2020 EQR. IHN should ensure that it reports DSN Provider Capacity Reporting data values for all required data fields and seek technical assistance from OHA as needed.	IHN sufficiently addressed the recommendation.
This recommendation was initially given during the CY 2021 EQR. IHN stated that it is working on interventions to improve provider data management as it relates to the provider directory; however, specific planned interventions were not provided.	IHN sufficiently addressed the recommendation.
IHN should ensure that all future reporting utilizes the state-established specialty provider taxonomies current to the review period and should demonstrate how it collects and uses member and DSN data to inform network adequacy monitoring and decision-making. IHN should ensure that all network adequacy interventions include plans for assessing their efficacy. IHN should address all findings from prior DSN Evaluations.	IHN sufficiently addressed the recommendation.
IHN should seek technical assistance with OHA to determine the nature of the provider capacity data issues and correct them.	IHN sufficiently addressed the recommendation.

CY 2023 Recommendation	CY 2024 Assessment
Secret Shopper Survey	
HSAG recommends that IHN use the case-level analytic data files to address the data deficiencies identified during the secret shopper survey calls (e.g., incorrect, or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	IHN sufficiently addressed the recommendation. IHN reported that it conducted routine outreach and monitoring activities to confirm provider data. IHN also plans to implement new auditing methodology to better capture access and availability. IHN should continue to monitor and improve any efforts in maintaining accurate provider data (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).
HSAG recommends that IHN confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. IHN should use the case-level analytic data files containing data deficiencies identified during the secret shopper survey calls.	IHN sufficiently addressed the recommendation. IHN reported that it conducted routine outreach and monitoring activities to confirm provider data. IHN also plans to implement new auditing methodology to better capture access and availability. IHN should continue to monitor and improve any efforts in maintaining accurate provider data and compliance with wait time standards.
Revealed Telephone Survey	
HSAG recommends that IHN use the case-level analytic data files to address the data deficiencies identified during the revealed telephone survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	IHN sufficiently addressed the recommendation. IHN reported that it conducted routine outreach and monitoring activities to confirm provider data. IHN also plans to implement new auditing methodology to better capture access and availability. IHN should continue to monitor and improve any efforts in maintaining accurate provider data (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).
HSAG recommends that IHN confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. IHN should use the case-level analytic data files containing data deficiencies identified during the revealed telephone survey calls and work with BH outpatient offices to identify the root cause for delays in appointment availability.	IHN sufficiently addressed the recommendation. IHN reported that it conducted routine outreach and monitoring activities to confirm provider data. IHN also plans to implement new auditing methodology to better capture access and availability. IHN should continue to monitor and improve any efforts in maintaining accurate provider data and compliance with wait time standards.

CY 2023 Recommendation	CY 2024 Assessment
Encounter Data Validation	
This recommendation was initially given during the CY 2022 EQR. IHN should investigate and follow up with its providers to determine why encounters were submitted to OHA, but no medical records/documentation were available for the requested dates of service.	IHN sufficiently addressed the recommendation.
This recommendation was initially given during the CY 2022 EQR. IHN should investigate the root cause for the omissions and consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews would then be provided to providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.	IHN sufficiently addressed the recommendation.
HSAG recommends that IHN proactively inform HSAG about special scenarios like the one observed with WDG, where the <i>Adjudication Date</i> was not populated due to WDG's capitated nature that it does not receive, process, or adjudicate claims.	IHN did not sufficiently address the recommendation. IHN has partially addressed the recommendation. While the commitment to proactive notification is a positive step, the response lacked details on how this will be operationalized or verified. To fully address the recommendation, IHN should implement a formalized process describing steps for verification and notification.
Since all <i>Tooth Number</i> surplus records were associated with Advantage Dental, HSAG recommends IHN collaborate with Advantage Dental to actively address and resolve the issue. This may involve refining data entry processes, enhancing validation protocols, and conducting regular audits to ensure accurate and complete data for <i>Tooth Number</i> information.	IHN sufficiently addressed the recommendation. The collaboration with Advantage Dental, identification of the data loss issue, and commitment to ensuring accurate HSAG extracts demonstrate a proactive approach to resolving the issue. Moving forward, implementing enhanced validation protocols and refining extraction processes would further solidify these efforts.
Mental Health Parity Evaluation	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.

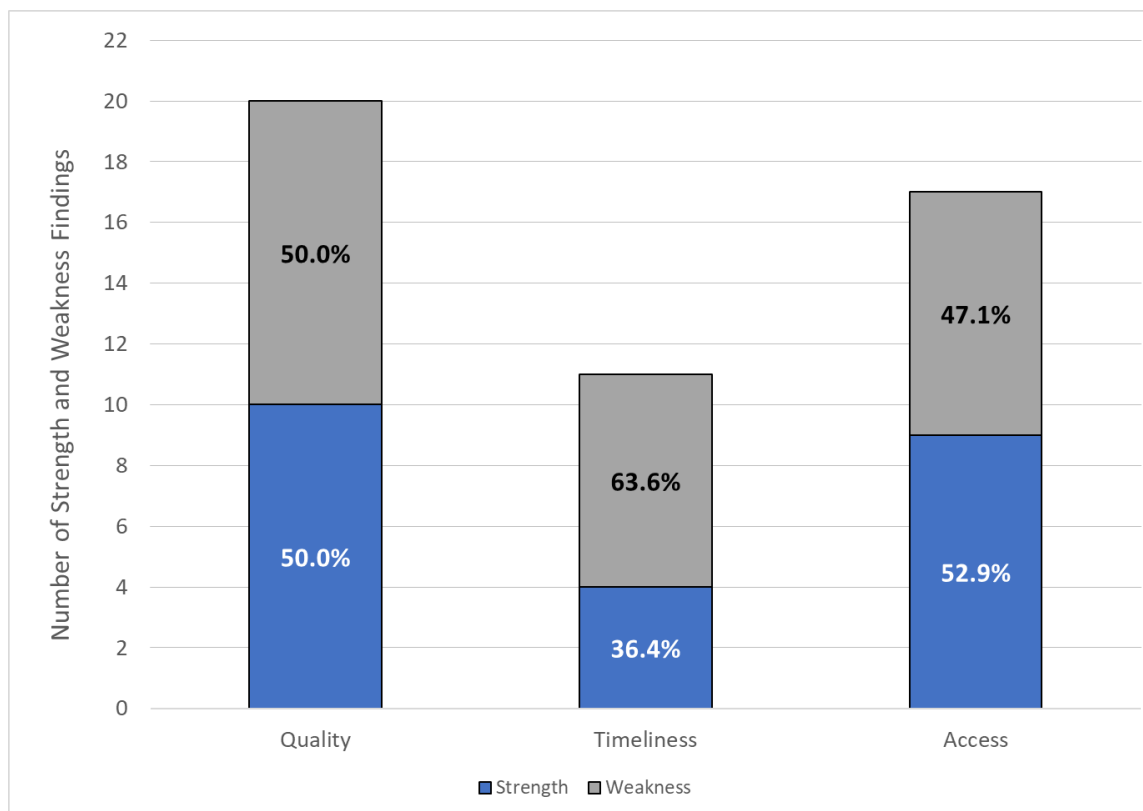
*Standard I—Availability of Services and Standard II—Assurances of Adequate Capacity and Services were combined, and all elements required by 42 CFR §438.206 and §438.207 were assessed under the combined Standard I—Assurance of Adequate Capacity and Availability of Services during the CY 2024 CMR activity.

Jackson Care Connect

Results and Conclusions

HSAG assessed the strengths and weaknesses of each CCO with respect to the quality, timeliness, and accessibility of health care services. Figure 5-15 illustrates the number of strengths exhibited by JCC relative to the number of weaknesses identified during the CY 2024 EQR activities across the three domains. The greater the proportion of weaknesses, the greater opportunities for improvement.

Figure 5-15—JCC Overall Number of Findings (Strengths and Weaknesses) by Domain



Detailed results from the EQR’s substantive findings are summarized in Table 5-15 for each activity. This table highlights the extent to which JCC furnishes high quality, timely, and appropriate access to health care services, and recommendations for how JCC can best address issues identified for each activity.⁶⁰

⁶⁰ See Section 4—Comparative Statewide Results for detailed, CCO-specific scores associated with EQR activity.

Table 5-15—JCC Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s) ⁶¹
Compliance Monitoring Review		
	Strength: JCC demonstrated best practices by establishing a step-by-step procedure for customer service to follow to ensure the appropriate department is notified of access issues reported by members.	 
	Strength: JCC demonstrated best practices by incorporating justice into its Equity, Diversity, and Inclusion strategic plan.	 
	Strength: JCC demonstrated best practices with its provider satisfaction survey, which includes questions about claims, authorizations, and appeals processes and the providers' views on using the provider portal as part of its provider retention efforts.	
	Weakness: JCC received a score of 76.3 percent in the <i>Assurance of Adequate Capacity and Availability of Services</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements, inability to demonstrate sufficient implementation of established processes, and deficiencies within its monitoring activities impacting the CCO's ability to ensure timely access to care and services. Why the weakness exists: JCC lacked a methodology for monitoring and maintaining its provider network for the federal and State-required components. Additionally, the policies and procedures implemented did not fully align with State-established time and distance standards, reporting requirements, and provision of access, accommodations, and equipment for members with physical and mental disabilities. Also, the CCO failed to demonstrate mechanisms for monitoring provider compliance with State-established time and distance and appointment standards, and evidence of taking corrective action when providers fail to meet appointment standards. Recommendations: JCC should develop and implement a methodology for monitoring and maintaining its provider network for the federal and State-required components. Additionally, the CCO should revise its policies and procedures to align with federal and State requirements for its timely access to care and services and reporting and demonstrate implementation. The CCO should also demonstrate the implementation of corrective action when providers fail to meet appointment standards.	  

⁶¹  = Quality,  = Timeliness,  = Access

Strength/ Weakness	Description	Domain(s) ⁶¹
	Weakness: JCC received a score of 75.0 percent in the <i>Provider Selection</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements, the inability to demonstrate sufficient implementation of established processes, and deficiencies within its monitoring activities impacting the CCO's ability to meet federal and State requirements for selecting, retaining, credentialing, and recredentialing network providers. Why the weakness exists: JCC did not demonstrate policies and procedures for the selecting and retaining providers. Additionally, the CCO did not adhere to State requirements for credentialing and recredentialing providers or its policy and procedure for credentialing and recredentialing, including collecting and reviewing the appropriate credentialing documentation and recredentialing time frames. The CCO also did not demonstrate comprehensive oversight of its subcontractors to ensure compliance with credentialing and recredentialing requirements. Finally, the CCO did not establish a mechanism for ensuring providers are not inadvertently discriminated against with its credentialing processes. Recommendations: JCC should establish policies and procedures for selecting and retaining providers. Additionally, the CCO should ensure that its subcontractors adhere to its credentialing and recredentialing policies and procedures and collect the appropriate credentialing documentation. The CCO should also implement a mechanism for ensuring providers are not inadvertently discriminated against with its credentialing processes.	
	Weakness: JCC received a score of 87.5 percent in the <i>Subcontractual Relationships and Delegation</i> standard due to insufficient documentation to support operations and ensure compliance with federal requirements for written agreements between the CCO and its subcontractors. Why the weakness exists: JCC's contracts with the subcontractors failed to include federally required language for written agreements with subcontractors. Recommendations: JCC should revise its written agreements to align with federally required language for written agreements with subcontractors.	
	Weakness: JCC received a score of 83.3 percent in the <i>Practice Guidelines</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements impacting the CCO's ability to adopt the appropriate clinical practice guidelines.	

Strength/ Weakness	Description	Domain(s) ⁶¹
	Why the weakness exists: JCC's policy and procedures did not fully align with the federal and State requirements for adopting the appropriate clinical practice guidelines. Recommendations: JCC should revise its policy and procedures to fully align with the federal and State requirements for adopting the appropriate clinical practice guidelines.	
Performance Improvement Projects		
Statewide Mental Health Service Access Monitoring PIP		
	Strength: JCC successfully continued the Implementation stage for the PIP, receiving a <i>Met</i> score for 100 percent of applicable evaluation elements in the PIP Validation Tool. In the Implementation stage, JCC accurately reported baseline and RY 2 performance indicator data, identified and analyzed barriers to improving MH service access, carried out interventions to address those barriers, and refined interventions based on intervention evaluation results.	
	Strength: JCC's RY 2 performance indicator results demonstrated statistically significant improvement in MH service access compared to baseline indicator results.	
Statewide Substance Use Disorder PIP		
	Strength: JCC accurately reported baseline and RY 1 performance indicator data; identified and analyzed barriers for initiation, engagement, and treatment of alcohol and other drug use disorders; and began to carry out interventions to address those barriers.	
	Weakness: JCC received a <i>Moderate Confidence</i> rating for overall confidence that the <i>Substance Use Disorder</i> PIP achieved significant improvement. Why the weakness exists: JCC's RY 1 improvement noted for both indicators (<i>Percentage of new SUD episodes that result in treatment and initiation within 14 days</i> and <i>Percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation</i>) over BY was not statistically significant. Recommendations: JCC should revisit root cause analyses identifying barriers to improving initiation, engagement, and treatment of alcohol and other drug use disorders to determine which barriers to improvement were not effectively addressed. JCC should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to further improve the percentage of new SUD episodes that result in treatment and initiation within 14 days and the percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation indicator results.	

Strength/ Weakness	Description	Domain(s) ⁶¹
Performance Measure Validation		
	Strength: JCC's MY 2023 performance on the <i>Members Receiving Preventive Dental or Oral Health Services—Ages 1 to 5 Years and Ages 6 to 14 Years</i> measure indicators demonstrated ongoing improvement since MY 2021. For members ages 1 to 5 years, JCC improved by more than 5 percentage points compared to MY 2022 (6.9 percentage points). For both ages 1 to 5 years and 6 to 14 years, JCC's MY 2023 rates exceeded the statewide aggregate and the benchmark set by OHA for MY 2023 by 5 percentage points or more.	
	Strength: JCC's MY 2023 performance on the <i>Oral Evaluation for Adults With Diabetes</i> measure demonstrated ongoing improvement since MY 2021.	
	Weakness: JCC's MY 2023 performance on the <i>Child and Adolescent Well-Care Visits—Ages 3 to 6 Years</i> measure improved overall from MY 2022 (8.6 percentage points), but still fell short of the benchmark set by OHA for MY 2023. Why the weakness exists: In response to EQR recommendations, JCC noted barriers such as provider and clinic staffing shortages and insufficient patient outreach. Recommendations: JCC reported it engaged in monthly metrics meetings with network partners to specifically raise and prioritize the <i>Child and Adolescent Well-Care Visits</i> measure. Additionally, JCC employed improved gap lists and leveraged an outreach program to help identify and engage member populations, with network and member outreach occurring monthly. JCC should continue implementing these efforts to raise its rates on this measure to the level of the benchmarks set by OHA.	
	Weakness: JCC's MY 2023 performance on the <i>Initiation and Engagement of SUD Treatment</i> measure indicators for members ages 18 years and older improved overall from MY 2022 (3.0 percentage points for <i>Initiation of SUD Treatment</i> and 1.1 percentage points for <i>Engagement of SUD Treatment</i>), but still fell short of the benchmark set by OHA for MY 2023 for both measure indicators (1.7 percentage points below the benchmark for <i>Initiation of SUD Treatment</i> and 1.1 percentage points below for <i>Engagement of SUD Treatment</i>). Why the weakness exists: In response to EQR recommendations, JCC noted barriers in identifying SUD episodes in a timely manner in order to meet the initiation and engagement timelines required by the metrics, as well as gaps in data sharing practices. Recommendations: JCC reported continuing leveraging its SUD workgroup to identify barriers and determine strategies for improvement and success for the <i>Initiation and Engagement of SUD Treatment</i> measure indicators. JCC is working to overcome a barrier of	

Strength/ Weakness	Description	Domain(s) ⁶¹
	identifying SUD episodes in a timely manner and navigating gaps in data sharing practices within the network. JCC has focused its efforts to improve data sharing practices and is exploring the best platform (PointClickCare or Reliance) to achieve its data sharing goals. JCC should continue implementing these efforts to raise its rates on this measure to the level of the benchmarks set by OHA.	
Validation of Network Adequacy		
Network Adequacy Validation Audit		
	Strength: JCC maintained detailed process documentation for analyst creation of the network adequacy report, ensuring business continuity of the network adequacy reporting process.	
Delivery System Network Evaluation		
	Weakness: JCC demonstrated a moderate level of compliance with network monitoring requirements. Why the weakness exists: JCC was not able to demonstrate how it collects and uses data on wait time to appointment availability, hours of operation, telehealth capacity and utilization, availability of culturally and linguistically appropriate care, or availability of physical accessibility accommodations to inform network adequacy monitoring and decision making. Recommendations: JCC should demonstrate how it collects and uses DSN data to inform network adequacy monitoring and decision making.	
	Weakness: JCC showed data quality issues within its provider data, including but not limited to service area activity and status of accepting new patients. This issue was also identified during the CY 2021, CY 2022, and CY 2023 DSN Evaluations. The issue was not addressed or responded to by JCC. Why the weakness exists: The percentage of providers operating within the service area was very low for most provider types, including PCPs. With the exception of PCPs, PCDs, and ALIM, less than 1 percent of all provider types were accepting new patients. Recommendations: JCC should seek technical assistance with OHA to determine the nature of the provider capacity data issues and correct them.	
	Weakness: JCC did not meet the State time and distance standard for MTD facilities. JCC did not meet the facility network adequacy standards for MTD facilities since none of its members were within acceptable travel times or distances from contracted MTD facilities. Additionally, JCC did not engage in OHA's time and distance exception request process.	

Strength/ Weakness	Description	Domain(s) ⁶¹
	Recommendations: JCC should engage in OHA’s time and distance exception request process for all instances of noncompliance with Oregon network adequacy standards, as well as take the necessary steps to maintain an adequate network that ensures acceptable access to all covered and necessary care, including mechanisms to support the recruitment, contracting, and availability of providers.	
Revealed Telephone Survey		
	Strength: Of the total PCP and OP SUD cases reached, 90.2 percent confirmed the correct location.	
	Strength: Of the total PCP and OP SUD cases that accepted the CCO, 97.7 percent of cases offered translation or interpreter services.	
	Strength: Of the PCP and OP SUD cases that offered an appointment, 94.1 percent of routine PCP visits for existing patients were compliant with the wait time standards. Similarly, 94.1 percent of routine and pregnant OP SUD visits, and 100 percent of urgent OP SUD visits were compliant with the wait time standards.	
	Weakness: Overall, 67.7 percent of the total PCP and OP SUD sampled cases were reached. Among the cases reached, 75.9 percent offered the requested services, 71.3 percent accepted OHP Medicaid, and 25.3 percent accepted JCC. Why the weakness exists: In addition to limitations related to the revealed survey approach, inaccuracies found in JCC’s provider data may have contributed to the low response rate and accuracy results. Recommendations: JCC should use the case-level analytic data files to address the data deficiencies identified during the survey calls (e.g., incorrect or disconnected telephone numbers; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
	Weakness: Among the total PCP and OP SUD cases reached, 18.4 percent accepted new patients. In addition, appointment availability was only offered for less than 15.0 percent of PCP cases and 30.0 percent of OP SUD cases. Of the PCP cases that offered appointments, 45.5 percent of new patient routine visits, 14.3 percent of new patient urgent visits, and 62.5 percent of existing patient urgent visits were compliant with the wait time standards. Additionally, 87.5 percent of opioid use disorder visits were compliant. Why the weakness exists: In addition to limitations related to the revealed survey approach, inaccuracies found in JCC’s provider data and insufficient provider panel capacity may have contributed to low access and availability rates (i.e., new patient acceptance, appointment availability, and wait times). Also, internal office staffing structures and procedures may have contributed to the long wait times.	

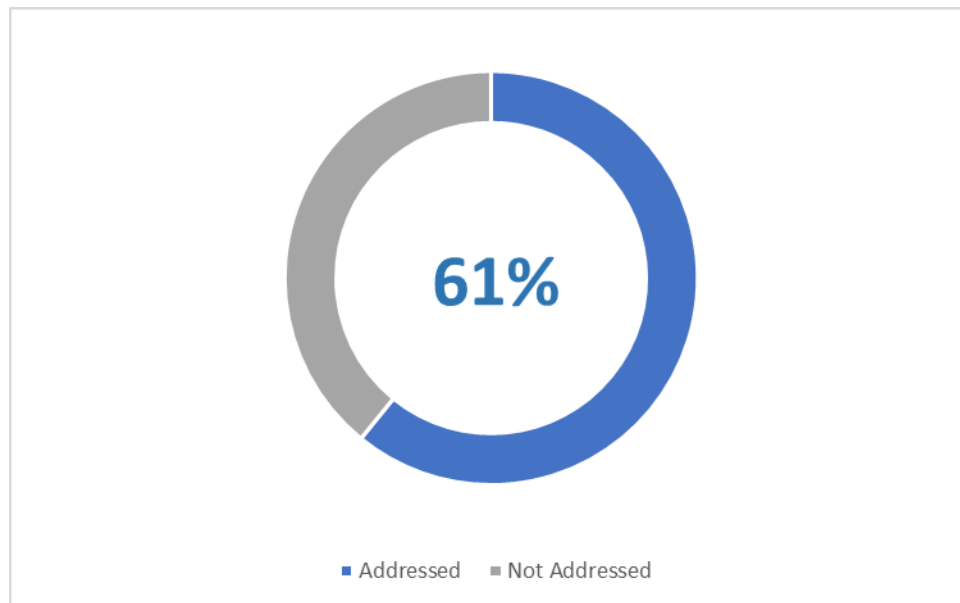
Strength/ Weakness	Description	Domain(s) ⁶¹
	Recommendations: JCC should confirm appointment availability with providers, including panel capacity to accept new patients. Further, JCC should use the case-level analytic data files to address data deficiencies identified during the survey calls.	
Encounter Data Validation		
Since EDV results were not available for inclusion in the 2024 EQR technical report, the strengths and weaknesses for each CCO could not be assessed. The findings will be incorporated in next year's EQR technical report.		
Mental Health Parity Evaluation		
The CCO met performance expectations. No significant strengths or weaknesses were noted during the review.		

Follow-Up on Prior Year Recommendations

HSAG evaluated JCC's approach to addressing the recommendations related to findings issued during CY 2023 and unresolved findings from CY 2020, CY 2021, and CY 2022 while conducting the CY 2024 EQR activities. The CCOs not addressing recommendations are at risk of being out of compliance with their contracts.

Figure 5-16 illustrates the degree in which the CCO sufficiently addressed the recommendations for QI made by HSAG during the CY 2023 EQR.

Figure 5-16—Percentage of CY 2023 EQR Recommendations Addressed by JCC



JCC-specific CY 2023 recommendations and follow-up CY 2024 assessments are summarized in Table 5-16.

Table 5-16—Assessment of JCC’s Approach to Addressing Previous Annual Recommendations

CY 2023 Recommendation	CY 2024 Assessment
Compliance Monitoring Review	
Standard I—Assurance of Adequate Capacity and Availability of Services*	
This recommendation was initially given during the CY 2021 EQR. JCC should develop thorough, documented processes that address all required elements of network evaluation. The CCO should be able to demonstrate evidence of monitoring its provider network and corrective action when providers fail to meet the standards. In addition, JCC should develop a documented process for monitoring provider capacity that includes monitoring specialty providers individually by specialty type and ensuring its network evaluation incorporates key data collected from its monitoring processes.	JCC did not sufficiently address the recommendation. JCC did not demonstrate monitoring its provider network in accordance with the state-established requirements, including thresholds. The CCO also did not demonstrate an established methodology for collecting the appropriate information to assess the sufficiency of the provider network to administer covered services. JCC also did not demonstrate the consistent monitoring of the provider network against all state-established network access standards or taking corrective action when providers failed to meet compliance. Note: Standard I—Assurance of Adequate Capacity and Availability of Services was comprehensively reviewed during the CY 2024 CMR cycle, and recommendations addressing all findings related to this standard are included in the CCO’s individual Results and Conclusions section.
Standard III—Coordination and Continuity of Care	
JCC should revise its policies and procedures to align with federal and State requirements.	JCC sufficiently addressed the recommendation.
Standard IV—Coverage and Authorization of Services	
JCC should revise its policies and procedures to align with federal and State requirements. JCC should demonstrate adherence to federal and State requirements for authorization of services and required content and time frames for providing NOABDs.	JCC did not sufficiently address the recommendation. JCC did not demonstrate that its subcontractors have in place and follow written policies and procedures for processing requests for initial and continuing authorization of services that were compliant with federal and State requirements or processes for ensuring consistent application of review criteria. Additionally, JCC did not demonstrate a process for eliminating the reconsideration process after issuing a denial, nor did the CCO demonstrate an enhanced process for ensuring appropriate decision-makers for authorizations and notices are issued for all denial

CY 2023 Recommendation	CY 2024 Assessment
	decisions. JCC should revise its processes to align with federal and State requirements. JCC should demonstrate adherence to federal and State requirements for authorization of services and providing NOABDs.
Standard V—Provider Selection	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Standard VI—Subcontractual Relationships and Delegation	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Standard VII—Member Rights and Protections	
JCC should revise its policies and procedures and member- and provider-facing materials to align with federal and State requirements.	JCC did not sufficiently address the recommendation. JCC did not demonstrate the appropriate information on member rights and advance directives were sufficiently communicated in the provider manual, nondiscrimination statement, and member handbook. JCC should revise its policies and procedures and member- and provider-facing materials to align with federal and State requirements.
Standard VIII—Confidentiality	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard IX—Enrollment and Disenrollment	
This recommendation was initially given during the CY 2022 EQR. JCC should ensure that it communicates to members all the reasons why members can disenroll from the CCO. Utilizing the model member handbook would ensure the CCO captures the requirements.	JCC sufficiently addressed the recommendation.
Standard X—Grievance and Appeal Systems	
JCC should revise its policies and procedures to align with federal and State requirements. Additionally, JCC should demonstrate adherence to federal and State requirements for time frames for acknowledging and responding to grievances and appeals; readability and required content of notices; and implementation of federal and State	JCC did not sufficiently address the recommendation. JCC did not demonstrate its processes and training materials were revised to align with federal and State requirements for one level of appeal following an adverse benefit determination. JCC also could not demonstrate a process to ensure providers and subcontractors are

CY 2023 Recommendation	CY 2024 Assessment
requirements within communications to members, providers, and subcontractors. JCC should also demonstrate maintaining one level of appeal.	notified of changes within five business days after OHA’s approval of updates to procedures and time frames. JCC should revise its processes to align with federal and State requirements. Additionally, JCC should ensure all provider and subcontractor communications are revised to align with federal and State requirements. JCC should also demonstrate maintaining one level of appeal.
Standard XI—Practice Guidelines	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Standard XII—Quality Assessment and Performance Improvement	
This recommendation was initially given during the CY 2022 EQR. JCC should ensure appropriate oversight of its QAPI program, including implementing a QI committee that meets the State’s requirements.	JCC did not sufficiently address the recommendation. JCC did not demonstrate the appropriate oversight of its QAPI program, including a QI committee that aligns with State requirements and mechanisms to assess the quality and appropriateness of care furnished to members with SHCN and using LTSS. JCC should ensure appropriate oversight of its QAPI program, including implementing a QI committee that meets the State’s requirements and mechanisms to assess the quality and appropriateness of care provided to members with SHCN and utilizing LTSS.
Standard XIII—Health Information Systems, including ISCA	
This recommendation was initially given during the CY 2022 EQR. JCC should develop and implement processes to monitor its BH providers’ compliance with MOTS reporting requirements.	Not Applicable. The recommendation was tied to a state-specific element that was removed from HSAG’s review.
Standard XIV—Member Information	
JCC should revise its policies, procedures, and member-facing materials to align with federal and State requirements. Additionally, JCC should track and monitor the timely provision of required member information.	JCC did not sufficiently address the recommendation. JCC’s policies and procedures continued to be out of alignment with federal and State requirements for readability and being readily accessible. Additionally, the CCO did not demonstrate the appropriate revisions were made to the provider directory and electronic documentation. JCC also did not ensure the appropriate information on physician incentive plans would be provided to members, if requested.

CY 2023 Recommendation	CY 2024 Assessment
	JCC should revise its policies, procedures, and member-facing materials to align with federal and State requirements. Additionally, JCC should track and monitor the timely provision of required member information.
Standard XVI—Emergency and Poststabilization Services	
JCC should revise the applicable plan documents to define “poststabilization services” and communicate the appropriate requirements.	JCC sufficiently addressed the recommendation.
Performance Improvement Projects	
Statewide Mental Health Service Access Monitoring PIP	
JCC should revise the narrative interpretation to address the documentation requirement.	JCC sufficiently addressed the recommendation.
JCC should revisit root cause analyses identifying barriers to improving access to MH services to determine which barriers to improvement were not effectively addressed. JCC should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to improve indicator results.	JCC sufficiently addressed the recommendation.
JCC should complete the Clinical and Programmatic Improvement Table to demonstrate significant clinical or programmatic improvement in processes and outcomes.	Not applicable. The PIP documentation requirements changed for the most recent validation cycle, and documenting clinical and programmatic improvement was no longer required or assessed.
Statewide Substance Use Disorder PIP	
JCC should correct the baseline indicator results in the Step 7 Indicator Results table and baseline narrative prior to submission for next year’s validation in 2024.	JCC sufficiently addressed the recommendation.
Performance Measure Validation	
JCC should conduct root cause analyses to identify specific factors affecting performance on the <i>Child and Adolescent Well-Care Visits—Ages 3 to 6 Years</i> measure indicator and develop, implement, and evaluate targeted interventions to ensure improvement strategies are adopted. Additionally, JCC should monitor its provider	JCC sufficiently addressed the recommendation. JCC addressed the recommendations provided by HSAG and continued its efforts to improve performance in this measure, which included engaging in monthly metrics meetings with network partners to specifically raise and prioritize the <i>Child and</i>

CY 2023 Recommendation	CY 2024 Assessment
network to identify gaps in access to care and work with providers to identify alternative approaches for ensuring the timeliness and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	<i>Adolescent Well-Care Visits</i> measure, and using improved gap lists and leveraging an outreach program to help identify and engage member populations with network and member outreach occurring monthly. JCC should continue implementing these efforts to raise its rates on this measure to the level of the benchmarks set by OHA.
JCC should continue ongoing monitoring and monthly SUD subject matter expert group meetings and develop interventions to raise its rates on the <i>Initiation of SUD Treatment</i> and <i>Engagement of SUD Treatment</i> measure indicators for members ages 18 years and older to the level of the benchmarks set by OHA.	JCC sufficiently addressed the recommendation. JCC addressed the recommendations provided by HSAG and continued its efforts to improve performance in this measure, which included continuing to leverage the SUD workgroup to identify barriers and determine strategies for improvement and success for the <i>Initiation and Engagement of SUD Treatment</i> measure indicators. JCC reported that it is working to overcome a barrier of identifying SUD episodes in a timely manner and navigating gaps in data sharing practices within the network, and the CCO has focused its efforts to improve data sharing practices and is exploring the best platform (e.g., PointClickCare or Reliance) to achieve its data sharing goals. JCC should continue implementing these efforts to raise its rates on this measure to the level of the benchmarks set by OHA.
Validation of Network Adequacy	
Delivery System Network Evaluation	
This recommendation was initially given during the CY 2021 EQR. JCC should work with OHA to determine the root cause of the low count for in-network providers and work to correct any deficiency.	JCC did not sufficiently address the recommendation. Although JCC described process improvements to its network data management including dedicated staffing, the Q1 <i>DSN Provider Capacity Report</i> from OHA (used for all CCOs in the 2024 DSN Evaluation) showed similar issues to those identified in 2021–2023, with very low percentages of providers indicated as operating in the service area and accepting new patients. The most likely reason for this is enterprise-wide reporting for JCC and affiliated providers via the parent group CareOregon, but it should be possible for the CCO to restrict its reporting to those providers that are meaningfully accessible within the service

CY 2023 Recommendation	CY 2024 Assessment
	region (with the caveat that any reporting methodology shall be determined and approved by the State). Additionally, JCC did not describe seeking technical assistance or otherwise coordinating with OHA.
JCC should ensure that all future reporting utilizes the state-established specialty provider taxonomies current to the review period and should demonstrate how it collects and uses DSN data to inform network adequacy monitoring and decision-making.	JCC sufficiently addressed the recommendation. While results from the CCO's 2024 DSN Provider Narrative may have similar scores to the 2023 DSN Provider Narrative in some respects, the overall quality of submitted documentation, implementation of OHA's required taxonomies in monitoring, and evidence of ongoing change management sufficiently demonstrated the CCO's intentionality in addressing prior issues. JCC should continue its efforts to improve the quality of its network adequacy monitoring and DSN submissions.
Secret Shopper Survey	
HSAG recommends that JCC use the case-level analytic data files to address the data deficiencies identified during the secret shopper survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	JCC sufficiently addressed the recommendation. JCC reported that it conducted routine outreach and monitoring activities to confirm provider data and appointment availability. JCC also reported implementing an enhanced tracking tool to monitor and identify data discrepancies. JCC should continue to monitor and improve any efforts in maintaining accurate provider data (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).
HSAG recommends that JCC confirm appointment availability with providers, including panel capacity to accept new patients. JCC should use the case-level analytic data files containing data deficiencies identified during the secret shopper survey calls.	JCC sufficiently addressed the recommendation. JCC reported that it conducted routine outreach and monitoring activities to confirm provider data and appointment availability. JCC also reported implementing an enhanced tracking tool to monitor and identify data discrepancies. JCC should continue to monitor and improve any efforts in maintaining accurate provider data and compliance with wait time standards.

CY 2023 Recommendation	CY 2024 Assessment
Revealed Telephone Survey	
HSAG recommends that JCC use the case-level analytic data files to address the data deficiencies identified during the revealed telephone survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	JCC sufficiently addressed the recommendation. JCC reported that it conducted routine outreach and monitoring activities to confirm provider data and appointment availability. JCC also reported implementing an enhanced tracking tool to monitor and identify data discrepancies. JCC should continue to monitor and improve any efforts in maintaining accurate provider data (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).
HSAG recommends that JCC confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. JCC should use the case-level analytic data files containing data deficiencies identified during the revealed telephone survey calls and work with BH outpatient offices to identify the root cause for delays in appointment availability.	JCC sufficiently addressed the recommendation. JCC reported that it conducted routine outreach and monitoring activities to confirm provider data and appointment availability. JCC also reported implementing an enhanced tracking tool to monitor and identify data discrepancies. JCC should continue to monitor and improve any efforts in maintaining accurate provider data and compliance with wait time standards.
Encounter Data Validation	
HSAG recommends that JCC proactively inform HSAG about special scenarios like the one observed with WDG, where the <i>Adjudication Date</i> was not populated due to WDG's capitated nature that it does not receive, process, or adjudicate claims.	JCC sufficiently addressed the recommendation. JCC's structured approach to proactive communication and collaboration demonstrates compliance, though ongoing adherence to this process in future reviews will confirm its effectiveness.
While encounter submission to OHA did not require the inclusion of the <i>Rendering Provider NPI</i> value if it matched the <i>Billing Provider NPI</i> value, the data request for the EDV comparative analysis had different requirements. To address this, HSAG recommends that JCC and its subcontractor(s) ensure that values for both <i>Billing Provider NPI</i> and <i>Rendering Provider NPI</i> are included in the data submission, irrespective of their equivalence. This adjustment will enhance the accuracy and completeness of the comparative analysis data. Additionally, it will provide HSAG with the means to verify and ensure the accuracy	JCC did not sufficiently address the recommendation. JCC has partially addressed the recommendation. While its plan for proactive communication is promising, the response does not specifically confirm the inclusion of both NPI values in future submissions. To fully address the recommendation, JCC should detail how these data elements will be incorporated and verified consistently in submissions.

CY 2023 Recommendation	CY 2024 Assessment
of the MMIS' process of populating the <i>Rendering Provider NPI</i> with the <i>Billing Provider NPI</i> .	
Mental Health Parity Evaluation	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.

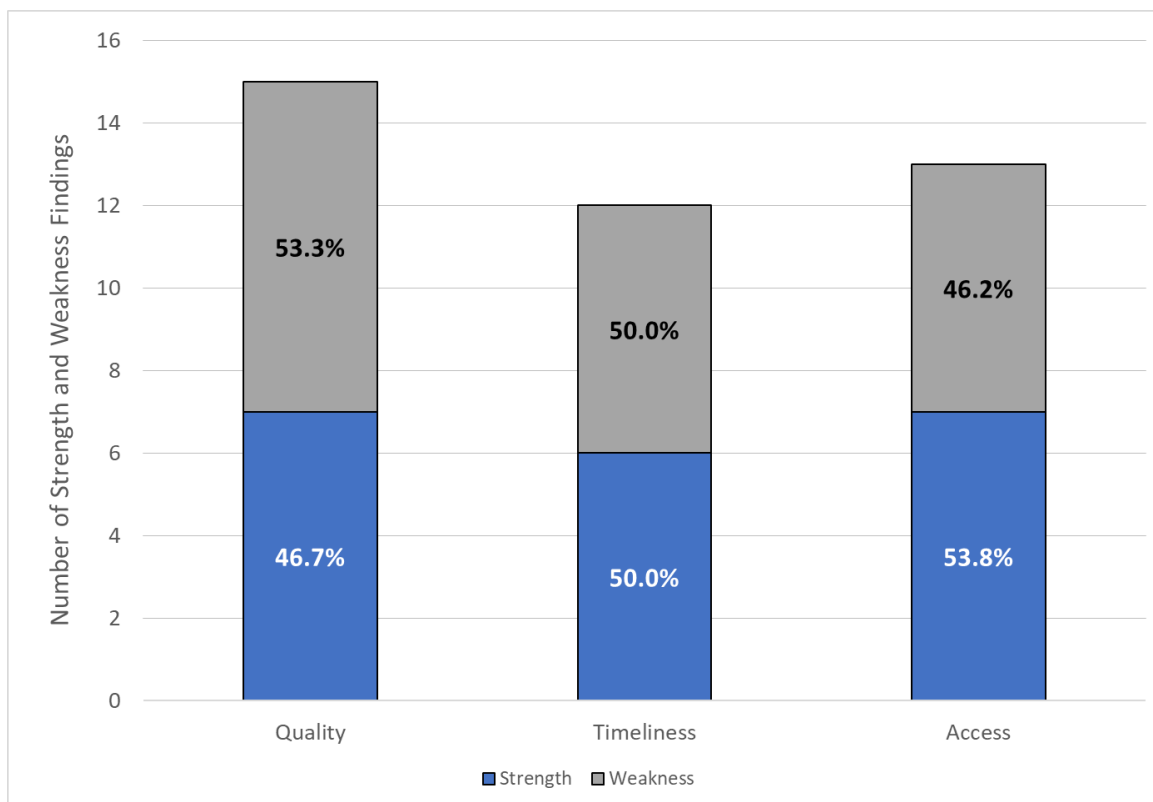
*Standard I—Availability of Services and Standard II—Assurances of Adequate Capacity and Services were combined, and all elements required by 42 CFR §438.206 and §438.207 were assessed under the combined Standard I—Assurance of Adequate Capacity and Availability of Services during the CY 2024 CMR activity.

PacificSource Community Solutions—Central Oregon

Results and Conclusions

HSAG assessed the strengths and weaknesses of each CCO with respect to the quality, timeliness, and accessibility of health care services. Figure 5-17 illustrates the number of strengths exhibited by PCS-CO relative to the number of weaknesses identified during the CY 2024 EQR activities across the three domains. The greater the proportion of weaknesses, the greater opportunities for improvement.

Figure 5-17—PCS-CO Overall Number of Findings (Strengths and Weaknesses) by Domain



Detailed results from the EQR’s substantive findings are summarized in Table 5-17 for each activity. This table highlights the extent to which PCS-CO furnishes high quality, timely, and appropriate access to health care services, and recommendations for how PCS-CO can best address issues identified for each activity.⁶²

⁶² See Section 4—Comparative Statewide Results for detailed, CCO-specific scores associated with EQR activity.

Table 5-17—PCS-CO Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s) ⁶³
Compliance Monitoring Review		
	Strength: PCS-CO demonstrated best practices by ensuring that providers do not establish different access hours for Medicaid members. This was achieved through monthly provider access survey calls conducted by a third-party vendor, the use of site visit checklists, and tracking member grievance data.	
	Weakness: PCS-CO received a score of 89.5 percent in the <i>Assurance of Adequate Capacity and Availability of Services</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements, the inability to demonstrate sufficient implementation of established processes, and deficiencies within its monitoring activities impacting the CCO’s ability to ensure timely access to care and services. Why the weakness exists: The implemented policies and procedures and member and provider communications did not fully align with the federal and State requirements for providing family planning services and accommodations and equipment for members with physical and mental disabilities. The CCO also failed to demonstrate the appropriate monitoring of provider compliance with state-established appointment standards. Recommendations: PCS-CO should revise its policies and procedures to align with federal and State requirements for timely access to care and services and demonstrate implementation. Additionally, the CCO should demonstrate appropriate monitoring of provider compliance with state-established appointment standards. The CCO should also ensure that member and provider communications align with federal and State requirements for service provision.	
	Weakness: PCS-CO received a score of 83.3 percent in the <i>Provider Selection</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements and failure to conduct appropriate monitoring activities impacting the CCO’s ability to meet federal and State requirements for selecting, retaining, credentialing, and recredentialing network providers. Why the weakness exists: PCS-CO lacked policies and procedures for selecting and retaining network providers. Additionally, the CCO did not adhere to State requirements for credentialing and recredentialing providers, including collecting the appropriate credentialing documentation and the time frame for recredentialing. The CCO also	

⁶³  = Quality,  = Timeliness,  = Access

Strength/ Weakness	Description	Domain(s) ⁶³
	could not demonstrate an ongoing monitoring process to ensure compliance with credentialing and recredentialing requirements. Recommendations: PCS-CO should develop policies and procedures for selecting and retaining network providers. Additionally, the CCO should demonstrate adherence to State requirements for credentialing and recredentialing providers, including collecting the appropriate credentialing documentation and the state-established time frame for recredentialing. The CCO should also conduct ongoing monitoring to ensure compliance with credentialing and recredentialing requirements.	
	Weakness: PCS-CO received a score of 75.0 percent in the <i>Subcontractual Relationships and Delegation</i> standard due to insufficient documentation to support operations and ensure compliance with federal requirements for written agreements between the CCO and its subcontractors and failure to follow up with corrective action required as a result of its monitoring activities, impacting the CCO's ability to adhere to federal requirements and the CCO's contractual requirements with the State. Why the weakness exists: PCS-CO failed to follow up and take corrective action when a subcontractor was noncompliant with its contractual obligations. Additionally, the CCO's contracts with the subcontractors failed to include federally required language for written agreements with subcontractors. Recommendations: PCS-CO should follow up when noncompliance is identified and hold its subcontractors accountable for contractual obligations. The CCO should also revise its written agreements to align with federally required language for written agreements with subcontractors.	
	Weakness: PCS-CO received a score of 83.3 percent in the <i>Practice Guidelines</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements impacting the CCO's ability to ensure decision-making was aligned with its clinical practice guidelines. Why the weakness exists: PCS-CO could not demonstrate a process that aligned with the federal and State requirements for ensuring decision-making was aligned with clinical practice guidelines. Recommendations: PCS-CO should develop and implement a process that aligns with the federal and State requirements for ensuring decision-making is aligned with clinical practice guidelines.	
Performance Improvement Projects		
Statewide Mental Health Service Access Monitoring PIP		
	Strength: PCS-CO successfully continued the Implementation stage for the PIP, receiving a <i>Met</i> score for 100 percent of applicable evaluation	

Strength/ Weakness	Description	Domain(s) ⁶³
	elements in the PIP Validation Tool. In the Implementation stage, PCS-CO accurately reported baseline and RY 2 performance indicator data, identified and analyzed barriers to improving MH service access, carried out interventions to address those barriers, and refined interventions based on intervention evaluation results.	
	Strength: PCS-CO's RY 2 performance indicator results demonstrated statistically significant improvement in MH service access compared to baseline indicator results.	
Statewide Substance Use Disorder PIP		
	Strength: PCS-CO accurately reported baseline and RY 1 performance indicator data; identified and analyzed barriers for initiation, engagement, and treatment of alcohol and other drug use disorders; and began to carry out interventions to address those barriers.	
	Weakness: PCS-CO received a <i>Moderate Confidence</i> rating for overall confidence that the <i>Substance Use Disorder</i> PIP achieved significant improvement. Why the weakness exists: PCS-CO's RY 1 improvement noted for both indicators (<i>Percentage of new SUD episodes that result in treatment and initiation within 14 days</i> and <i>Percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation</i>) over BY was not statistically significant. Recommendations: PCS-CO should revisit root cause analyses identifying barriers to improving initiation, engagement, and treatment of alcohol and other drug use disorders to determine which barriers to improvement were not effectively addressed. PCS-CO should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to further improve the percentage of new SUD episodes that result in treatment and initiation within 14 days and the percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation indicator results.	
Performance Measure Validation		
	Strength: PCS-CO's MY 2023 performance on the <i>Child and Adolescent Well-Care Visits—Ages 3 to 6 Years</i> measure indicator demonstrated ongoing improvement since MY 2021. In addition, the CCO's MY 2023 rate exceeded the statewide aggregate and the benchmark set by OHA for MY 2023.	
	Strength: PCS-CO's MY 2023 performance on the <i>Members Receiving Preventive Dental or Oral Health Services—Ages 1 to 5 Years and Ages 6 to 14 Years</i> measure indicators demonstrated ongoing improvement since MY 2021. PCS-CO's MY 2023 performance for members ages 1 to 5 years and ages 6 to 14 years receiving preventive dental or oral	

Strength/ Weakness	Description	Domain(s) ⁶³
	health services improved by more than 5 percentage points compared to MY 2022, 10.5 percentage points for members ages 1 to 5 years, and 6.3 percentage points for members ages 6 to 14 years. In addition, the CCO's MY 2023 rates for both the <i>Ages 1 to 5 Years</i> and <i>Ages 6 to 14 Years</i> measure indicators exceeded the benchmark set by OHA for MY 2023 by 5 percentage points or more.	
	Strength: PCS-CO's MY 2023 performance on the <i>Initiation and Engagement of SUD Treatment</i> measure for ages 13 to 17 years demonstrated improvement since MY 2022 of more than 5 percentage points for both indicators; a 7.1 percent increase for <i>Initiation of SUD Treatment</i> and a 5.9 percent increase for <i>Engagement of SUD Treatment</i> . In addition, the CCO's MY 2023 rate exceeded the statewide aggregate for MY 2023 for both indicators.	  
	Weakness: PCS-CO's MY 2023 performance rates on the <i>Initiation of SUD Treatment</i> measure indicators for members ages 18 years and older dropped more than 5 percentage points from MY 2022 and fell below the benchmark set by OHA for MY 2023. Why the weakness exists: Although PCS-CO's eligible population remained steady from MY 2022 to MY 2023 for members ages 18 years and older, the number of members diagnosed with SUD initiating treatment declined by 5.1 percentage points. Recommendations: PCS-CO should conduct root cause analyses to identify specific factors affecting performance on the <i>Initiation of SUD Treatment</i> measure indicator. Once identified, targeted interventions should be developed, implemented, and evaluated to ensure effective improvement strategies are adopted to increase performance over time. Additionally, PCS-CO should continue to monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches to ensuring the quality, timeliness, and accessibility of health care services (i.e., telehealth strategies, mobile clinics).	  
Validation of Network Adequacy		
Network Adequacy Validation Audit		
	Strength: PCS-CO had established a robust process to keep provider data up to date and accurate through its quarterly attestation reminders to providers and credentialing process. This process ensured PCS-CO had numerous validation steps included to keep their provider data up to date and accurate.	
Delivery System Network Evaluation		
	Weakness: PCS-CO did not meet the pediatric and facility time and distance standard for OT providers and MTD facilities, respectively.	

Strength/ Weakness	Description	Domain(s) ⁶³
	Why the weakness exists: PCS-CO did not meet the facility network adequacy standards for MTD providers since fewer than 95 percent of its members were within acceptable travel times or distances of MTD facilities. Additionally, 0.0 percent of pediatric PCS-CO members had access to OT providers since PCS-CO's network had no contracted OT providers serving pediatric members. Finally, PCS-CO had not engaged in OHA's time and distance exception request process. It is expected that the CCO have at least one provider of all monitored types within its network, regardless of time and distance standard compliance, rather than rely on single case agreements or similar methods. Recommendations: PCS-CO should ensure that it takes the necessary steps to maintain an adequate network that can provide all covered and necessary care. The CCO should work to contract with at least one provider or facility of each missing type that can supply such services as part of the CCO's network, even if that provider is not within the service region. Such providers should still be meaningfully accessible through regional transportation (e.g., driving to a nearby population center). The CCO should engage with OHA on potential solutions for these needs, including engagement in OHA's time and distance standard exception request process.	
Revealed Telephone Survey		
	Strength: Of the PCP cases that offered an appointment, 90.5 percent of urgent visits for existing patients were compliant with the wait time standard.	
	Weakness: Overall, 64.9 percent of the total PCP and OP SUD sampled cases were reached. Among the cases reached, 80.3 percent confirmed the correct location, 57.4 percent offered the requested services, 46.7 percent accepted OHP Medicaid, and 41.0 percent accepted PCS-CO. Also, 86.0 percent of cases offered translation or interpreter services. Why the weakness exists: In addition to limitations related to the revealed survey approach, inaccuracies found in PCS-CO's provider data may have contributed to the low response rate and accuracy results. Recommendations: PCS-CO should use the case-level analytic data files to address the data deficiencies identified during the survey calls (e.g., incorrect or disconnected telephone numbers; incorrect location; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
	Weakness: Among the total PCP and OP SUD cases reached, 37.7 percent accepted new patients. In addition, appointment availability was offered for less than 40.0 percent of PCP cases and 35.0 percent of OP SUD cases. Of the PCP cases that offered appointments, 66.7 percent of new patient routine visits, 73.3 percent of new patient urgent visits, and	

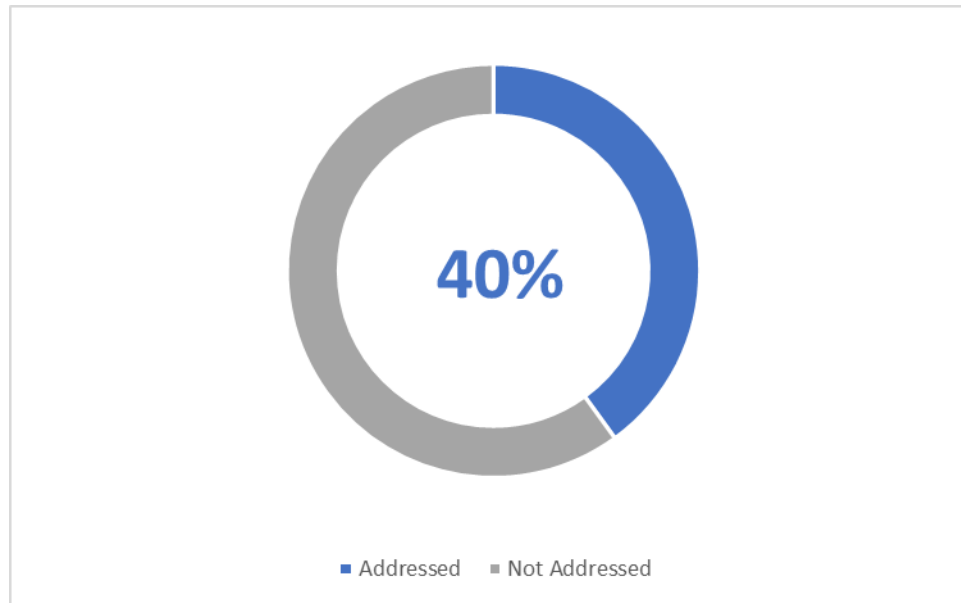
Strength/ Weakness	Description	Domain(s) ⁶³
	86.4 percent of existing patient routine visits were compliant with the wait time standards. Additionally, of the OP SUD cases that offered an appointment, 56.3 percent of urgent visits, 73.7 percent of opioid use disorder visits, 77.3 percent of pregnant OP SUD visits, and 87.5 percent of routine visits were compliant. Why the weakness exists: In addition to limitations related to the revealed survey approach, inaccuracies found in PCS-CO's provider data and insufficient provider panel capacity may have contributed to low access and availability rates (i.e., new patient acceptance, appointment availability, and wait times). Also, internal office staffing structures and procedures may have contributed to the long wait times. Recommendations: PCS-CO should confirm appointment availability with providers, including panel capacity to accept new patients. Further, PCS-CO should use the case-level analytic data files to address data deficiencies identified during the survey calls.	
Encounter Data Validation		
Since EDV results were not available for inclusion in the 2024 EQR technical report, the strengths and weaknesses for each CCO could not be assessed. The findings will be incorporated in next year's EQR technical report.		
Mental Health Parity Evaluation		
	Strength: PCS-CO submitted a detailed summary of the changes implemented in CY 2023 to medical management and sufficiently addressed pharmacy management NQTLs as required from the previous year's MHP Evaluation. The information provided was clearly communicated in the narrative and was accompanied by supporting documentation.	

Follow-Up on Prior Year Recommendations

HSAG evaluated PCS-CO's approach to addressing the recommendations related to findings issued during CY 2023 and unresolved findings from CY 2020, CY 2021, and CY 2022 while conducting the CY 2024 EQR activities. The CCOs not addressing recommendations are at risk of being out of compliance with their contracts.

Figure 5-18 illustrates the degree in which the CCO sufficiently addressed the recommendations for QI made by HSAG during the CY 2023 EQR.

Figure 5-18—Percentage of CY 2023 EQR Recommendations Addressed by PCS-CO



PCS-CO-specific CY 2023 recommendations and follow-up CY 2024 assessments are summarized in Table 5-18.

Table 5-18—Assessment of PCS-CO’s Approach to Addressing Previous Annual Recommendations

CY 2023 Recommendation	CY 2024 Assessment
Compliance Monitoring Review	
<i>Standard I—Assurance of Adequate Capacity and Availability of Services*</i>	
This recommendation was initially given during the CY 2021 EQR. PCS-CO should ensure its provider manual includes accurate information related to female access to a women’s health specialist.	PCS-CO did not sufficiently address the recommendation. PCS-CO’s member handbook and provider manual included inconsistent information related to female access to a women’s health specialist. Note: Standard I—Assurance of Adequate Capacity and Availability of Services was comprehensively reviewed during the CY 2024 CMR cycle, and recommendations addressing all findings related to this standard are included in the CCO’s individual Results and Conclusions section.
<i>Standard III—Coordination and Continuity of Care</i>	
PCS-CO should revise its policies and procedures to align with State requirements. PCS-CO should also demonstrate implementation of appropriate assessments, reassessments, and revision of	PCS-CO sufficiently addressed the recommendation.

CY 2023 Recommendation	CY 2024 Assessment
treatment plans according to federal and State requirements.	
Standard IV—Coverage and Authorization of Services	
PCS-CO should revise its policies and procedures to align with federal and State requirements. PCS-CO should also demonstrate the implementation of appropriate service offerings. PCS-CO should also demonstrate proper outreach to retrieve the information needed to process service authorization requests and adhere to federal and State required time frames for providing NOABDs.	PCS-CO did not sufficiently address the recommendation. Although PCS-CO began revising its processes to comply with federal and State requirements, the CCO could not demonstrate implementation of processes for the appropriate decision-makers in denials. HSAG recommends that PCS-CO demonstrate implementation of processes to ensure the utilization of appropriate decision-makers with the appropriate expertise when denying services.
Standard V—Provider Selection	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Standard VI—Subcontractual Relationships and Delegation	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard VII—Member Rights and Protections	
PCS-CO should revise its policies and procedures and member- and provider-facing materials to align with federal and State requirements.	PCS-CO sufficiently addressed the recommendation.
Standard VIII—Confidentiality	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard IX—Enrollment and Disenrollment	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Standard X—Grievance and Appeal Systems	
PCS-CO should revise its policies and procedures to align with federal and State requirements. PCS-CO should also adhere to federal and State requirements for the appropriate decision-makers on grievances and appeals, maintenance of an expedited process for appeals, and time frames for acknowledging and resolving grievances and appeals. PCS-CO should also demonstrate implementation of federal and State requirements	PCS-CO sufficiently addressed the recommendation.

CY 2023 Recommendation	CY 2024 Assessment
within communications to providers and subcontractors.	
Standard XI—Practice Guidelines	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard XII—Quality Assessment and Performance Improvement	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Standard XIII—Health Information Systems, including ISCA	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard XIV—Member Information	
PCS-CO should revise its policies, procedures, and member-facing materials to align with federal and State requirements. PCS-CO should also notify members of the availability of member information.	PCS-CO did not sufficiently address the recommendation. Although PCS-CO revised its policies and procedures and some of its member notifications to align with federal and State requirements, the printed and online versions of the provider directory failed to include information specific to accessibility accommodations. HSAG recommends that PCS-CO revise its provider directory to align with federal and State requirements.
Standard XVI—Emergency and Poststabilization Services	
PCS-CO should demonstrate evidence of processes to ensure payment of emergency and poststabilization services.	PCS-CO sufficiently addressed the recommendation.
Performance Improvement Projects	
Statewide Mental Health Service Access Monitoring PIP	
PCS-CO should revisit root cause analyses identifying barriers to improving access to MH services to determine which barriers to improvement were not effectively addressed. PCS-CO should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to improve indicator results.	PCS-CO sufficiently addressed the recommendation.
Statewide Substance Use Disorder PIP	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.

CY 2023 Recommendation	CY 2024 Assessment
Performance Measure Validation	
This recommendation was initially given during the CY 2021 EQR. PCS-CO should continue to monitor key performance measure rates in alignment with its QAPI goals and objectives. For all key measures that fall below established performance or improvement thresholds, PCS-CO should conduct root cause analyses to identify specific factors affecting performance. Once identified, targeted interventions should be developed, implemented, and evaluated to ensure effective improvement strategies are adopted to increase performance over time. Additionally, PCS-CO should continue to monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches to ensuring the quality, timeliness, and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	PCS-CO did not sufficiently address the recommendation. PCS-CO did not provide a response or supporting documentation to address the recommendation.
Validation of Network Adequacy	
Delivery System Network Evaluation	
PCS-CO should seek technical assistance with OHA to determine the nature of the provider capacity data issues and take corrective action, as necessary.	PCS-CO sufficiently addressed the recommendation.
Secret Shopper Survey	
This recommendation was initially given during the CY 2021 EQR. HSAG recommends that PCS-CO use the case-level analytic data files to address the data deficiencies identified during the secret shopper survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	PCS-CO did not sufficiently address the recommendation. PCS-CO did not provide a response or supporting documentation to address the recommendation.
HSAG recommends that PCS-CO confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. PCS-CO should use the case-level analytic data files containing data deficiencies identified during the secret shopper survey calls.	PCS-CO did not sufficiently address the recommendation. PCS-CO did not provide a response or supporting documentation to address the recommendation.

CY 2023 Recommendation	CY 2024 Assessment
Revealed Telephone Survey	
HSAG recommends that PCS-CO use the case-level analytic data files to address the data deficiencies identified during the revealed telephone survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	PCS-CO did not sufficiently address the recommendation. PCS-CO did not provide a response or supporting documentation to address the recommendation.
HSAG recommends that PCS-CO confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. PCS-CO should use the case-level analytic data files containing data deficiencies identified during the revealed telephone survey calls and work with BH outpatient offices to identify the root cause for delays in appointment availability.	PCS-CO did not sufficiently address the recommendation. PCS-CO did not provide a response or supporting documentation to address the recommendation.
Encounter Data Validation	
This recommendation was initially given during the CY 2021 EQR. PCS-CO should continually work with its vendor to monitor its encounter submissions to OHA to ensure complete, accurate, and timely encounter data submissions.	PCS-CO did not sufficiently address the recommendation. PCS-CO did not provide a response or supporting documentation to address the recommendation.
This recommendation was initially given during the CY 2021 EQR. PCS-CO should implement standard quality controls to ensure accurate data extracts. Through the development of standard data extraction procedures and quality control, the number of errors associated with extracted data could be reduced. Additionally, HSAG recommends that PCS-CO continually work to monitor its encounter submissions to OHA to ensure complete, accurate, and timely encounter data submissions.	PCS-CO did not sufficiently address the recommendation. PCS-CO did not provide a response or supporting documentation to address the recommendation.
This recommendation was initially given during the CY 2022 EQR. PCS-CO should investigate the root cause for the omissions and consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews would then be provided to	PCS-CO did not sufficiently address the recommendation. PCS-CO did not provide a response or supporting documentation to address the recommendation.

CY 2023 Recommendation	CY 2024 Assessment
providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.	
While encounter submission to OHA did not require the inclusion of the <i>Rendering Provider NPI</i> value if it matched the <i>Billing Provider NPI</i> value, the data request for the EDV comparative analysis had different requirements. To address this, HSAG recommends that PCS-CO and its subcontractor(s) ensure that values for both <i>Billing Provider NPI</i> and <i>Rendering Provider NPI</i> are included in the data submission, irrespective of their equivalence. This adjustment will enhance the accuracy and completeness of the comparative analysis data. Additionally, it will provide HSAG with the means to verify and ensure the accuracy of the MMIS' process of populating the <i>Rendering Provider NPI</i> with the <i>Billing Provider NPI</i> .	PCS-CO did not sufficiently address the recommendation. PCS-CO did not provide a response or supporting documentation to address the recommendation.
Mental Health Parity Evaluation	
PCS-CO should identify processes, strategies, evidentiary standards, and other factors that are used in formulary design and the application for prescription drugs.	PCS-CO sufficiently addressed the recommendation.
PCS-CO should identify processes, strategies, evidentiary standards, and other factors that are used in formulary tiering.	PCS-CO sufficiently addressed the recommendation.

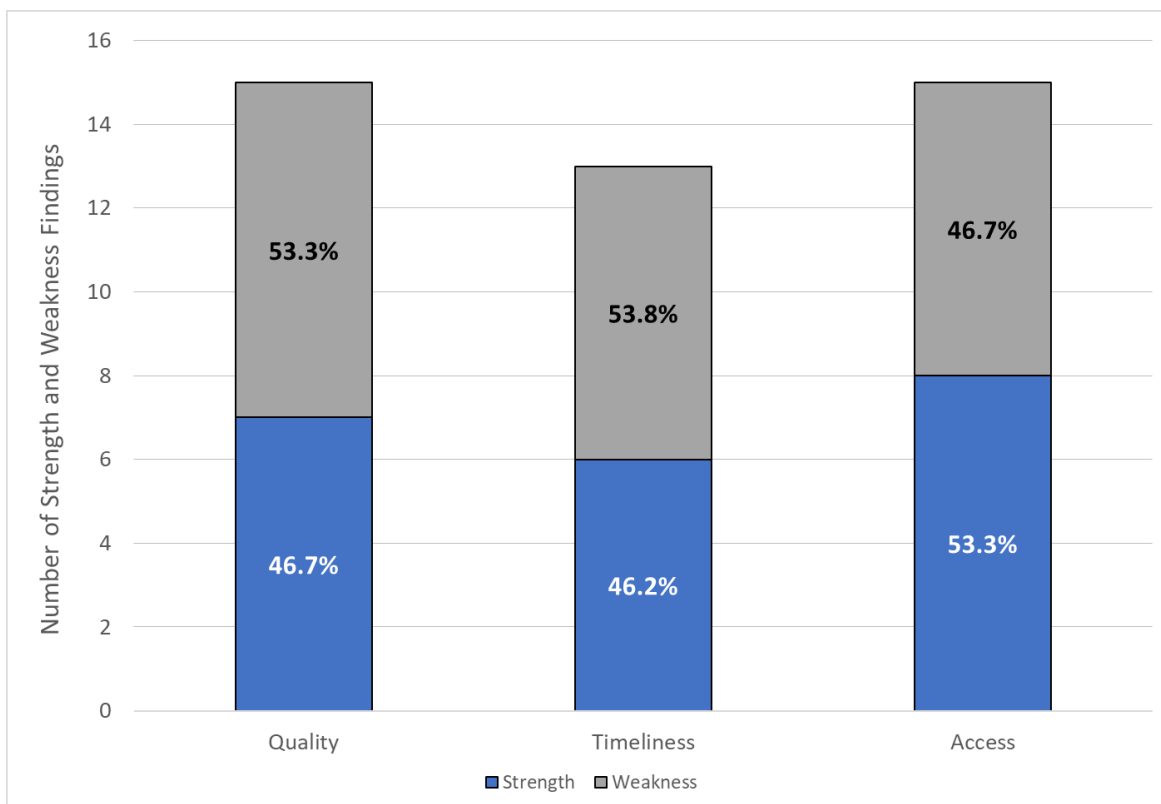
*Standard I—Availability of Services and Standard II—Assurances of Adequate Capacity and Services were combined, and all elements required by 42 CFR §438.206 and §438.207 were assessed under the combined Standard I—Assurance of Adequate Capacity and Availability of Services during the CY 2024 CMR activity.

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Results and Conclusions

HSAG assessed the strengths and weaknesses of each CCO with respect to the quality, timeliness, and accessibility of health care services. Figure 5-19 illustrates the number of strengths exhibited by PCS-CG relative to the number of weaknesses identified during the CY 2024 EQR activities across the three domains. The greater the proportion of weaknesses, the greater opportunities for improvement.

Figure 5-19—PCS-CG Overall Number of Findings (Strengths and Weaknesses) by Domain



Detailed results from the EQR’s substantive findings are summarized in Table 5-19 for each activity. This table highlights the extent to which PCS-CG furnishes high quality, timely, and appropriate access to health care services, and recommendations for how PCS-CG can best address issues identified for each activity.⁶⁴

⁶⁴ See Section 4—Comparative Statewide Results for detailed, CCO-specific scores associated with EQR activity.

Table 5-19—PCS-CG Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s) ⁶⁵
Compliance Monitoring Review		
	Strength: PCS-CG demonstrated best practices by ensuring that providers do not establish different access hours for Medicaid members. This was achieved through monthly provider access survey calls conducted by a third-party vendor, the use of site visit checklists, and tracking member grievance data.	  
	Weakness: PCS-CG received a score of 89.5 percent in the <i>Assurance of Adequate Capacity and Availability of Services</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements, the inability to demonstrate sufficient implementation of established processes, and deficiencies within its monitoring activities impacting the CCO’s ability to ensure timely access to care and services. Why the weakness exists: The implemented policies and procedures and member and provider communications did not fully align with the federal and State requirements for providing family planning services and accommodations and equipment for members with physical and mental disabilities. The CCO also failed to demonstrate the appropriate monitoring of provider compliance with state-established appointment standards. Recommendations: PCS-CG should revise its policies and procedures to align with federal and State requirements for timely access to care and services and demonstrate implementation. Additionally, the CCO should demonstrate appropriate monitoring of provider compliance with state-established appointment standards. The CCO should also ensure that member and provider communications align with federal and State requirements for service provision.	  
	Weakness: PCS-CG received a score of 83.3 percent in the <i>Provider Selection</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements and failure to conduct appropriate monitoring activities impacting the CCO’s ability to meet federal and State requirements for selecting, retaining, credentialing, and recredentialing network providers. Why the weakness exists: PCS-CG lacked policies and procedures for selecting and retaining network providers. Additionally, the CCO did not adhere to State requirements for credentialing and recredentialing providers, including collecting the appropriate credentialing documentation and the time frame for recredentialing. The CCO also	 

⁶⁵  = Quality,  = Timeliness,  = Access

Strength/ Weakness	Description	Domain(s) ⁶⁵
	could not demonstrate an ongoing monitoring process to ensure compliance with credentialing and recredentialing requirements. Recommendations: PCS-CG should develop policies and procedures for selecting and retaining network providers. Additionally, the CCO should demonstrate adherence to State requirements for credentialing and recredentialing providers, including collecting the appropriate credentialing documentation and the state-established time frame for recredentialing. The CCO should also conduct ongoing monitoring to ensure compliance with credentialing and recredentialing requirements.	
	Weakness: PCS-CG received a score of 75.0 percent in the <i>Subcontractual Relationships and Delegation</i> standard due to insufficient documentation to support operations and ensure compliance with federal requirements for written agreements between the CCO and its subcontractors and failure to follow up with corrective action required as a result of its monitoring activities, impacting the CCO's ability to adhere to federal requirements and the CCO's contractual requirements with the State. Why the weakness exists: PCS-CG failed to follow up and take corrective action when a subcontractor was noncompliant with its contractual obligations. Additionally, the CCO's contracts with the subcontractors failed to include federally required language for written agreements with subcontractors. Recommendations: PCS-CG should follow up when noncompliance is identified and hold its subcontractors accountable for contractual obligations. The CCO should also revise its written agreements to align with federally required language for written agreements with subcontractors.	
	Weakness: PCS-CG received a score of 83.3 percent in the <i>Practice Guidelines</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements impacting the CCO's ability to ensure decision-making was aligned with its clinical practice guidelines. Why the weakness exists: PCS-CG could not demonstrate a process that aligned with the federal and State requirements for ensuring decision-making was aligned with clinical practice guidelines. Recommendations: PCS-CG should develop and implement a process that aligns with the federal and State requirements for ensuring decision-making is aligned with clinical practice guidelines.	
Performance Improvement Projects		
Statewide Mental Health Service Access Monitoring PIP		
	Strength: PCS-CG successfully continued the Implementation stage for the PIP, receiving a <i>Met</i> score for 100 percent of applicable evaluation	

Strength/ Weakness	Description	Domain(s) ⁶⁵
	elements in the PIP Validation Tool. In the Implementation stage, PCS-CG accurately reported baseline and RY 2 performance indicator data, identified and analyzed barriers to improving MH service access, carried out interventions to address those barriers, and refined interventions based on intervention evaluation results.	
	Strength: PCS-CG's RY 2 performance indicator results demonstrated statistically significant improvement in MH service access compared to baseline indicator results.	
Statewide Substance Use Disorder PIP		
	Strength: PCS-CG accurately reported baseline and RY 1 performance indicator data; identified and analyzed barriers for initiation, engagement, and treatment of alcohol and other drug use disorders; and began to carry out interventions to address those barriers.	
	Weakness: PCS-CG received a <i>No Confidence</i> rating for overall confidence that the <i>Substance Use Disorder</i> PIP achieved significant improvement. Why the weakness exists: PCS-CG demonstrated a decline in performance from baseline to RY 1 for both Indicator 1 (<i>Percentage of new SUD episodes that result in treatment and initiation within 14 days</i>) and Indicator 2 (<i>Percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation</i>) results. Recommendations: PCS-CG should revisit root cause analyses identifying barriers to improving initiation, engagement, and treatment of alcohol and other drug use disorders to determine which barriers to improvement were not effectively addressed. PCS-CG should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to further improve the percentage of new SUD episodes that result in treatment and initiation within 14 days and the percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation indicator results.	
Performance Measure Validation		
	Strength: PCS-CG's MY 2023 performance on the <i>Child and Adolescent Well-Care Visits—Ages 3 to 6 Years</i> measure indicator performance rate exceeded the statewide aggregate and the benchmark set by OHA for MY 2023 by 5 percentage points or more.	
	Strength: PCS-CG's MY 2023 performance on the <i>Members Receiving Preventive Dental or Oral Health Services—Ages 1 to 5 Years and Ages 6 to 14 Years</i> measure indicators demonstrated ongoing improvement since MY 2021. In addition, the CCO's MY 2023 rate exceeded the statewide aggregate and the benchmark set by OHA for MY 2023 for	

Strength/ Weakness	Description	Domain(s) ⁶⁵
	both age groups and by 5 percentage points or more for members ages 6 to 14 years (8.7 percentage points).	
	Strength: PCS-CG's MY 2023 performance on the <i>Oral Evaluation for Adults With Diabetes</i> measure indicator demonstrated improvement since MY 2022. In addition, the CCO's MY 2023 rate exceeded the statewide aggregate and the benchmark set by OHA for MY 2023 by 5 percentage points or more (5.2 percentage points and 5.6 percentage points, respectively).	
	Weakness: PCS-CG's MY 2023 performance rate on the <i>Initiation of SUD Treatment</i> measure indicator for members ages 18 years and older dropped more than 5 percentage points from MY 2022 and fell below the benchmarks set by OHA for MY 2023. Additionally, for members ages 13 to 17 years, PCS-CG's performance declined more than 5 percentage points for both the <i>Initiation of SUD Treatment</i> and <i>Engagement of SUD Treatment</i> measure indicators; a 24 percentage point decrease for the <i>Initiation of SUD Treatment</i> measure indicator and a 14.1 percentage point decrease for the <i>Engagement of SUD Treatment</i> measure indicator. Both indicators also scored below the statewide aggregate. Why the weakness exists: PCS-CG's eligible population increased from MY 2022 to MY 2023 for members ages 18 years and older, but the number of members diagnosed with SUD initiating treatment remained the same. Recommendations: PCS-CG should conduct root cause analyses to identify specific factors affecting performance on the <i>Initiation of SUD Treatment</i> measure indicator. Once identified, targeted interventions should be developed, implemented, and evaluated to ensure effective improvement strategies are adopted to increase performance over time. Additionally, PCS-CG should continue to monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches to ensuring the quality, timeliness, and accessibility of health care services (i.e., telehealth strategies, mobile clinics).	
Validation of Network Adequacy		
Network Adequacy Validation Audit		
	Strength: PCS-CG had established a robust process to keep provider data up to date and accurate through its quarterly attestation reminders to providers and credentialing process. This process ensured PCS-CG had numerous validation steps included to keep their provider data up to date and accurate.	

Strength/ Weakness	Description	Domain(s) ⁶⁵
Delivery System Network Evaluation		
	Weakness: PCS-CG did not meet the State time and distance standard for OT and POD providers. Why the weakness exists: PCS-CG did not meet the adult and pediatric network adequacy standards for POD providers and the pediatric network adequacy standard for OT providers since substantially fewer than 95 percent of members resided within acceptable travel times or distances. PCS-CG did not contract with any OT providers offering services to pediatric members. Similarly, 0.0 percent of PCS-CG members had access to MTD facilities. Additionally, PCS-CG had not engaged in OHA's time and distance exception request process. It is expected that the CCO have at least one provider of all monitored types within its network, regardless of time and distance standard compliance, rather than rely on single case agreements or similar methods. Recommendations: PCS-CG should ensure that it takes the necessary steps to maintain an adequate network that can provide all covered and necessary care. The CCO should work to contract with at least one provider or facility of each missing type that can supply such services as part of the CCO's network, even if that provider is not within the service region. Such providers should still be meaningfully accessible through regional transportation (e.g., driving to a nearby population center). The CCO should engage with OHA on potential solutions for these needs, including participation in OHA's time and distance exception request process.	
Revealed Telephone Survey		
	Strength: Of the total PCP and OP SUD cases accepting the CCO, 93.0 percent of cases offered translation or interpreter services.	
	Strength: Of the PCP cases that offered an appointment, 100 percent of routine appointments for new and existing patients were compliant with the wait time standards. Additionally, among the OP SUD cases that offered an appointment, routine visits, opioid use disorder visits, and pregnant OP SUD visits had compliance rates greater than 95.0 percent.	
	Weakness: Overall, 77.5 percent of the total PCP and OP SUD sampled cases were reached. Among the cases reached, 83.0 percent confirmed the correct location, 60.0 percent offered the requested services, 53.0 percent accepted OHP Medicaid, and 43.0 percent accepted PCS-CG. Why the weakness exists: In addition to limitations related to the revealed survey approach, inaccuracies found in PCS-CG's provider data may have contributed to the low response rate and accuracy results.	

Strength/ Weakness	Description	Domain(s) ⁶⁵
	Recommendations: PCS-CG should use the case-level analytic data files to address the data deficiencies identified during the survey calls (e.g., incorrect or disconnected telephone numbers; incorrect location; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
	Weakness: Among the total PCP and OP SUD cases reached, 43.0 percent accepted new patients. In addition, appointment availability was only offered for 52.4 percent of PCP cases and in less than 37.0 percent of OP SUD cases. Of the PCP cases that offered appointments, only 18.2 percent of urgent visits for new and existing patients were compliant with the wait time standards. Additionally, of the OP SUD cases that offered an appointment, only 57.1 percent of urgent visits were compliant. Why the weakness exists: In addition to limitations related to the revealed survey approach, inaccuracies found in PCS-CG's provider data and insufficient provider panel capacity may have contributed to low access and availability rates (i.e., new patient acceptance, appointment availability, and wait times). Also, internal office staffing structures and procedures may have contributed to the long wait times. Recommendations: PCS-CG should confirm appointment availability with providers, including panel capacity to accept new patients. Further, PCS-CG should use the case-level analytic data files to address data deficiencies identified during the survey calls.	
Encounter Data Validation		
Since EDV results were not available for inclusion in the 2024 EQR technical report, the strengths and weaknesses for each CCO could not be assessed. The findings will be incorporated in next year's EQR technical report.		
Mental Health Parity Evaluation		
	Strength: PCS-CG submitted a detailed summary of the changes implemented in CY 2023 to medical management and sufficiently addressed pharmacy management NQTLs as required from the previous year's MHP Evaluation. The information provided was clearly communicated in the narrative and was accompanied by supporting documentation.	
	Weakness: PCS-CG showed substantial differences in the percentage of paid, out-of-network OP MH/SUD claims compared to OP M/S paid claims. Although the difference in the percentage of paid claims may be legitimate, they may also highlight procedural or network differences, indicating potential barriers for members accessing MH/SUD services. Why the weakness exists: out-of-network OP MH/SUD claims were paid less frequently than M/S claims.	

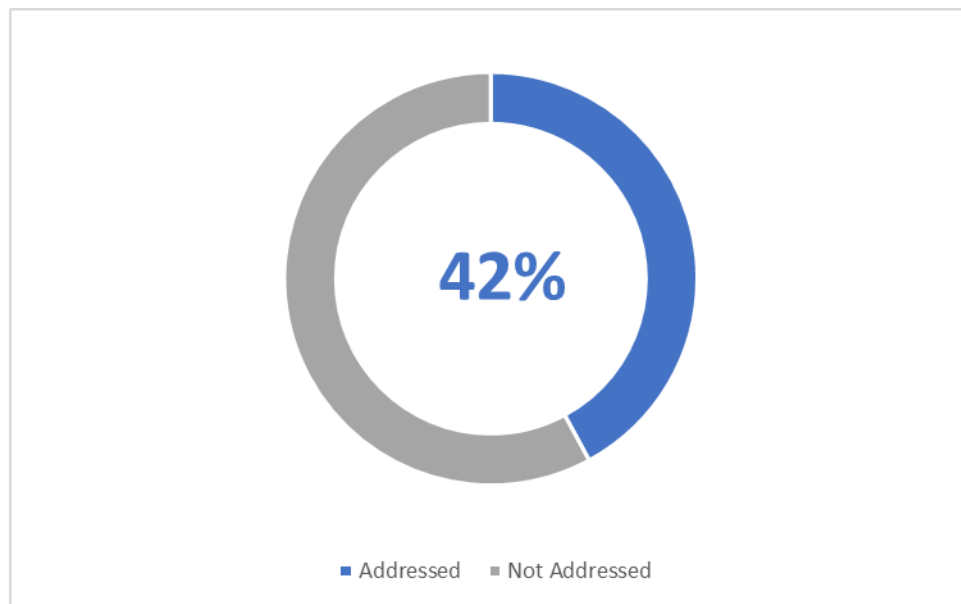
Strength/ Weakness	Description	Domain(s) ⁶⁵
	Recommendations: PCS-CG should review out-of-network claim denials to understand the factors affecting the lower percentage of out-of-network OP MH/SUD paid claims compared to out-of-network OP M/S paid claims. The CCO should assess whether any barriers exist for members accessing MH/SUD services, including the need to seek services outside of the CCO’s network (e.g., appointment availability).	

Follow-Up on Prior Year Recommendations

HSAG evaluated PCS-CG’s approach to addressing the recommendations related to findings issued during CY 2023 and unresolved findings from CY 2020, CY 2021, and CY 2022 while conducting the CY 2024 EQR activities. The CCOs not addressing recommendations are at risk of being out of compliance with their contracts.

Figure 5-20 illustrates the degree in which the CCO sufficiently addressed the recommendations for QI made by HSAG during the CY 2023 EQR.

Figure 5-20—Percentage of CY 2023 EQR Recommendations Addressed by PCS-CG



PCS-CG-specific CY 2023 recommendations and follow-up CY 2024 assessments are summarized in Table 5-20.

Table 5-20—Assessment of PCS-CG’s Approach to Addressing Previous Annual Recommendations

CY 2023 Recommendation	CY 2024 Assessment
Compliance Monitoring Review	
Standard I—Assurance of Adequate Capacity and Availability of Services*	
This recommendation was initially given during the CY 2021 EQR. PCS-CG should ensure its provider manual includes accurate information related to female access to a women’s health specialist.	PCS-CG did not sufficiently address the recommendation. PCS-CG’s member handbook and provider manual included inconsistent information related to female access to a women’s health specialist. Note: Standard I—Assurance of Adequate Capacity and Availability of Services was comprehensively reviewed during the CY 2024 CMR cycle, and recommendations addressing all findings related to this standard are included in the CCO’s individual Results and Conclusions section.
Standard III—Coordination and Continuity of Care	
PCS-CG should revise its policies and procedures to align with State requirements. PCS-CG should also demonstrate implementation of appropriate assessments, reassessments, and revision of treatment plans according to federal and State requirements.	PCS-CG sufficiently addressed the recommendation.
Standard IV—Coverage and Authorization of Services	
PCS-CG should revise its policies and procedures to align with federal and State requirements. PCS-CG should also demonstrate the implementation of appropriate service offerings. PCS-CG should also demonstrate proper outreach to retrieve the information needed to process service authorization requests.	PCS-CG did not sufficiently address the recommendation. Although PCS-CG began revising its processes to comply with federal and State requirements, the CCO could not demonstrate implementation of processes for the appropriate decision-makers in denials. HSAG recommends that PCS-CG demonstrate implementation of processes to ensure the utilization of appropriate decision-makers with the appropriate expertise when denying services.
Standard V—Provider Selection	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Standard VI—Subcontractual Relationships and Delegation	
This standard was not assessed during the 2023 CMR.	Not applicable.

CY 2023 Recommendation	CY 2024 Assessment
Standard VII—Member Rights and Protections	
PCS-CG should revise its policies and procedures and member- and provider-facing materials to align with federal and State requirements.	PCS-CG sufficiently addressed the recommendation.
Standard VIII—Confidentiality	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Standard IX—Enrollment and Disenrollment	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Standard X—Grievance and Appeal Systems	
PCS-CG should revise its policies and procedures to align with federal and State requirements. PCS-CG should also adhere to federal and State requirements for the appropriate decision-makers on grievances and appeals, maintenance of an expedited process for appeals, and time frames for acknowledging and resolving grievances and appeals. PCS-CG should also demonstrate implementation of federal and State requirements within communications to providers and subcontractors.	PCS-CG sufficiently addressed the recommendation.
Standard XI—Practice Guidelines	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard XII—Quality Assessment and Performance Improvement	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Standard XIII—Health Information Systems, including ISCA	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard XIV—Member Information	
PCS-CG should revise its policies, procedures, and member-facing materials to align with federal and State requirements. PCS-CG should also notify members of the availability of member information.	PCS-CG did not sufficiently address the recommendation. Although PCS-CG revised its policies and procedures and some of its member notifications to align with federal and State requirements, the printed and online versions of the provider directory failed to include information specific to accessibility

CY 2023 Recommendation	CY 2024 Assessment
	accommodations. HSAG recommends that PCS-CG revise its provider directory to align with federal and State requirements.
Standard XVI—Emergency and Poststabilization Services	
PCS-CG should demonstrate evidence of processes to ensure payment of emergency and poststabilization services.	PCS-CG sufficiently addressed the recommendation.
Performance Improvement Projects	
Statewide Mental Health Service Access Monitoring PIP	
PCS-CG should revisit root cause analyses identifying barriers to improving access to MH services to determine which barriers to improvement were not effectively addressed. PCS-CG should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to improve indicator results.	PCS-CG sufficiently addressed the recommendation.
Statewide Substance Use Disorder PIP	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Performance Measure Validation	
This recommendation was initially given during the CY 2021 EQR. PCS-CG should continue to monitor key performance measure rates in alignment with its QAPI goals and objectives. PCS-CG should conduct root cause analyses to identify specific factors affecting performance, specifically for the <i>Members Receiving Preventive Dental or Oral Health Services—Ages 1 to 5 Years</i> measure indicator. Once identified, targeted interventions should be developed, implemented, and evaluated to ensure effective improvement strategies are adopted to increase performance over time. Additionally, PCS-CG should continue to monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches to ensuring the quality, timeliness, and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	PCS-CG did not sufficiently address the recommendation. PCS-CG did not provide a response or supporting documentation to address the recommendation.

CY 2023 Recommendation	CY 2024 Assessment
Validation of Network Adequacy	
Delivery System Network Evaluation	
PCS-CG should seek technical assistance with OHA to determine the nature of the provider capacity data issues and take corrective action, as necessary.	PCS-CG sufficiently addressed the recommendation.
Secret Shopper Survey	
This recommendation was initially given during the CY 2021 EQR. HSAG recommends that PCS-CG use the case-level analytic data files to address the data deficiencies identified during the secret shopper survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	PCS-CG did not sufficiently address the recommendation. PCS-CG did not provide a response or supporting documentation to address the recommendation.
HSAG recommends that PCS-CG confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. PCS-CG should use the case-level analytic data files containing data deficiencies identified during the secret shopper survey calls.	PCS-CG did not sufficiently address the recommendation. PCS-CG did not provide a response or supporting documentation to address the recommendation.
Revealed Telephone Survey	
HSAG recommends that PCS-CG use the case-level analytic data files to address the data deficiencies identified during the revealed telephone survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	PCS-CG did not sufficiently address the recommendation. PCS-CG did not provide a response or supporting documentation to address the recommendation.
HSAG recommends that PCS-CG confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. PCS-CG should use the case-level analytic data files containing data deficiencies identified during the revealed telephone survey calls and work with BH outpatient offices to identify the root cause for delays in appointment availability.	PCS-CG did not sufficiently address the recommendation. PCS-CG did not provide a response or supporting documentation to address the recommendation.

CY 2023 Recommendation	CY 2024 Assessment
Encounter Data Validation	
This recommendation was initially given during the CY 2022 EQR. PCS-CG should investigate the root cause for the omissions and consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews would then be provided to providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.	PCS-CG did not sufficiently address the recommendation. PCS-CG did not provide a response or supporting documentation to address the recommendation.
While encounter submission to OHA did not require the inclusion of the <i>Rendering Provider NPI</i> value if it matched the <i>Billing Provider NPI</i> value, the data request for the EDV comparative analysis had different requirements. To address this, HSAG recommends that PCS-CG and its subcontractor(s) ensure that values for both <i>Billing Provider NPI</i> and <i>Rendering Provider NPI</i> are included in the data submission, irrespective of their equivalence. This adjustment will enhance the accuracy and completeness of the comparative analysis data. Additionally, it will provide HSAG with the means to verify and ensure the accuracy of the MMIS' process of populating the <i>Rendering Provider NPI</i> with the <i>Billing Provider NPI</i> .	PCS-CG did not sufficiently address the recommendation. PCS-CG did not provide a response or supporting documentation to address the recommendation.
Mental Health Parity Evaluation	
PCS-CG should identify processes, strategies, evidentiary standards, and other factors that are used in formulary design and the application for prescription drugs.	PCS-CG sufficiently addressed the recommendation.
PCS-CG should identify processes, strategies, evidentiary standards, and other factors that are used in formulary tiering.	PCS-CG sufficiently addressed the recommendation.
PCS-CG should review out-of-network claim denials to understand the factors affecting the lower percentage of paid MH/SUD OP claims compared to M/S OP claims. PCS-CG should assess whether any barriers exist for members accessing MH/SUD services, including the need to seek services outside of the CCO's network (e.g., appointment availability).	PCS-CG did not sufficiently address the recommendation. PCS-CG did not provide a response or supporting documentation to address the recommendation.

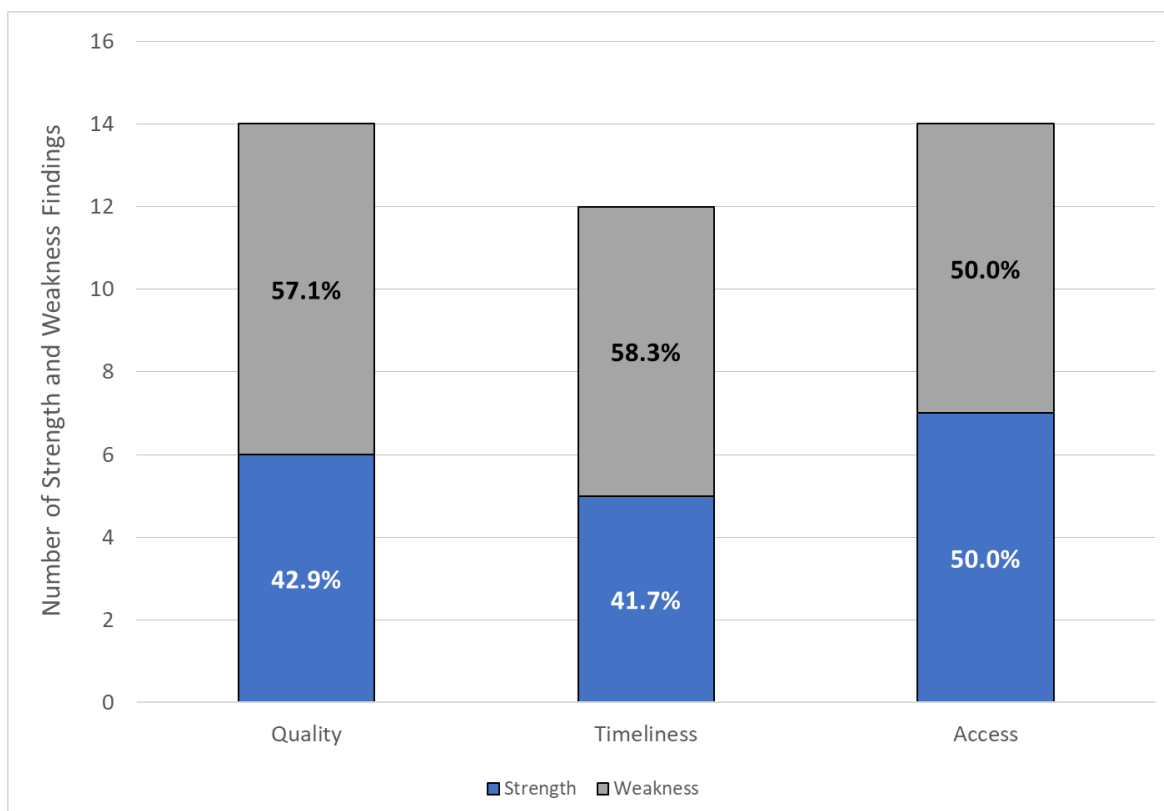
*Standard I—Availability of Services and Standard II—Assurances of Adequate Capacity and Services were combined, and all elements required by 42 CFR §438.206 and §438.207 were assessed under the combined Standard I—Assurance of Adequate Capacity and Availability of Services during the CY 2024 CMR activity.

PacificSource Community Solutions—Lane

Results and Conclusions

HSAG assessed the strengths and weaknesses of each CCO with respect to the quality, timeliness, and accessibility of health care services. Figure 5-21 illustrates the number of strengths exhibited by PCS-LN relative to the number of weaknesses identified during the CY 2024 EQR activities across the three domains. The greater the proportion of weaknesses, the greater opportunities for improvement.

Figure 5-21—PCS-LN Overall Number of Findings (Strengths and Weaknesses) by Domain



Detailed results from the EQR’s substantive findings are summarized in Table 5-21 for each activity. This table highlights the extent to which PCS-LN furnishes high quality, timely, and appropriate access to health care services, and recommendations for how PCS-LN can best address issues identified for each activity.⁶⁶

⁶⁶ See Section 4—Comparative Statewide Results for detailed, CCO-specific scores associated with EQR activity.

Table 5-21—PCS-LN Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s) ⁶⁷
Compliance Monitoring Review		
	Strength: PCS-LN demonstrated best practices by ensuring that providers do not establish different access hours for Medicaid members. This was achieved through monthly provider access survey calls conducted by a third-party vendor, the use of site visit checklists, and tracking member grievance data.	
	Weakness: PCS-LN received a score of 89.5 percent in the <i>Assurance of Adequate Capacity and Availability of Services</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements, the inability to demonstrate sufficient implementation of established processes, and deficiencies within its monitoring activities impacting the CCO’s ability to ensure timely access to care and services. Why the weakness exists: The implemented policies and procedures and member and provider communications did not fully align with the federal and State requirements for providing family planning services and accommodations and equipment for members with physical and mental disabilities. The CCO also failed to demonstrate the appropriate monitoring of provider compliance with state-established appointment standards. Recommendations: PCS-LN should revise its policies and procedures to align with federal and State requirements for timely access to care and services and demonstrate implementation. Additionally, the CCO should demonstrate appropriate monitoring of provider compliance with state-established appointment standards. The CCO should also ensure that member and provider communications align with federal and State requirements for service provision.	
	Weakness: PCS-LN received a score of 83.3 percent in the <i>Provider Selection</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements and failure to conduct appropriate monitoring activities impacting the CCO’s ability to meet federal and State requirements for selecting, retaining, credentialing, and recredentialing network providers. Why the weakness exists: PCS-LN lacked policies and procedures for selecting and retaining network providers. Additionally, the CCO did not adhere to State requirements for credentialing and recredentialing providers, including collecting the appropriate credentialing documentation and the time frame for recredentialing. The CCO also	

⁶⁷  = Quality,  = Timeliness,  = Access

Strength/ Weakness	Description	Domain(s) ⁶⁷
	could not demonstrate an ongoing monitoring process to ensure compliance with credentialing and recredentialing requirements. Recommendations: PCS-LN should develop policies and procedures for selecting and retaining network providers. Additionally, the CCO should demonstrate adherence to State requirements for credentialing and recredentialing providers, including collecting the appropriate credentialing documentation and the state-established time frame for recredentialing. The CCO should also conduct ongoing monitoring to ensure compliance with credentialing and recredentialing requirements.	
	Weakness: PCS-LN received a score of 75.0 percent in the <i>Subcontractual Relationships and Delegation</i> standard due to insufficient documentation to support operations and ensure compliance with federal requirements for written agreements between the CCO and its subcontractors and failure to follow up with corrective action required as a result of its monitoring activities, impacting the CCO's ability to adhere to federal requirements and the CCO's contractual requirements with the State. Why the weakness exists: PCS-LN failed to follow up and take corrective action when a subcontractor was noncompliant with its contractual obligations. Additionally, the CCO's contracts with the subcontractors failed to include federally required language for written agreements with subcontractors. Recommendations: PCS-LN should follow up when noncompliance is identified and hold its subcontractors accountable for contractual obligations. The CCO should also revise its written agreements to align with federally required language for written agreements with subcontractors.	
	Weakness: PCS-LN received a score of 83.3 percent in the <i>Practice Guidelines</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements impacting the CCO's ability to ensure decision-making was aligned with its clinical practice guidelines. Why the weakness exists: PCS-LN could not demonstrate a process that aligned with the federal and State requirements for ensuring decision-making was aligned with clinical practice guidelines. Recommendations: PCS-LN should develop and implement a process that aligns with the federal and State requirements for ensuring decision-making is aligned with clinical practice guidelines.	
Performance Improvement Projects		
Statewide Mental Health Service Access Monitoring PIP		
	Strength: PCS-LN successfully continued the Implementation stage for the PIP, receiving a <i>Met</i> score for 100 percent of applicable evaluation	

Strength/ Weakness	Description	Domain(s) ⁶⁷
	elements in the PIP Validation Tool. In the Implementation stage, PCS-LN accurately reported baseline and RY 2 performance indicator data, identified and analyzed barriers to improving MH service access, carried out interventions to address those barriers, and refined interventions based on intervention evaluation results.	
	Strength: PCS-LN's RY 2 performance indicator results demonstrated statistically significant improvement in MH service access compared to baseline indicator results.	
Statewide Substance Use Disorder PIP		
	Strength: PCS-LN accurately reported baseline and RY 1 performance indicator data; identified and analyzed barriers for initiation, engagement, and treatment of alcohol and other drug use disorders; and began to carry out interventions to address those barriers.	
	Weakness: PCS-LN received a <i>No Confidence</i> rating for overall confidence that the <i>Substance Use Disorder</i> PIP achieved significant improvement. Why the weakness exists: PCS-LN demonstrated a decline in performance from baseline to RY 1 for both Indicator 1 (<i>Percentage of new SUD episodes that result in treatment and initiation within 14 days</i>) and Indicator 2 (<i>Percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation</i>) results. Recommendations: PCS-LN should revisit root cause analyses identifying barriers to improving initiation, engagement, and treatment of alcohol and other drug use disorders to determine which barriers to improvement were not effectively addressed. PCS-LN should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to further improve the percentage of new SUD episodes that result in treatment and initiation within 14 days and the percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation indicator results.	
Performance Measure Validation		
	Strength: PCS-LN's MY 2023 performance on the <i>Members Receiving Preventive Dental or Oral Health Services—Ages 1 to 5 Years</i> measure indicator improved by 5 percentage points or more since MY 2022. The 6 to 14 years age group demonstrated ongoing improvement since MY 2021. In addition, PCS-LN exceeded the benchmark set by OHA for MY 2023 by 5 percentage points or more in both the <i>Ages 1 to 5 Years</i> and <i>Ages 6 to 14 Years</i> measure indicators.	
	Strength: PCS-LN MY 2023 performance on the <i>Oral Evaluation for Adults With Diabetes</i> measure demonstrated ongoing improvement	

Strength/ Weakness	Description	Domain(s) ⁶⁷
	since MY 2021. In addition, PCS-LN exceeded the statewide aggregate and the benchmark set by OHA for MY 2023.	
	Weakness: PCS-LN MY 2023 performance rates on the <i>Initiation of SUD Treatment</i> measure indicator for members ages 18 years and older dropped more than 5 percentage points (8.5 percentage points) from MY 2022 and fell below the benchmark set by OHA for MY 2023. Why the weakness exists: PCS-LN's eligible population increased from MY 2022 to MY 2023 for members ages 18 years and older, but the number of members diagnosed with SUD initiating treatment decreased. Recommendations: PCS-LN should conduct root cause analyses to identify specific factors affecting performance on the <i>Initiation of SUD Treatment</i> measure indicator. Once identified, targeted interventions should be developed, implemented, and evaluated to ensure effective improvement strategies are adopted to increase performance over time. Additionally, PCS-LN should continue to monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches to ensuring the quality, timeliness, and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	
Validation of Network Adequacy		
Network Adequacy Validation Audit		
	Strength: PCS-LN had established a robust process to keep provider data up to date and accurate through its quarterly attestation reminders to providers and credentialing process. This process ensured PCS-LN had numerous validation steps included to keep their provider data up to date and accurate.	
Delivery System Network Evaluation		
	Weakness: PCS-LN did not meet the pediatric and facility time and distance standard for OT providers and MTD facilities, respectively. Why the weakness exists: PCS-LN did not meet the facility network adequacy standards for MTD providers since fewer than 95 percent of its members were within acceptable travel times or distances of MTD facilities. Additionally, 0.0 percent of pediatric PCS-LN members had access to OT providers since PCS-LN's network had no contracted OT providers serving pediatric members. Finally, PCS-LN did not engage in OHA's time and distance exception request process. It is expected that the CCO have at least one provider of all monitored types within its network, regardless of time and distance standard compliance, rather than rely on single case agreements or similar methods. Recommendations: PCS-LN should ensure that it takes the necessary steps to maintain an adequate network that can provide all covered and	

Strength/ Weakness	Description	Domain(s) ⁶⁷
	necessary care. The CCO should work to contract with at least one provider or facility of each missing type that can supply such services as part of the CCO's network, even if that provider is not within the service region. Such providers should still be meaningfully accessible through regional transportation (e.g., driving to a nearby population center). The CCO should engage with OHA on potential solutions for these needs via the time and distance exception request process.	
Revealed Telephone Survey		
	Strength: Of the total PCP and OP SUD cases accepting the CCO, 93.7 percent of cases offered translation or interpreter services.	
	Strength: Of the OP SUD cases that offered an appointment, greater than 90.0 percent of all OP SUD appointment types were compliant with wait time standards.	
	Weakness: Overall, 66.8 percent of the total PCP and OP SUD sampled cases were reached. Among the cases reached, 84.6 percent confirmed the correct location, 60.4 percent offered the requested services, 47.7 percent accepted OHP Medicaid, and 42.3 percent accepted PCS-LN. Why the weakness exists: In addition to limitations related to the revealed survey approach, inaccuracies found in PCS-LN's provider data may have contributed to the low response rate and accuracy results. Recommendations: PCS-LN should use the case-level analytic data files to address the data deficiencies identified during the survey calls (e.g., incorrect or disconnected telephone numbers; incorrect location; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
	Weakness: Among the total PCP and OP SUD cases reached, 36.2 percent accepted new patients. In addition, appointment availability was only offered for less than 31.0 percent of PCP cases and 48.0 percent of OP SUD cases. Of the PCP cases that offered an appointment, all compliance rates, except for existing patient routine visits, resulted in low rates, which ranged from 50.0 percent (new patient urgent visits) to 83.3 percent (existing patient urgent visits). Why the weakness exists: In addition to limitations related to the revealed survey approach, inaccuracies found in PCS-LN's provider data and insufficient provider panel capacity may have contributed to low access and availability rates (i.e., new patient acceptance, appointment availability, and wait times). Also, internal office staffing structures and procedures may have contributed to the long wait times. Recommendations: PCS-LN should confirm appointment availability with providers, including panel capacity to accept new patients. Further,	

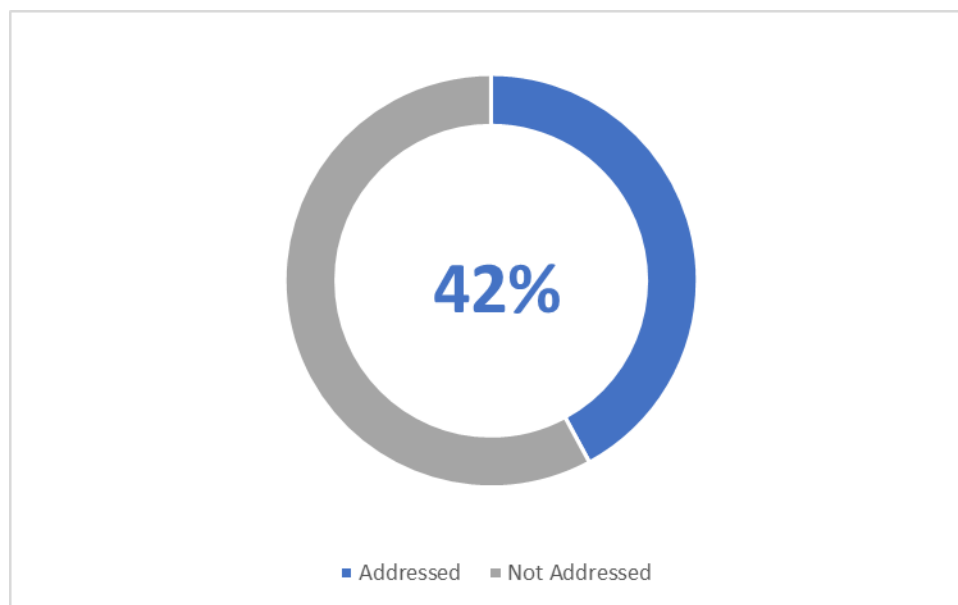
Strength/ Weakness	Description	Domain(s) ⁶⁷
	PCS-LN should use the case-level analytic data files to address data deficiencies identified during the survey calls.	
Encounter Data Validation		
Since EDV results were not available for inclusion in the 2024 EQR technical report, the strengths and weaknesses for each CCO could not be assessed. The findings will be incorporated in next year's EQR technical report.		
Mental Health Parity Evaluation		
	Strength: PCS-LN submitted a detailed summary of the changes implemented in CY 2023 to medical management and sufficiently addressed pharmacy management NQTLs as required from the previous year's MHP Evaluation. The information provided was clearly communicated in the narrative and was accompanied by supporting documentation.	
	Weakness: PCS-LN showed substantial differences in the percentage of paid, out-of-network OP MH/SUD claims compared to OP M/S paid claims. Although the difference in the percentage of paid claims may be legitimate, they may also highlight procedural or network differences, indicating potential barriers for members accessing MH/SUD services. Why the weakness exists: out-of-network OP MH/SUD claims were paid less frequently than M/S claims. Recommendations: PCS-LN should review out-of-network claim denials to understand the factors affecting the lower percentage of out-of-network OP MH/SUD paid claims compared to out-of-network OP M/S paid claims. The CCO should assess whether any barriers exist for members accessing MH/SUD services, including the need to seek services outside of the CCO's network (e.g., appointment availability).	

Follow-Up on Prior Year Recommendations

HSAG evaluated PCS-LN's approach to addressing the recommendations related to findings issued during CY 2023 and unresolved findings from CY 2020, CY 2021, and CY 2022 while conducting the CY 2024 EQR activities. The CCOs not addressing recommendations are at risk of being out of compliance with their contracts.

Figure 5-22 illustrates the degree in which the CCO sufficiently addressed the recommendations for QI made by HSAG during the CY 2023 EQR.

Figure 5-22—Percentage of CY 2023 EQR Recommendations Addressed by PCS-LN



PCS-LN-specific CY 2023 recommendations and follow-up CY 2024 assessments are summarized in Table 5-22.

Table 5-22—Assessment of PCS-LN’s Approach to Addressing Previous Annual Recommendations

CY 2023 Recommendation	CY 2024 Assessment
Compliance Monitoring Review	
<i>Standard I—Assurance of Adequate Capacity and Availability of Services*</i>	
This recommendation was initially given during the CY 2021 EQR. PCS-LN should ensure its provider manual includes accurate information related to female access to a women’s health specialist.	PCS-LN did not sufficiently address the recommendation. PCS-LN’s member handbook and provider manual included inconsistent information related to female access to a women’s health specialist. Note: Standard I—Assurance of Adequate Capacity and Availability of Services was comprehensively reviewed during the CY 2024 CMR cycle, and recommendations addressing all findings related to this standard are included in the CCO’s individual Results and Conclusions section.
<i>Standard III—Coordination and Continuity of Care</i>	
PCS-LN should revise its policies and procedures to align with State requirements. PCS-LN should	PCS-LN sufficiently addressed the recommendation.

CY 2023 Recommendation	CY 2024 Assessment
also demonstrate implementation of appropriate assessments, reassessments, and revision of treatment plans according to federal and State requirements.	
Standard IV—Coverage and Authorization of Services	
PCS-LN should revise its policies and procedures to align with federal and State requirements. PCS-LN should also demonstrate the implementation of appropriate service offerings. PCS-LN should also demonstrate proper outreach to retrieve the information needed to process service authorization requests and adhere to federal and State required time frames for providing NOABDs.	PCS-LN did not sufficiently address the recommendation. Although PCS-LN began revising its processes to comply with federal and State requirements, the CCO could not demonstrate implementation of processes for the appropriate decision-makers in denials. HSAG recommends that PCS-LN demonstrate implementation of processes to ensure the utilization of appropriate decision-makers with the appropriate expertise when denying services.
Standard V—Provider Selection	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Standard VI—Subcontractual Relationships and Delegation	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard VII—Member Rights and Protections	
PCS-LN should revise its policies and procedures and member- and provider-facing materials to align with federal and State requirements.	PCS-LN sufficiently addressed the recommendation.
Standard VIII—Confidentiality	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Standard IX—Enrollment and Disenrollment	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Standard X—Grievance and Appeal Systems	
PCS-LN should revise its policies and procedures to align with federal and State requirements. PCS-LN should also adhere to federal and State requirements for the appropriate decision-makers on grievances and appeals, maintenance of an expedited process for appeals, time frames for acknowledging and resolving grievances and appeals, and the readability of notices. PCS-LN	PCS-LN sufficiently addressed the recommendation.

CY 2023 Recommendation	CY 2024 Assessment
should also demonstrate implementation of federal and State requirements within communications to providers and subcontractors.	
Standard XI—Practice Guidelines	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard XII—Quality Assessment and Performance Improvement	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Standard XIII—Health Information Systems, including ISCA	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard XIV—Member Information	
PCS-LN should revise its policies, procedures, and member-facing materials to align with federal and State requirements. PCS-LN should also notify members of the availability of member information.	PCS-LN did not sufficiently address the recommendation. Although PCS-LN revised its policies and procedures and some of its member notifications to align with federal and State requirements, the printed and online versions of the provider directory failed to include information specific to accessibility accommodations. HSAG recommends that PCS-LN revise its provider directory to align with federal and State requirements.
Standard XVI—Emergency and Poststabilization Services	
PCS-LN should demonstrate evidence of processes to ensure payment of emergency and poststabilization services.	PCS-LN sufficiently addressed the recommendation.
Performance Improvement Projects	
Statewide Mental Health Service Access Monitoring PIP	
PCS-LN should revisit root cause analyses identifying barriers to improving access to MH services to determine which barriers to improvement were not effectively addressed. PCS-LN should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to improve indicator results.	PCS-LN sufficiently addressed the recommendation.

CY 2023 Recommendation	CY 2024 Assessment
Statewide Substance Use Disorder PIP	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Performance Measure Validation	
This recommendation was initially given during the CY 2021 EQR. PCS-LN should continue to monitor key performance measure rates in alignment with its QAPI goals and objectives. PCS-LN should conduct root cause analyses to identify specific factors affecting performance for the <i>Child and Adolescent Well-Care Visits—Ages 3 to 6 Years</i> measure indicator. Once identified, targeted interventions should be developed, implemented, and evaluated to ensure effective improvement strategies are adopted to increase performance over time. Additionally, PCS-LN should continue to monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches to ensuring the quality, timeliness, and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	PCS-LN did not sufficiently address the recommendation. PCS-LN did not provide a response or supporting documentation to address the recommendation.
Validation of Network Adequacy	
Delivery System Network Evaluation	
PCS-LN should seek technical assistance with OHA to determine the nature of the provider capacity data issues and take corrective action, as necessary.	PCS-LN sufficiently addressed the recommendation.
Secret Shopper Survey	
This recommendation was initially given during the CY 2021 EQR. HSAG recommends that PCS-LN use the case-level analytic data files to address the data deficiencies identified during the secret shopper survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	PCS-LN did not sufficiently address the recommendation. PCS-LN did not provide a response or supporting documentation to address the recommendation.
HSAG recommends that PCS-LN confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. PCS-LN should	PCS-LN did not sufficiently address the recommendation. PCS-LN did not provide a response or supporting documentation to address the recommendation.

CY 2023 Recommendation	CY 2024 Assessment
use the case-level analytic data files containing data deficiencies identified during the secret shopper survey calls.	
Revealed Telephone Survey	
HSAG recommends that PCS-LN use the case-level analytic data files to address the data deficiencies identified during the revealed telephone survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, program information, and translation/interpreter services offered).	PCS-LN did not sufficiently address the recommendation. PCS-LN did not provide a response or supporting documentation to address the recommendation.
HSAG recommends that PCS-LN confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. PCS-LN should use the case-level analytic data files containing data deficiencies identified during the revealed telephone survey calls and work with BH outpatient offices to identify the root cause for delays in appointment availability.	PCS-LN did not sufficiently address the recommendation. PCS-LN did not provide a response or supporting documentation to address the recommendation.
Encounter Data Validation	
This recommendation was initially given during the CY 2022 EQR. PCS-LN should investigate the root cause for the omissions and consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews would then be provided to providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.	PCS-LN did not sufficiently address the recommendation. PCS-LN did not provide a response or supporting documentation to address the recommendation.
While encounter submission to OHA did not require the inclusion of the <i>Rendering Provider NPI</i> value if it matched the <i>Billing Provider NPI</i> value, the data request for the EDV comparative analysis had different requirements. To address this, HSAG recommends that PCS-LN and its subcontractor(s) ensure that values for both <i>Billing Provider NPI</i> and <i>Rendering Provider NPI</i> are included in the data submission, irrespective of their equivalence. This adjustment will enhance the accuracy and completeness of the comparative	PCS-LN did not sufficiently address the recommendation. PCS-LN did not provide a response or supporting documentation to address the recommendation.

CY 2023 Recommendation	CY 2024 Assessment
analysis data. Additionally, it will provide HSAG with the means to verify and ensure the accuracy of the MMIS' process of populating the <i>Rendering Provider NPI</i> with the <i>Billing Provider NPI</i> .	
Mental Health Parity Evaluation	
PCS-LN should identify processes, strategies, evidentiary standards, and other factors that are used in formulary design and the application for prescription drugs.	PCS-LN sufficiently addressed the recommendation.
PCS-LN should identify processes, strategies, evidentiary standards, and other factors that are used in formulary tiering.	PCS-LN sufficiently addressed the recommendation.
PCS-LN should review out-of-network claim denials to understand the factors affecting the lower percentage of paid MH/SUD OP claims compared to M/S OP claims. PCS-LN should assess whether any barriers exist for members accessing MH/SUD services, including the need to seek services outside of the CCO's network (e.g., appointment availability).	PCS-LN did not sufficiently address the recommendation. PCS-LN did not provide a response or supporting documentation to address the recommendation.

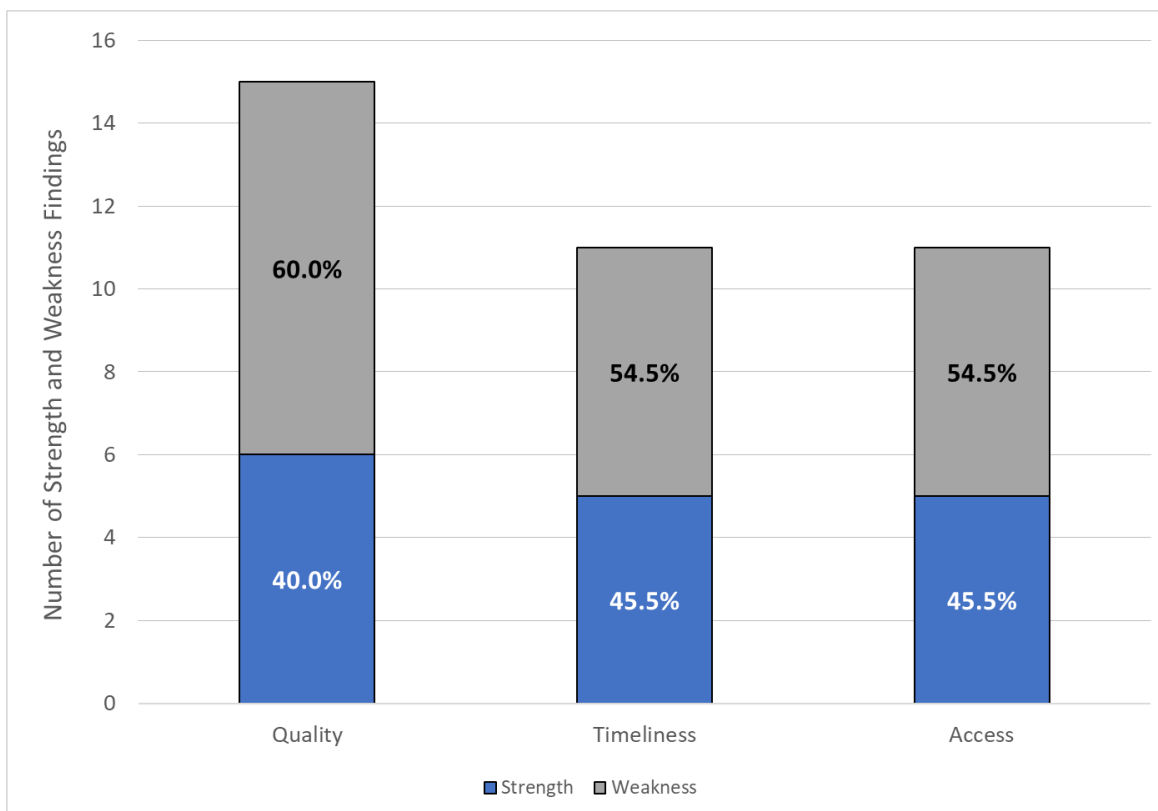
*Standard I—Availability of Services and Standard II—Assurances of Adequate Capacity and Services were combined, and all elements required by 42 CFR §438.206 and §438.207 were assessed under the combined Standard I—Assurance of Adequate Capacity and Availability of Services during the CY 2024 CMR activity.

PacificSource Community Solutions—Marion Polk

Results and Conclusions

HSAG assessed the strengths and weaknesses of each CCO with respect to the quality, timeliness, and accessibility of health care services. Figure 5-23 illustrates the number of strengths exhibited by PCS-MP relative to the number of weaknesses identified during the CY 2024 EQR activities across the three domains. The greater the proportion of weaknesses, the greater opportunities for improvement.

Figure 5-23—PCS-MP Overall Number of Findings (Strengths and Weaknesses) by Domain



Detailed results from the EQR’s substantive findings are summarized in Table 5-23 for each activity. This table highlights the extent to which PCS-MP furnishes high quality, timely, and appropriate access to health care services, and recommendations for how PCS-MP can best address issues identified for each activity.⁶⁸

⁶⁸ See Section 4—Comparative Statewide Results for detailed, CCO-specific scores associated with EQR activity.

Table 5-23—PCS-MP Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s) ⁶⁹
Compliance Monitoring Review		
	Strength: PCS-MP demonstrated best practices by ensuring that providers do not establish different access hours for Medicaid members. This was achieved through monthly provider access survey calls conducted by a third-party vendor, the use of site visit checklists, and tracking member grievance data.	  
	Weakness: PCS-MP received a score of 89.5 percent in the <i>Assurance of Adequate Capacity and Availability of Services</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements, the inability to demonstrate sufficient implementation of established processes, and deficiencies within its monitoring activities impacting the CCO’s ability to ensure timely access to care and services. Why the weakness exists: The implemented policies and procedures and member and provider communications did not fully align with the federal and State requirements for providing family planning services and accommodations and equipment for members with physical and mental disabilities. The CCO also failed to demonstrate the appropriate monitoring of provider compliance with state-established appointment standards. Recommendations: PCS-MP should revise its policies and procedures to align with federal and State requirements for timely access to care and services and demonstrate implementation. Additionally, the CCO should demonstrate appropriate monitoring of provider compliance with state-established appointment standards. The CCO should also ensure that member and provider communications align with federal and State requirements for service provision.	  
	Weakness: PCS-MP received a score of 83.3 percent in the <i>Provider Selection</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements and failure to conduct appropriate monitoring activities impacting the CCO’s ability to meet federal and State requirements for selecting, retaining, credentialing, and recredentialing network providers. Why the weakness exists: PCS-MP lacked policies and procedures for selecting and retaining network providers. Additionally, the CCO did not adhere to State requirements for credentialing and recredentialing providers, including collecting the appropriate credentialing documentation and the time frame for recredentialing. The CCO also	 

⁶⁹  = Quality,  = Timeliness,  = Access

Strength/ Weakness	Description	Domain(s) ⁶⁹
	could not demonstrate an ongoing monitoring process to ensure compliance with credentialing and recredentialing requirements. Recommendations: PCS-MP should develop policies and procedures for selecting and retaining network providers. Additionally, the CCO should demonstrate adherence to State requirements for credentialing and recredentialing providers, including collecting the appropriate credentialing documentation and the state-established time frame for recredentialing. The CCO should also conduct ongoing monitoring to ensure compliance with credentialing and recredentialing requirements.	
	Weakness: PCS-MP received a score of 75.0 percent in the <i>Subcontractual Relationships and Delegation</i> standard due to insufficient documentation to support operations and ensure compliance with federal requirements for written agreements between the CCO and its subcontractors and failure to follow up with corrective action required as a result of its monitoring activities, impacting the CCO's ability to adhere to federal requirements and the CCO's contractual requirements with the State. Why the weakness exists: PCS-MP failed to follow up and take corrective action when a subcontractor was noncompliant with its contractual obligations. Additionally, the CCO's contracts with the subcontractors failed to include federally required language for written agreements with subcontractors. Recommendations: PCS-MP should follow up when noncompliance is identified and hold its subcontractors accountable for contractual obligations. The CCO should also revise its written agreements to align with federally required language for written agreements with subcontractors.	
	Weakness: PCS-MP received a score of 83.3 percent in the <i>Practice Guidelines</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements impacting the CCO's ability to ensure decision-making was aligned with its clinical practice guidelines. Why the weakness exists: PCS-MP could not demonstrate a process that aligned with the federal and State requirements for ensuring decision-making was aligned with clinical practice guidelines. Recommendations: PCS-MP should develop and implement a process that aligns with the federal and State requirements for ensuring decision-making is aligned with clinical practice guidelines.	
Performance Improvement Projects		
Statewide Mental Health Service Access Monitoring PIP		
	Strength: PCS-MP accurately reported baseline and RY 2 performance indicator data, identified and analyzed barriers to improving MH	

Strength/ Weakness	Description	Domain(s) ⁶⁹
	service access, carried out interventions to address those barriers, and refined interventions based on intervention evaluation results.	
	Weakness: PCS-MP received a <i>Moderate Confidence</i> rating for overall confidence that the <i>Mental Health Service Access Monitoring</i> PIP achieved significant improvement. Why the weakness exists: PCS-MP's indicator results declined from baseline to RY 1 and the improvement noted from baseline to RY 2 was not statistically significant. Recommendations: PCS-MP should revisit root cause analyses identifying barriers to improving access to MH services to determine which barriers to improvement were not effectively addressed. PCS-MP should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to further improve the percentage of members with a MH service need who received MH services indicator results.	
Statewide Substance Use Disorder PIP		
	Strength: PCS-MP accurately reported baseline and RY 1 performance indicator data; identified and analyzed barriers for initiation, engagement, and treatment of alcohol and other drug use disorders; and began to carry out interventions to address those barriers.	
	Weakness: PCS-MP received a <i>Moderate Confidence</i> rating for overall confidence that the <i>Substance Use Disorder</i> PIP achieved significant improvement. Why the weakness exists: PCS-MP's RY 1 improvement noted for both indicators (<i>Percentage of new SUD episodes that result in treatment and initiation within 14 days</i> and <i>Percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation</i>) over BY was not statistically significant. Recommendations: PCS-MP should revisit root cause analyses identifying barriers to improving initiation, engagement, and treatment of alcohol and other drug use disorders to determine which barriers to improvement were not effectively addressed. PCS-MP should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to further improve the percentage of new SUD episodes that result in treatment and initiation within 14 days and the percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation indicator results.	
Performance Measure Validation		
	Strength: PCS-MP's MY 2023 performance on the <i>Members Receiving Preventive Dental or Oral Health Services—Ages 1 to 5 Years and Ages 6 to 14 Years</i> measure indicators demonstrated ongoing improvement for the 1 to 5 years age group since MY 2021 and remained steady since	

Strength/ Weakness	Description	Domain(s) ⁶⁹
	MY 2022 in the 6 to 14 years age group. In addition, the CCO's MY 2023 rates in both age groups exceeded the benchmark set by OHA for MY 2023 by 5 percentage points or more, and the rates for both age measure indicators also exceeded the statewide aggregate.	
	Strength: PCS-MP's MY 2023 performance on the <i>Initiation and Engagement of SUD Treatment</i> measure for ages 13 to 17 years demonstrated improvement since MY 2022 of more than 5 percentage points for both indicators; a 9.5 percentage point increase for initiation and a 9.1 percentage point increase for engagement. In addition, the CCO's MY 2023 rate exceeded the statewide aggregate for MY 2023 for both indicators.	
	Weakness: PCS-MP's MY 2023 performance rate on the <i>Initiation of SUD Treatment</i> measure indicator for members ages 18 years and older dropped more than 5 percentage points (5.2 percentage points) from MY 2022 and fell below the benchmarks set by OHA for MY 2023. Why the weakness exists: PCS-MP's eligible population increased from MY 2022 to MY 2023 for members ages 18 years and older, but the number of members diagnosed with SUD initiating treatment decreased slightly from prior years. Recommendations: PCS-MP should conduct root cause analyses to identify specific factors affecting performance on the <i>Initiation of SUD Treatment</i> measure indicator. Once identified, targeted interventions should be developed, implemented, and evaluated to ensure effective improvement strategies are adopted to increase performance over time. Additionally, PCS-MP should continue to monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches to ensuring the quality, timeliness, and accessibility of health care services (i.e., telehealth strategies, mobile clinics).	
Validation of Network Adequacy		
Network Adequacy Validation Audit		
	Strength: PCS-MP had established a robust process to keep provider data up to date and accurate through its quarterly attestation reminders to providers and credentialing process.	
Delivery System Network Evaluation		
The CCO met performance expectations. No significant strengths or weaknesses were noted during the review.		

Strength/ Weakness	Description	Domain(s) ⁶⁹
Revealed Telephone Survey		
	Strength: Of the OP SUD cases that offered an appointment, 100 percent of urgent visits were compliant with the wait time standard.	
	Weakness: Overall, 62.2 percent of the total PCP and OP SUD sampled cases were reached. Among the cases reached, 80.3 percent confirmed the correct location, 65.0 percent offered the requested services, 60.7 percent accepted OHP Medicaid, and 50.4 percent accepted PCS-MP. Also, 88.1 percent of cases offered translation or interpreter services. Why the weakness exists: In addition to limitations related to the revealed survey approach, inaccuracies found in PCS-MP's provider data may have contributed to the low response rate and accuracy results. Recommendations: PCS-MP should use the case-level analytic data files to address the data deficiencies identified during the survey calls (e.g., incorrect or disconnected telephone numbers; incorrect location; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
	Weakness: Among the total PCP and OP SUD cases reached, 35.9 percent accepted new patients. In addition, appointment availability was only offered for less than 42.0 percent of PCP cases and 32.0 percent of OP SUD cases. Of the PCP cases that offered an appointment, all compliance rates resulted in low rates, which ranged from 16.7 percent (new patient urgent visits) to 84.0 percent (existing patient urgent visits). Of the OP SUD cases that offered an appointment, all compliance rates, except for urgent visits, resulted in low rates, which ranged from 20.0 percent (pregnant OP SUD visits) to 86.7 percent (routine visits). Why the weakness exists: In addition to limitations related to the revealed survey approach, inaccuracies found in PCS-MP's provider data and insufficient provider panel capacity may have contributed to low access and availability rates (i.e., new patient acceptance, appointment availability, and wait times). Also, internal office staffing structures and procedures may have contributed to the long wait times. Recommendations: PCS-MP should confirm appointment availability with providers, including panel capacity to accept new patients. Further, PCS-MP should use the case-level analytic data files to address data deficiencies identified during the survey calls.	
Encounter Data Validation		
Since EDV results were not available for inclusion in the 2024 EQR technical report, the strengths and weaknesses for each CCO could not be assessed. The findings will be incorporated in next year's EQR technical report.		

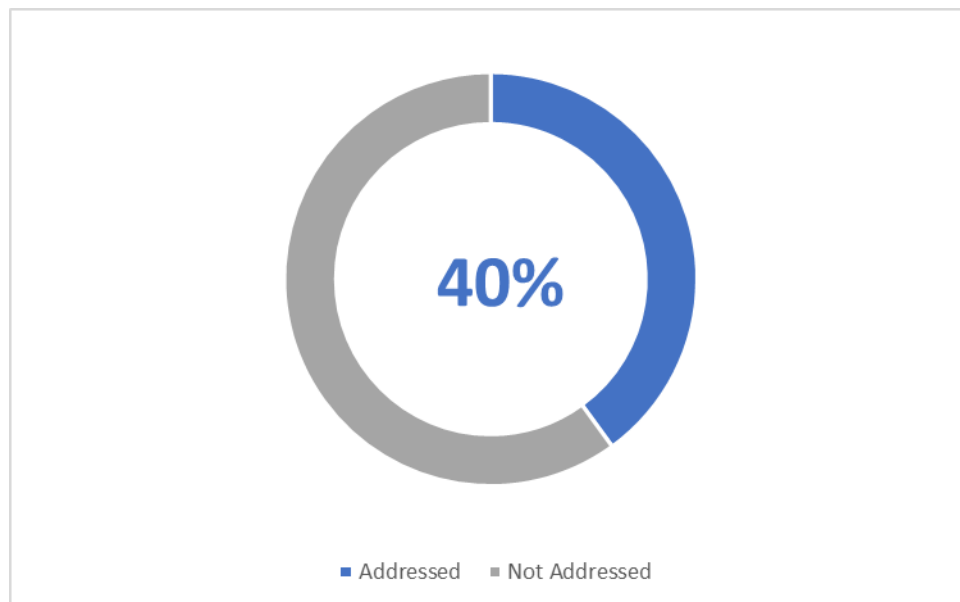
Strength/ Weakness	Description	Domain(s) ⁶⁹
Mental Health Parity Evaluation		
	Strength: PCS-MP submitted a detailed summary of the changes implemented in CY 2023 to medical management and sufficiently addressed pharmacy management NQTLs as required from the previous year's MHP Evaluation. The information provided was clearly communicated in the narrative and was accompanied by supporting documentation.	

Follow-Up on Prior Year Recommendations

HSAG evaluated PCS-MP's approach to addressing the recommendations related to findings issued during CY 2023 and unresolved findings from CY 2020, CY 2021, and CY 2022 while conducting the CY 2024 EQR activities. The CCOs not addressing recommendations are at risk of being out of compliance with their contracts.

Figure 5-24 illustrates the degree in which the CCO sufficiently addressed the recommendations for QI made by HSAG during the CY 2023 EQR.

Figure 5-24—Percentage of CY 2023 EQR Recommendations Addressed by PCS-MP



PCS-MP-specific CY 2023 recommendations and follow-up CY 2024 assessments are summarized in Table 5-24.

Table 5-24—Assessment of PCS-MP’s Approach to Addressing Previous Annual Recommendations

CY 2023 Recommendation	CY 2024 Assessment
Compliance Monitoring Review	
Standard I—Assurance of Adequate Capacity and Availability of Services*	
This recommendation was initially given during the CY 2021 EQR. PCS-MP should ensure its provider manual includes accurate information related to female access to a women’s health specialist.	PCS-MP did not sufficiently address the recommendation. PCS-MP’s member handbook and provider manual included inconsistent information related to female access to a women’s health specialist. Note: Standard I—Assurance of Adequate Capacity and Availability of Services was comprehensively reviewed during the CY 2024 CMR cycle, and recommendations addressing all findings related to this standard are included in the CCO’s individual Results and Conclusions section.
Standard III—Coordination and Continuity of Care	
PCS-MP should revise its policies and procedures to align with State requirements. PCS-MP should also demonstrate implementation of appropriate assessments, reassessments, and revision of treatment plans according to federal and State requirements.	PCS-MP sufficiently addressed the recommendation.
Standard IV—Coverage and Authorization of Services	
PCS-MP should revise its policies and procedures to align with federal and State requirements. PCS-MP should also demonstrate the implementation of appropriate service offerings. PCS-MP should also demonstrate proper outreach to retrieve the information needed to process service authorization requests and adhere to federal and State required time frames for providing NOABDs.	PCS-MP did not sufficiently address the recommendation. Although PCS-MP began revising its processes to comply with federal and State requirements, the CCO could not demonstrate implementation of processes for the appropriate decision-makers in denials. HSAG recommends that PCS-MP demonstrate implementation of processes to ensure the utilization of appropriate decision-makers with the appropriate expertise when denying services.
Standard V—Provider Selection	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Standard VI—Subcontractual Relationships and Delegation	
This standard was not assessed during the 2023 CMR.	Not applicable.

CY 2023 Recommendation	CY 2024 Assessment
Standard VII—Member Rights and Protections	
PCS-MP should revise its policies and procedures and member- and provider-facing materials to align with federal and State requirements.	PCS-MP sufficiently addressed the recommendation.
Standard VIII—Confidentiality	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Standard IX—Enrollment and Disenrollment	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Standard X—Grievance and Appeal Systems	
PCS-MP should revise its policies and procedures to align with federal and State requirements. PCS-MP should also adhere to federal and State requirements for the appropriate decision-makers on grievances and appeals, maintenance of an expedited process for appeals, and time frames for acknowledging and resolving grievances and appeals. PCS-MP should also demonstrate implementation of federal and State requirements within communications to providers and subcontractors.	PCS-MP sufficiently addressed the recommendation.
Standard XI—Practice Guidelines	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard XII—Quality Assessment and Performance Improvement	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Standard XIII—Health Information Systems, including ISCA	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard XIV—Member Information	
PCS-MP should revise its policies, procedures, and member-facing materials to align with federal and State requirements. PCS-MP should also notify members of the availability of member information.	PCS-MP did not sufficiently address the recommendation. Although PCS-MP revised its policies and procedures and some of its member notifications to align with federal and State requirements, the printed and online versions of the provider directory failed to include information specific to accessibility

CY 2023 Recommendation	CY 2024 Assessment
	accommodations. HSAG recommends that PCS-MP revise its provider directory to align with federal and State requirements.
Standard XVI—Emergency and Poststabilization Services	
PCS-MP should demonstrate evidence of processes to ensure payment of emergency and poststabilization services.	PCS-MP sufficiently addressed the recommendation.
Performance Improvement Projects	
Statewide Mental Health Service Access Monitoring PIP	
PCS-MP should revisit root cause analyses identifying barriers to improving access to MH services to determine which barriers to improvement were not effectively addressed. PCS-MP should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to improve indicator results.	PCS-MP sufficiently addressed the recommendation.
Statewide Substance Use Disorder PIP	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Performance Measure Validation	
This recommendation was initially given during the CY 2021 EQR. PCS-MP should continue to monitor key performance measure rates in alignment with its QAPI goals and objectives. For all key measures that fall below established performance or improvement thresholds, PCS-MP should conduct root cause analyses to identify specific factors affecting performance. Once identified, targeted interventions should be developed, implemented, and evaluated to ensure effective improvement strategies are adopted to increase performance over time. Additionally, PCS-MP should continue to monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches to ensuring the quality, timeliness, and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	PCS-MP did not sufficiently address the recommendation. PCS-MP did not provide a response or supporting documentation to address the recommendation.

CY 2023 Recommendation	CY 2024 Assessment
Validation of Network Adequacy	
Delivery System Network Evaluation	
PCS-MP should seek technical assistance with OHA to determine the nature of the provider capacity data issues and take corrective action, as necessary.	PCS-MP sufficiently addressed the recommendation.
Secret Shopper Survey	
This recommendation was initially given during the CY 2021 EQR. HSAG recommends that PCS-MP use the case-level analytic data files to address the data deficiencies identified during the secret shopper survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	PCS-MP did not sufficiently address the recommendation. PCS-MP did not provide a response or supporting documentation to address the recommendation.
HSAG recommends that PCS-MP confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. PCS-MP should use the case-level analytic data files containing data deficiencies identified during the secret shopper survey calls.	PCS-MP did not sufficiently address the recommendation. PCS-MP did not provide a response or supporting documentation to address the recommendation.
Revealed Telephone Survey	
HSAG recommends that PCS-MP use the case-level analytic data files to address the data deficiencies identified during the revealed telephone survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, program information, and translation/interpreter services offered).	PCS-MP did not sufficiently address the recommendation. PCS-MP did not provide a response or supporting documentation to address the recommendation.
HSAG recommends that PCS-MP confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. PCS-MP should use the case-level analytic data files containing data deficiencies identified during the revealed telephone survey calls and work with BH outpatient offices to identify the root cause for delays in appointment availability.	PCS-MP did not sufficiently address the recommendation. PCS-MP did not provide a response or supporting documentation to address the recommendation.

CY 2023 Recommendation	CY 2024 Assessment
Encounter Data Validation	
This recommendation was initially given during the CY 2022 EQR. PCS-MP should ensure its contracted providers' accountability in responding to medical record requests for the purposes of auditing, inspection, and oversight. HSAG recommends PCS-MP consider strengthening and/or enforcing its contract requirements with its providers in providing the requested documentation.	PCS-MP did not sufficiently address the recommendation. PCS-MP did not provide a response or supporting documentation to address the recommendation.
This recommendation was initially given during the CY 2022 EQR. PCS-MP should investigate the root cause for the omissions and consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews would then be provided to providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.	PCS-MP did not sufficiently address the recommendation. PCS-MP did not provide a response or supporting documentation to address the recommendation.
While encounter submission to OHA did not require the inclusion of the <i>Rendering Provider NPI</i> value if it matched the <i>Billing Provider NPI</i> value, the data request for the EDV comparative analysis had different requirements. To address this, HSAG recommends that PCS-MP and its subcontractor(s) ensure that values for both <i>Billing Provider NPI</i> and <i>Rendering Provider NPI</i> are included in the data submission, irrespective of their equivalence. This adjustment will enhance the accuracy and completeness of the comparative analysis data. Additionally, it will provide HSAG with the means to verify and ensure the accuracy of the MMIS' process of populating the <i>Rendering Provider NPI</i> with the <i>Billing Provider NPI</i> .	PCS-MP did not sufficiently address the recommendation. PCS-MP did not provide a response or supporting documentation to address the recommendation.
Mental Health Parity Evaluation	
PCS-MP should identify processes, strategies, evidentiary standards, and other factors that are used in formulary design and the application for prescription drugs.	PCS-MP sufficiently addressed the recommendation.

CY 2023 Recommendation	CY 2024 Assessment
PCS-MP should identify processes, strategies, evidentiary standards, and other factors that are used in formulary tiering.	PCS-MP sufficiently addressed the recommendation.
PCS-MP should review out-of-network claim denials to understand factors affecting the lower percentage of paid MH/SUD OP claims compared to M/S OP claims. PCS-MP should assess whether any barriers exist for members accessing MH/SUD services, including the need to seek services outside of the CCO's network (e.g., appointment availability).	PCS-MP did not sufficiently address the recommendation. PCS-MP did not provide a response or supporting documentation to address the recommendation.

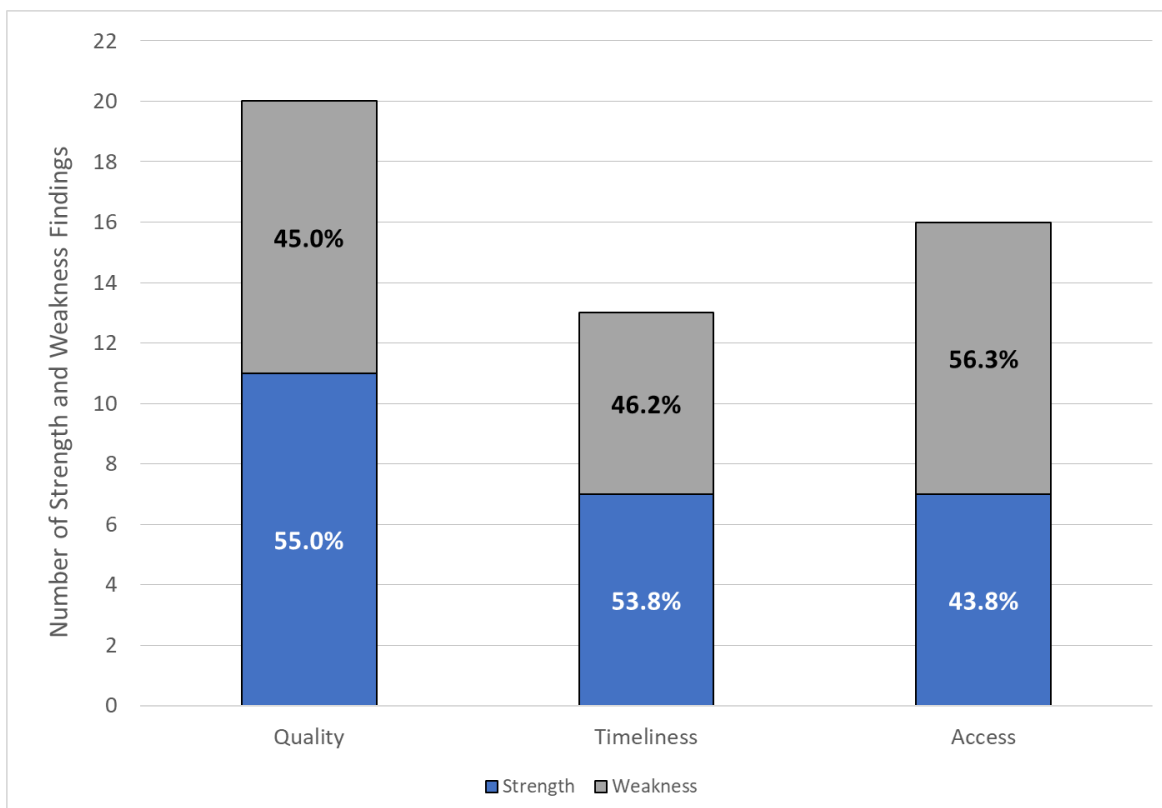
*Standard I—Availability of Services and Standard II—Assurances of Adequate Capacity and Services were combined, and all elements required by 42 CFR §438.206 and §438.207 were assessed under the combined Standard I—Assurance of Adequate Capacity and Availability of Services during the CY 2024 CMR activity.

Trillium Community Health Plan, Inc.—Southwest

Results and Conclusions

HSAG assessed the strengths and weaknesses of each CCO with respect to the quality, timeliness, and accessibility of health care services. Table 5-25 illustrates the number of strengths exhibited by TCHP-SW relative to the number of weaknesses identified during the CY 2024 EQR activities across the three domains. The greater the proportion of weaknesses, the greater opportunities for improvement.

Figure 5-25—TCHP-SW Overall Number of Findings (Strengths and Weaknesses) by Domain



Detailed results from the EQR’s substantive findings are summarized in Table 5-25 for each activity. This table highlights the extent to which TCHP-SW furnishes high quality, timely, and appropriate access to health care services, and recommendations for how TCHP-SW can best address issues identified for each activity.⁷⁰

⁷⁰ See Section 4—Comparative Statewide Results for detailed, CCO-specific scores associated with EQR activity.

Table 5-25—TCHP-SW Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s) ⁷¹
Compliance Monitoring Review		
	Strength: TCHP-SW demonstrated best practices by implementing monitoring efforts such as heat mapping of languages spoken by providers and members to reveal gaps and examining health outcomes data to reveal and act on disparities across service regions, race, gender, and other demographics.	
	Strength: TCHP-SW demonstrated best practices with its provider retention efforts by implementing the Provider Engagement Operating Model (POEM) 2.0.	
	Strength: TCHP-SW demonstrated best practices by including a nondiscrimination statement in its credentialing denial letter sent to providers.	
	Strength: TCHP-SW demonstrated best practices by clearly outlining the CCO's and subcontractor's responsibilities in its contracts.	
	Strength: TCHP-SW achieved full compliance with the <i>Practice Guidelines</i> standard, demonstrating that the CCO had established policies and procedures, along with the appropriate structure, to ensure that clinical practice guidelines were adopted, reviewed, updated, and disseminated. These guidelines took into account the needs of members and were based on evidence or on a consensus among providers in the relevant field. Additionally, decision-making was aligned with these guidelines.	
	Weakness: TCHP-SW received a score of 86.8 percent in the <i>Assurance of Adequate Capacity and Availability of Services</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements and deficiencies within its monitoring activities impacting the CCO's ability to ensure timely access to care and services. Why the weakness exists: The implemented policies and procedures did not fully align with the federal and State requirements for accessing women's health care specialists and family planning providers, hours of operation, and access, accommodations, and equipment for members with physical and mental disabilities. Additionally, the CCO failed to demonstrate the appropriate mechanisms for assessing compliance with state-established appointment standards. Recommendations: TCHP-SW should revise its policies and procedures to align with federal and State requirements for timely	

⁷¹  = Quality,  = Timeliness,  = Access

Strength/ Weakness	Description	Domain(s) ⁷¹
	access to care and services and demonstrate implementation. The CCO should also ensure that its mechanisms are sufficient to assess compliance with the state-established appointment standards.	
	Weakness: TCHP-SW received a score of 75.0 percent in the <i>Provider Selection</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements and deficiencies within its monitoring activities, impacting the CCO's ability to meet federal and State requirements for credentialing and recredentialing network providers. Why the weakness exists: TCHP-SW's and its subcontractors' policies and procedures did not fully align with federal and State requirements for collecting the appropriate credentialing documentation and the time frames for recredentialing. Additionally, the CCO did not demonstrate comprehensive monitoring of subcontractors for adherence to requirements for credentialing and recredentialing. Also, the CCO did not demonstrate oversight of subcontractors to ensure compliance with notice requirements for declining provider participation in its network. Recommendations: TCHP-SW should revise and ensure that its subcontractors revise policies and procedures to align with the federal and State requirements for credentialing and recredentialing. Additionally, the CCO should demonstrate ongoing monitoring of its subcontractors to ensure adherence to credentialing and recredentialing requirements. The CCO should also demonstrate oversight of subcontractors to ensure compliance with notice requirements for declining provider participation in its network.	
	Weakness: TCHP-SW received a score of 87.5 percent in the <i>Subcontractual Relationships and Delegation</i> standard due to failure to conduct appropriate monitoring activities impacting the CCO's ability to adhere to federal requirements and the CCO's contractual requirements with the State. Why the weakness exists: TCHP-SW failed to demonstrate that it conducts the appropriate oversight and monitoring of its subcontractors and holds them accountable for contractual requirements. Recommendations: TCHP-SW should hold its subcontractors accountable for contractual obligations and conduct the appropriate oversight and monitoring of its subcontractors.	
Performance Improvement Projects		
Statewide Mental Health Service Access Monitoring PIP		
	Strength: TCHP-SW accurately reported baseline and RY 2 performance indicator data, identified and analyzed barriers to improving MH service access, carried out interventions to address those	

Strength/ Weakness	Description	Domain(s) ⁷¹
	barriers, and refined interventions based on intervention evaluation results.	
	Weakness: TCHP-SW received a <i>Moderate Confidence</i> rating for overall confidence that the <i>Mental Health Service Access Monitoring</i> PIP achieved significant improvement. Why the weakness exists: TCHP-SW's indicator results declined from baseline to RY 1 and the improvement from baseline to RY 2 was not statistically significant. Recommendations: TCHP-SW should revisit root cause analyses identifying barriers to improving access to MH services to determine which barriers to improvement were not effectively addressed. TCHP-SW should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to further improve the percentage of members with a MH service need who received MH services.	 
Statewide Substance Use Disorder PIP		
	Strength: TCHP-SW accurately reported baseline and RY 1 performance indicator data; identified and analyzed barriers for initiation, engagement, and treatment of alcohol and other drug use disorders; and began to carry out interventions to address those barriers.	
	Weakness: TCHP-SW received a <i>Low Confidence</i> rating for overall confidence that the <i>Substance Use Disorder</i> PIP achieved significant improvement. Why the weakness exists: TCHP-SW's improvement in Indicator 1 (<i>Percentage of new SUD episodes that result in treatment and initiation within 14 days</i>) from baseline to RY 1 was not statistically significant. In addition, the CCO's performance for Indicator 2 (<i>Percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation</i>) declined from BY to RY 1. Recommendations: TCHP-SW should revisit root cause analyses identifying barriers to improving initiation, engagement, and treatment of alcohol and other drug use disorders to determine which barriers to improvement were not effectively addressed. TCHP-SW should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to further improve the percentage of new SUD episodes that result in treatment and initiation within 14 days and the percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation indicator results.	  

Strength/ Weakness	Description	Domain(s) ⁷¹
Performance Measure Validation		
	Strength: TCHP-SW's MY 2023 performance on the <i>Members Receiving Preventive Dental or Oral Health Services—Ages 6 to 14 Years</i> measure indicator demonstrated ongoing improvement since MY 2021. In addition, TCHP-SW improved performance measure rates for both age groups by 5 percentage points or more from the prior year; an 8.8 percentage point increase for members ages 1 to 5 years and a 6.6 percentage point increase for members ages 6 to 14 years. TCHP-SW also exceeded the benchmark set by OHA for MY 2023 by more than 5 percentage points; an 8.6 percentage point increase for members ages 1 to 5 years and a 5.6 percentage point increase for members ages 6 to 14 years.	
	Strength: TCHP-SW's MY 2023 performance on the <i>Initiation of SUD Treatment—Ages 13 to 17 Years</i> measure indicator demonstrated a performance measure rate increase of more than 5 percentage points (14.6 percentage points) from MY 2022.	
	Strength: TCHP-SW's MY 2023 performance on the <i>Oral Evaluation for Adults With Diabetes</i> measure demonstrated ongoing improvement since MY 2021. In addition, the performance measure rate increased by more than 5 percentage points (5.7 percentage points) from MY 2022.	
	Weakness: TCHP-SW MY 2023 performance on the <i>Child and Adolescent Well-Care Visits—Ages 3 to 6 Years</i> measure indicator remained steady but fell 17.2 percentage points below the benchmark set by OHA for MY 2023. Why the weakness exists: TCHP-SW was unable to create performance measure improvement in alignment with the increased benchmark goal for MY 2023. Recommendations: TCHP-SW should conduct root cause analyses to identify specific factors affecting performance on the <i>Child and Adolescent Well-Care Visits—Ages 3 to 6 Years</i> measure indicator. Once identified, targeted interventions should be developed, implemented, and evaluated to ensure effective improvement strategies are adopted to increase performance over time. Additionally, TCHP-SW should continue to monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches to ensuring the quality, timeliness, and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	
	Weakness: Though not incentivized for MY 2023, TCHP-SW's MY 2023 performance on the <i>Engagement of SUD Treatment—Ages 13 to 17 Years</i> measure indicator demonstrated a performance measure rate decrease, resulting in a performance measure rate more than	

Strength/ Weakness	Description	Domain(s) ⁷¹
	5 percentage points (10.5 percentage points) below the statewide aggregate. Why the weakness exists: TCHP-SW has a small member population for members ages 13 to 17 years for this metric, increasing percent change with decreasing numerator compliance. TCHP-SW was not able to maintain performance rates in alignment with the statewide aggregate. Recommendations: TCHP-SW should conduct root cause analyses to identify specific factors affecting performance on the <i>Engagement of SUD Treatment—Ages 13 to 17 Years</i> measure indicator. Once identified, targeted interventions should be developed, implemented, and evaluated to ensure effective improvement strategies are adopted to increase performance over time. Additionally, TCHP-SW should continue to monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches to ensuring the quality, timeliness, and accessibility of health care services.	
Validation of Network Adequacy		
Network Adequacy Validation Audit		
	Strength: TCHP-SW had established robust processes to keep provider data up to date and accurate through its provider credentialing audits, quarterly comprehensive provider roster audits and monthly provider audits for any provider changes, additions, or terminations.	 
Delivery System Network Evaluation		
	Strength: TCHP-SW established an interdepartmental workgroup (i.e., the Network Adequacy Collaborative) focused on the frequent monitoring and strategic resolution of Medicaid network gaps. This workgroup met monthly and incorporated provider feedback and input along with multiple qualitative and quantitative data sources.	 
	Weakness: TCHP-SW showed potential data quality issues and/or barriers to overall network access, including but not limited to provider active status, service location, and status of accepting new patients. Why the weakness exists: A moderate to low percentage of both MH providers and SUD providers was determined to be active in TCHP-SW's network within the prior two years. Low percentages of all providers were reported to operate within the CCO's service area. With the exception of PCPs and PCDs, all providers indicated 100 percent acceptance of new patients. Recommendations: TCHP-SW should seek technical assistance with OHA to determine the nature of the data quality issues and/or barriers to care, and take any necessary corrective actions.	 

Strength/ Weakness	Description	Domain(s) ⁷¹
	Weakness: TCHP-SW did not meet the pediatric and facility time and distance standards for M-ONC, PUL, RHEU, providers, and MTD facilities. Why the weakness exists: TCHP-SW did not meet the pediatric network adequacy standards for M-ONC providers since fewer than 95 percent of its members were within acceptable travel times or distances of providers serving pediatric members. Additionally, 0.0 percent of pediatric TCHP-SW members had access to RHEU providers since the CCO did not have any contracted RHEU providers within its provider network. Finally, TCHP-SW had not engaged in OHA's time and distance exception request process for all noncompliant provider types (i.e., M-ONC). It is expected that the CCO have at least one provider of all monitored types within its network, regardless of time and distance standard compliance, rather than rely on single case agreements or similar methods. Recommendations: TCHP-SW should ensure that it takes the necessary steps to maintain an adequate network that can provide all covered and necessary care. The CCO should work to contract with at least one provider or facility of each missing type that can supply such services as part of the CCO's network, even if that provider is not within the service region. Such providers should still be meaningfully accessible through regional transportation (e.g., driving to a nearby population center). The CCO should work with OHA on potential solutions for these needs as well as engage in OHA's time and distance exception request process for all instances of noncompliance.	
Revealed Telephone Survey		
	Strength: Of the OP SUD cases that offered an appointment, 94.4 percent of routine OP SUD visits and 90.0 percent of new patient urgent visits were compliant with the wait time standard.	
	Weakness: Overall, 84.9 percent of the total PCP and OP SUD sampled cases were reached. Among the cases reached, 83.5 percent confirmed the correct location, 66.5 percent offered the requested services, 64.6 percent accepted OHP Medicaid, and 43.7 percent accepted TCHP-SW. Also, 85.5 percent of cases offered translation or interpreter services. Why the weakness exists: In addition to limitations related to the revealed survey approach, inaccuracies found in TCHP-SW's provider data may have contributed to the low response rate and accuracy results. Recommendations: TCHP-SW should use the case-level analytic data files to address the data deficiencies identified during the survey calls (e.g., incorrect or disconnected telephone numbers; incorrect location; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	

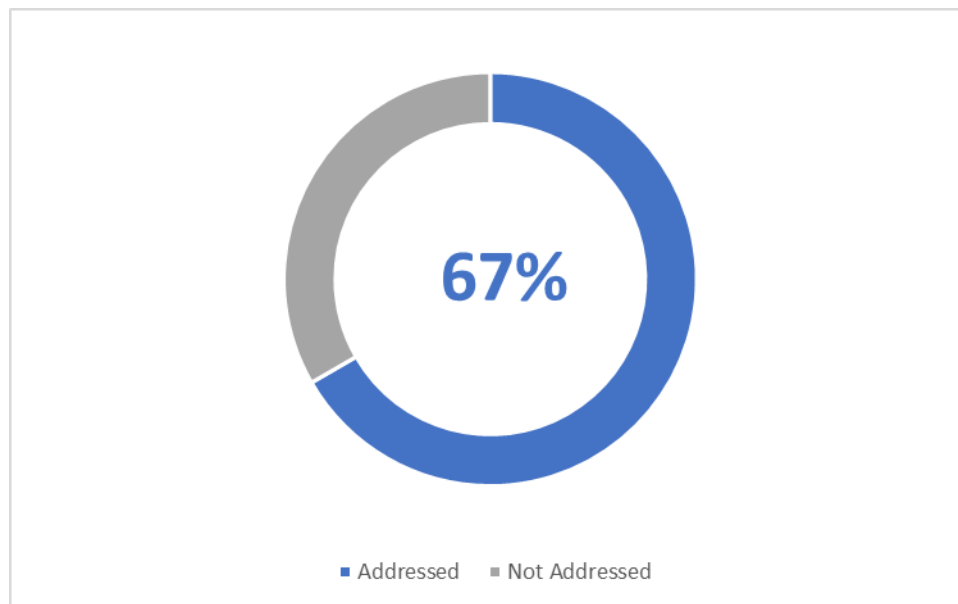
Strength/ Weakness	Description	Domain(s) ⁷¹
	Weakness: Among the total PCP and OP SUD cases reached, 39.2 percent accepted new patients. In addition, appointment availability was only offered for less than 30.0 percent of PCP cases and 38.0 percent of OP SUD cases. Of the PCP cases that offered an appointment, all compliance rates, except for new patient urgent visits, resulted in low rates, which ranged from 45.8 percent (new patient routine visits) to 86.7 percent (existing patient urgent visits). Of the OP SUD cases that offered an appointment, all compliance rates, except for routine visits, resulted in low rates, which ranged from 15.8 percent (pregnant OP SUD visits) to 89.5 percent (urgent visits). Why the weakness exists: In addition to limitations related to the revealed survey approach, inaccuracies found in TCHP-SW's provider data and insufficient provider panel capacity may have contributed to low access and availability rates (i.e., new patient acceptance, appointment availability, and wait times). Also, internal office staffing structures and procedures may have contributed to the long wait times. Recommendations: TCHP-SW should confirm appointment availability with providers, including panel capacity to accept new patients. Further, TCHP-SW should use the case-level analytic data files to address data deficiencies identified during the survey calls.	
Encounter Data Validation		
Since EDV results were not available for inclusion in the 2024 EQR technical report, the strengths and weaknesses for each CCO could not be assessed. The findings will be incorporated in next year's EQR technical report.		
Mental Health Parity Evaluation		
The CCO met performance expectations. No significant strengths or weaknesses were noted during the review.		

Follow-Up on Prior Year Recommendations

HSAG evaluated TCHP-SW's approach to addressing the recommendations related to findings issued during CY 2023 and unresolved findings from CY 2020, CY 2021, and CY 2022 while conducting the CY 2024 EQR activities. The CCOs not addressing recommendations are at risk of being out of compliance with their contracts.

Figure 5-26 illustrates the degree in which the CCO sufficiently addressed the recommendations for QI made by HSAG during the CY 2023 EQR.

Figure 5-26—Percentage of CY 2023 EQR Recommendations Addressed by TCHP-SW



TCHP-SW-specific CY 2023 recommendations and follow-up CY 2024 assessments are summarized in Table 5-26.

Table 5-26—Assessment of TCHP-SW’s Approach to Addressing Previous Annual Recommendations

CY 2023 Recommendation	CY 2024 Assessment
Compliance Monitoring Review	
Standard I—Assurance of Adequate Capacity and Availability of Services*	
This recommendation was initially given during the CY 2021 EQR. TCHP-SW should ensure processes include ongoing monitoring of provider network compliance against all network access standards and taking corrective actions when providers fail to meet network access requirements. In addition, TCHP-SW should ensure its GeoAccess monitoring includes individual provider specialties and revise its policies and procedures to align with current monitoring practices.	TCHP-SW did not sufficiently address the recommendation. TCHP-SW demonstrated appropriate monitoring of providers against the quantitative standards including individual provider specialties. The CCO also demonstrated taking corrective action when providers failed to meet network access requirements. However, TCHP-SW did not fully demonstrate the appropriate mechanisms to assess compliance with timely access to services standards required by the State. Note: Standard I—Assurance of Adequate Capacity and Availability of Services was comprehensively reviewed during the CY 2024 CMR cycle, and recommendations addressing all findings related to this standard are included in the CCO’s individual Results and Conclusions section.

CY 2023 Recommendation	CY 2024 Assessment
Standard III—Coordination and Continuity of Care	
TCHP-SW should demonstrate implementation of appropriate assessments and reassessments, according to federal and State requirements. TCHP-SW should also demonstrate compliance with its policies, specifically for outreach attempts to members for care coordination services.	TCHP-SW sufficiently addressed the recommendation.
Standard IV—Coverage and Authorization of Services	
TCHP-SW should revise its policies and procedures to align with federal and State requirements. TCHP-SW should also demonstrate the implementation of appropriate service offerings. TCHP-SW should also demonstrate proper outreach to retrieve the information needed to process service authorization requests.	TCHP-SW did not sufficiently address the recommendation. TCHP-SW subcontractors could not demonstrate processes that fully aligned with the State’s requirements for processing PA requests. Also, the CCO had not finalized its internal process to address the practice of reconsiderations following the issuance of an NOABD and having a peer-to-peer consultation. Additionally, the CCO’s policies continued to be noncompliant with the State requirements for follow-up attempts to obtain the additional information. TCHP-SW should revise its policies and procedures to align with federal and State requirements and ensure that its subcontractors’ processes are in alignment. TCHP-SW should also demonstrate processes for the proper outreach to retrieve the information needed to process service authorization requests.
Standard V—Provider Selection	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard VI—Subcontractual Relationships and Delegation	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard VII—Member Rights and Protections	
TCHP-SW should revise its policies and procedures and member- and provider-facing materials to align with federal and State requirements.	TCHP-SW sufficiently addressed the recommendation.
Standard VIII—Confidentiality	
This standard was not assessed during the 2023 CMR.	Not applicable.

CY 2023 Recommendation	CY 2024 Assessment
Standard IX—Enrollment and Disenrollment	
This recommendation was initially given during the CY 2022 EQR. TCHP-SW should revise all applicable documents to include all discrimination reasons required by State and federal regulations.	TCHP-SW did not sufficiently address the recommendation. Although TCHP-SW revised its provider manual, participating provider contract template, and disclosure form to include the discrimination reasons required by State and federal regulations, the CCO did not demonstrate revising its employee training material to include these reasons. TCHP-SW should revise all applicable documents to include all discrimination reasons required by State and federal regulations.
Standard X—Grievance and Appeal Systems	
TCHP-SW should revise its policies and procedures to align with federal and State requirements. TCHP-SW should adhere to federal and State requirements for content in resolution notices and time frames for acknowledging and resolving grievances and appeals. TCHP-SW should also demonstrate implementation of federal and State requirements within communications to staff, members, providers, and subcontractors.	TCHP-SW sufficiently addressed the recommendation.
Standard XI—Practice Guidelines	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard XII—Quality Assessment and Performance Improvement	
This recommendation was initially given during the CY 2022 EQR. The CCO should revise its QAPI program structure to align with federal and State requirements for assessing the quality and appropriateness of care.	TCHP-SW sufficiently addressed the recommendation.
Standard XIII—Health Information Systems, including ISCA	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Standard XIV—Member Information	
TCHP-SW should revise its policies, procedures, and member-facing materials to align with federal and State requirements. Additionally, TCHP-SW should track and monitor the timely provision of required member information.	TCHP-SW did not sufficiently address the recommendation. TCHP-SW demonstrated revising its policies, procedures, and some of its member-facing materials to align with federal and State requirements. Additionally, TCHP-SW demonstrated the appropriate mechanisms to

CY 2023 Recommendation	CY 2024 Assessment
	monitor the timely provision of required member information. However, the CCO did not demonstrate its printed provider directory fully aligned with State requirements. HSAG recommends that TCHP-SW revise its provider directory to fully align with federal and State requirements.
Standard XVI—Emergency and Poststabilization Services	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Performance Improvement Projects	
Statewide Mental Health Service Access Monitoring PIP	
TCHP-SW should ensure all indicator data and statistical testing results are accurately and consistently reported throughout the PIP documentation.	TCHP-SW sufficiently addressed the recommendation.
TCHP-SW should revise the RY 1 narrative and ensure it aligns with the RY 1 data reported in the Step 7 table of the resubmission. TCHP-SW should state in the narrative whether the RY 1 results represented an improvement or decline in performance compared to baseline results, and whether the change was statistically significant.	TCHP-SW sufficiently addressed the recommendation.
TCHP-SW should revisit root cause analyses identifying barriers to improving access to MH services to determine which barriers to improvement were not effectively addressed. TCHP-SW should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to improve indicator results.	TCHP-SW sufficiently addressed the recommendation.
Statewide Substance Use Disorder PIP	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Performance Measure Validation	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.

CY 2023 Recommendation	CY 2024 Assessment
Validation of Network Adequacy	
Delivery System Network Evaluation	
This recommendation was initially given during the CY 2021 EQR. TCHP-SW should ensure that it reports DSN Provider Capacity Reporting data values, specifically for the <i>Credentialing Date</i> data field, and seek technical assistance from OHA as needed.	TCHP-SW sufficiently addressed the recommendation.
TCHP-SW should seek technical assistance with OHA to determine the nature of the provider capacity data issues, including but not limited to provider counts and acceptance of new patients, and correct them.	TCHP-SW sufficiently addressed the recommendation.
TCHP-SW should seek technical assistance with OHA to determine the nature of the provider capacity data issues, related to dental, BH, and PUL specialty provider services, and correct them.	TCHP-SW sufficiently addressed the recommendation.
Secret Shopper Survey	
This recommendation was initially given during the CY 2021 EQR. HSAG recommends that TCHP-SW use the case-level analytic data files to address the data deficiencies identified during the secret shopper survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	TCHP-SW sufficiently addressed the recommendation. TCHP-SW reported that it validated and updated provider data files. TCHP-SW should continue to monitor and improve any efforts in maintaining accurate provider data (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).
HSAG recommends that TCHP-SW confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. TCHP-SW should use the case-level analytic data files containing data deficiencies identified during the secret shopper survey calls.	TCHP-SW sufficiently addressed the recommendation. TCHP-SW reported that it conducted routine outreach and monitoring activities to confirm provider data and appointment availability. TCHP-SW should continue to monitor and improve any efforts in maintaining accurate provider data and compliance with wait time standards.
Revealed Telephone Survey	
HSAG recommends that TCHP-SW use the case-level analytic data files to address the data deficiencies identified during the revealed telephone survey calls (e.g., incorrect or disconnected telephone numbers; incorrect	TCHP-SW sufficiently addressed the recommendation. TCHP-SW reported that it validated and updated provider data files. TCHP-SW should continue to monitor and improve any efforts in maintaining accurate provider data (e.g.,

CY 2023 Recommendation	CY 2024 Assessment
addresses; and provider specialty information that does not correspond to the sampled location, plan name, program information, and translation/interpreter services offered).	incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).
HSAG recommends that TCHP-SW confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. TCHP-SW should use the case-level analytic data files containing data deficiencies identified during the survey calls and work with BH outpatient offices to identify the root cause for delays in appointment availability.	TCHP-SW sufficiently addressed the recommendation. TCHP-SW reported that it conducted routine outreach and monitoring activities to confirm provider data and appointment availability. TCHP-SW should continue to monitor and improve any efforts in maintaining accurate provider data and compliance with wait time standards.
Encounter Data Validation	
This recommendation was initially given during the CY 2021 EQR. HSAG recommends that TCHP-SW implement standard quality controls to ensure accurate data extracts and decrease record omission and surplus rates. Through the development of standard data extraction procedures and quality control, the number of errors associated with extracted data could be reduced.	TCHP-SW did not sufficiently address the recommendation. TCHP-SW has partially addressed the recommendation. TCHP-SW stated that it has an internal policy and procedure for data extracts, which will be updated accordingly. No performance improvements, barriers, or strategies for continued improvement were identified in the response. While updating the policy and procedure is a step forward, the response lacks details on specific quality controls, implemented actions, or evidence of reduced errors. To fully address the recommendation, TCHP-SW should demonstrate concrete measures and outcomes related to data accuracy and completeness.
This recommendation was initially given during the CY 2021 EQR. HSAG recommends that TCHP-SW implement standard quality controls to ensure accurate data extracts. Through the development of standard data extraction procedures and quality control, the number of errors associated with extracted data could be reduced. For the diagnosis-related group (DRG) data element, HSAG also recommends TCHP-SW work with OHA to ensure that the DRG values submitted to OHA are in alignment with and are an accurate representation of values within TCHP-SW's data system. Additionally, HSAG recommends that TCHP-SW continually monitor	TCHP-SW did not sufficiently address the recommendation. TCHP-SW has partially addressed the recommendation. TCHP-SW stated it has an internal policy and procedure for data extracts and plans to update it accordingly. No specific actions, performance improvements, or strategies for monitoring and quality control were provided. While acknowledging the need to update its policy and procedure is a positive step, the lack of specific quality controls, monitoring efforts, or evidence of outcomes limits the response. To fully address the recommendation, TCHP-SW should detail implemented measures, demonstrate

CY 2023 Recommendation	CY 2024 Assessment
its encounter submissions to OHA to ensure complete, accurate, and timely encounter data submissions.	alignment of DRG values, and ensure ongoing monitoring of data submissions.
This recommendation was initially given during the CY 2022 EQR. TCHP-SW should investigate and follow up with its providers regarding its provider information and determine why encounters were submitted to OHA, but the provider indicated the member was not a patient at the practice.	TCHP-SW sufficiently addressed the recommendation. TCHP-SW implemented robust communication, training, and audit practices to ensure compliance and documentation accuracy. Continuous updates to the provider manual and resources further strengthen its approach.
This recommendation was initially given during the CY 2022 EQR. TCHP-SW should investigate the root cause for the omissions and consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews would then be provided to providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.	TCHP-SW sufficiently addressed the recommendation. TCHP-SW implemented regular reviews, audits, and education initiatives. Continued evaluation of progress and tailored recommendations for providers will further enhance its compliance and effectiveness.
HSAG recommends TCHP-SW follow the submission guidance outlined in the data requirements document, which indicated, “Only include claims and encounters that are in a final, fully adjudicated status as of May 31, 2023.” This would ensure HSAG receives encounters with the same claim status from the anchor date of May 31, 2023.	TCHP-SW did not sufficiently address the recommendation. TCHP-SW has partially addressed the recommendation. While updating the policy and procedure is a step in the right direction, the response lacks evidence of specific actions taken to ensure compliance or any demonstrated outcomes. To fully address the recommendation, TCHP-SW should provide details on implemented measures and verify adherence to submission guidance in future processes.
HSAG suggests submitting the raw data extracts separately, maintaining the integrity of the original data and preventing potential misalignments during the stacking process. Additionally, HSAG recommends TCHP-SW establish robust quality checks during the data compilation phase to promptly identify and address any discrepancies. This proactive approach will contribute to maintaining data accuracy and reliability throughout the submission process.	TCHP-SW did not sufficiently address the recommendation. TCHP-SW has partially addressed the recommendation. While updating the policy and procedure is a step toward compliance, the response lacks details on implemented quality checks or measures to ensure data integrity. To fully address the recommendation, TCHP-SW should provide evidence of updated processes, describe specific quality checks, and demonstrate its effectiveness in preventing data misalignments.

CY 2023 Recommendation	CY 2024 Assessment
Mental Health Parity Evaluation	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.

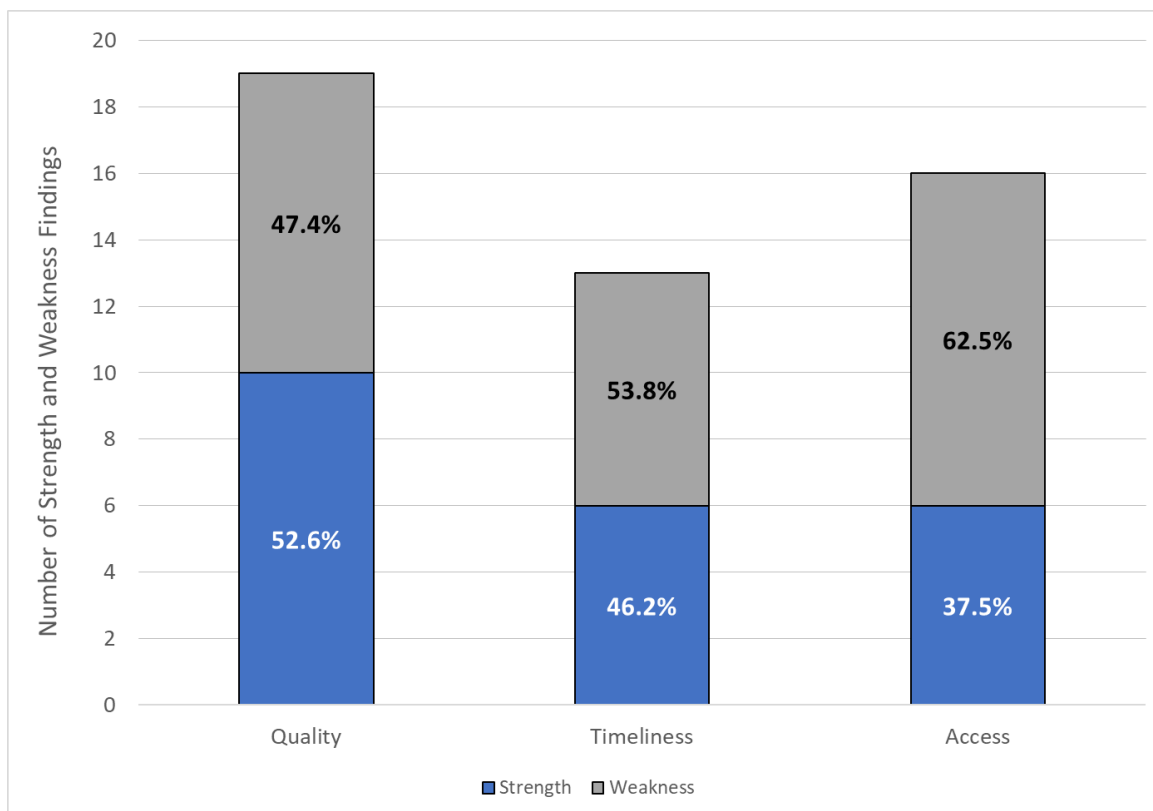
*Standard I—Availability of Services and Standard II—Assurances of Adequate Capacity and Services were combined, and all elements required by 42 CFR §438.206 and §438.207 were assessed under the combined Standard I—Assurance of Adequate Capacity and Availability of Services during the CY 2024 CMR activity.

Trillium Community Health Plan, Inc.—Tri-County

Results and Conclusions

HSAG assessed the strengths and weaknesses of each CCO with respect to the quality, timeliness, and accessibility of health care services. Figure 5-27 illustrates the number of strengths exhibited by TCHP-TC relative to the number of weaknesses identified during the CY 2024 EQR activities across the three domains. The greater the proportion of weaknesses, the greater opportunities for improvement.

Figure 5-27—TCHP-TC Overall Number of Findings (Strengths and Weaknesses) by Domain



Detailed results from the EQR’s substantive findings are summarized in Table 5-27 for each activity. This table highlights the extent to which TCHP-TC furnishes high quality, timely, and appropriate access to health care services, and recommendations for how TCHP-TC can best address issues identified for each activity.⁷²

⁷² See Section 4—Comparative Statewide Results for detailed, CCO-specific scores associated with EQR activity.

Table 5-27—TCHP-TC Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s) ⁷³
Compliance Monitoring Review		
	Strength: TCHP-TC demonstrated best practices by implementing monitoring efforts such as heat mapping of languages spoken by providers and members to reveal gaps and examining health outcomes data to reveal and act on disparities across service regions, race, gender, and other demographics.	  
	Strength: TCHP-TC demonstrated best practices with its provider retention efforts by implementing POEM 2.0.	 
	Strength: TCHP-TC demonstrated best practices by including a nondiscrimination statement in its credentialing denial letter sent to providers.	
	Strength: TCHP-TC demonstrated best practices by clearly outlining the CCO's and subcontractor's responsibilities in its contracts.	
	Strength: TCHP-TC achieved full compliance with the <i>Practice Guidelines</i> standard, demonstrating that the CCO had established policies and procedures, along with the appropriate structure, to ensure that clinical practice guidelines were adopted, reviewed, updated, and disseminated. These guidelines took into account the needs of members and were based on evidence or on a consensus among providers in the relevant field. Additionally, decision-making was aligned with these guidelines.	 
	Weakness: TCHP-TC received a score of 86.8 percent in the <i>Assurance of Adequate Capacity and Availability of Services</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements and deficiencies within its monitoring activities impacting the CCO's ability to ensure timely access to care and services. Why the weakness exists: The implemented policies and procedures did not fully align with the federal and State requirements for accessing women's health care specialists and family planning providers, hours of operation, and access, accommodations, and equipment for members with physical and mental disabilities. Additionally, the CCO failed to demonstrate the appropriate mechanisms for assessing compliance with state-established appointment standards. Recommendations: TCHP-TC should revise its policies and procedures to align with federal and State requirements for timely access to care and services and demonstrate implementation. The CCO	  

⁷³  = Quality,  = Timeliness,  = Access

Strength/ Weakness	Description	Domain(s) ⁷³
	should also ensure that its mechanisms are sufficient to assess compliance with the state-established appointment standards.	
	Weakness: TCHP-TC received a score of 75.0 percent in the <i>Provider Selection</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements and deficiencies within its monitoring activities, impacting the CCO's ability to meet federal and State requirements for credentialing and recredentialing network providers. Why the weakness exists: TCHP-TC's and its subcontractors' policies and procedures did not fully align with federal and State requirements for collecting the appropriate credentialing documentation and the time frames for recredentialing. Additionally, the CCO did not demonstrate comprehensive monitoring of subcontractors for adherence to requirements for credentialing and recredentialing. Also, the CCO did not demonstrate oversight of subcontractors to ensure compliance with notice requirements for declining provider participation in its network. Recommendations: TCHP-TC should revise and ensure that its subcontractors revise policies and procedures to align with the federal and State requirements for credentialing and recredentialing. Additionally, the CCO should demonstrate ongoing monitoring of its subcontractors to ensure adherence to credentialing and recredentialing requirements. The CCO should also demonstrate oversight of subcontractors to ensure compliance with notice requirements for declining provider participation in its network.	 
	Weakness: TCHP-TC received a score of 87.5 percent in the <i>Subcontractual Relationships and Delegation</i> standard due to failure to conduct appropriate monitoring activities impacting the CCO's ability to adhere to federal requirements and the CCO's contractual requirements with the State. Why the weakness exists: TCHP-TC failed to demonstrate that it conducts the appropriate oversight and monitoring of its subcontractors and holds them accountable for contractual requirements. Recommendations: TCHP-TC should hold its subcontractors accountable for contractual obligations and conduct the appropriate oversight and monitoring of its subcontractors.	
Performance Improvement Projects		
Statewide Mental Health Service Access Monitoring PIP		
	Strength: TCHP-TC accurately reported baseline and RY 2 performance indicator data, identified and analyzed barriers to improving MH service access, carried out interventions to address those barriers, and refined interventions based on intervention evaluation results.	

Strength/ Weakness	Description	Domain(s) ⁷³
	Weakness: TCHP-TC received a <i>No Confidence</i> rating for overall confidence that the <i>Mental Health Service Access Monitoring</i> PIP achieved significant improvement. Why the weakness exists: TCHP-TC's indicator results demonstrated a decline in performance from baseline to RY 2. Recommendations: TCHP-TC should revisit root cause analyses identifying barriers to improving access to MH services to determine which barriers to improvement were not effectively addressed. TCHP-TC should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to improve the percentage of members with a MH service need who received MH services indicator results.	
Statewide Substance Use Disorder PIP		
	Strength: TCHP-TC accurately reported baseline and RY 1 performance indicator data; identified and analyzed barriers for initiation, engagement, and treatment of alcohol and other drug use disorders; and began to carry out interventions to address those barriers.	
	Weakness: TCHP-TC received a <i>Moderate Confidence</i> rating for overall confidence that the <i>Substance Use Disorder</i> PIP achieved significant improvement. Why the weakness exists: TCHP-TC's RY 1 improvement noted for Indicator 2) <i>Percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation</i>) results over BY was not statistically significant. Recommendations: TCHP-TC should revisit root cause analyses identifying barriers to improving initiation, engagement, and treatment of alcohol and other drug use disorders to determine which barriers to improvement were not effectively addressed. TCHP-TC should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to further improve percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.	
Performance Measure Validation		
	Strength: TCHP-TC's MY 2023 rates on the <i>Initiation of SUD Treatment</i> and <i>Engagement of SUD Treatment</i> measure indicators for members ages 18 years and older improved from MY 2022. TCHP-TC's performance measure rates for both measure indicators exceeded the statewide aggregate and the benchmarks set by OHA for MY 2023. Additionally, TCHP-TC's performance on the <i>Initiation of SUD Treatment</i> measure indicator for ages 13 to 17 years demonstrated an improvement since MY 2022 of more than 5 percentage points (15.8 percentage points). In addition, the CCO's MY 2023 rate	

Strength/ Weakness	Description	Domain(s) ⁷³
	exceeded the statewide aggregate for MY 2023 for both the <i>Initiation of SUD Treatment</i> and <i>Engagement of SUD Treatment</i> measure indicators.	
	Strength: TCHP-TC's MY 2023 performance for the <i>Members Receiving Preventive Dental or Oral Health Services—Ages 6 to 14 Years</i> measure indicator improved by more than 5 percentage points compared to MY 2022 (6.1 percentage points).	
	Weakness: TCHP-TC's MY 2023 performance on the <i>Child and Adolescent Well-Care Visits—Ages 3 to 6 Years</i> measure indicator declined nearly 5 percentage points and fell to 41.5 percentage points, 27.1 percentage points below the benchmark set by OHA for MY 2023. Why the weakness exists: TCHP-TC's eligible population increased from MY 2022 to MY 2023, but the number of members who had at least one well-care visit with a PCP or OB/GYN provider declined. Recommendations: TCHP-TC should conduct root cause analyses to identify specific factors affecting performance on the <i>Child and Adolescent Well-Care Visits—Ages 3 to 6 Years</i> measure indicator. Once identified, targeted interventions should be developed, implemented, and evaluated to ensure effective improvement strategies are adopted to increase performance over time. Additionally, TCHP-TC should continue to monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches to ensuring the quality, timeliness, and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	
	Weakness: TCHP-TC's MY 2023 performance on the <i>Oral Evaluation for Adults With Diabetes</i> measure has continually declined from MY 2021 and fell below the benchmark set by OHA for MY 2023. Why the weakness exists: TCHP-TC's eligible population increased from MY 2022 to MY 2023 for members, but the number of members with diabetes receiving oral evaluation is not increasing at the same rate. Recommendations: TCHP-TC should conduct root cause analyses to identify specific factors affecting performance on the <i>Oral Evaluation for Adults With Diabetes</i> measure indicator. Once identified, targeted interventions should be developed, implemented, and evaluated to ensure effective improvement strategies are adopted to increase performance over time. Additionally, TCHP-TC should continue to monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches to ensuring the quality, timeliness, and accessibility of health care services.	

Strength/ Weakness	Description	Domain(s) ⁷³
Validation of Network Adequacy		
Network Adequacy Validation Audit		
	Strength: TCHP-TC had established robust processes to keep provider data up to date and accurate through its provider credentialing audits, quarterly comprehensive provider roster audits and monthly provider audits for any provider changes, additions, or terminations.	 
Delivery System Network Evaluation		
	Strength: TCHP-TC established an interdepartmental workgroup (i.e., the Network Adequacy Collaborative) focused on the frequent monitoring and strategic resolution of Medicaid network gaps. This workgroup met monthly and incorporated provider feedback and input along with multiple qualitative and quantitative data sources.	 
	Weakness: TCHP-TC showed potential data quality issues and/or barriers to overall network access, including but not limited to provider active status and status of accepting new patients. Why the weakness exists: A moderate to low percentage of both MH providers and SUD providers was determined to be active in TCHP-TC's network within the prior two years. With the exception of PCPs and PCDs, most providers indicated 100 percent acceptance of new patients. Recommendations: TCHP-TC should seek technical assistance with OHA to determine the nature of the data quality issues and/or barriers to care, and take any necessary corrective actions.	 
	Weakness: TCHP-TC did not meet the time and distance standards for M-ONC and R-ONC providers serving pediatric members and for MTD facilities. Why the weakness exists: While more than 90 percent of pediatric members were within acceptable travel times and distances to M-ONC and R-ONC providers, TCHP-TC's results were below the network adequacy compliance thresholds. Similarly, TCHP-TC members' access to MTD facilities was below the network adequacy compliance threshold but remained greater than 90 percent. Additionally, the CCO had not engaged with OHA's time and distance exception request process for these provider types. Recommendations: TCHP-TC should engage in OHA's time and distance exception request process for all instances of noncompliance.	
Revealed Telephone Survey		
	Strength: Among the total PCP and OP SUD appointments offered, 95.0 percent of urgent PCP visits for existing patients and urgent OP SUD visits were compliant with the wait time standards.	 

Strength/ Weakness	Description	Domain(s) ⁷³
	Weakness: Overall, 75.1 percent of the total PCP and OP SUD sampled cases were reached. Among the cases reached, 84.1 percent confirmed the correct location, 68.2 percent offered the requested services, 64.9 percent accepted OHP Medicaid, and 53.0 percent accepted TCHP-TC. Also, 85.0 percent of cases offered translation or interpreter services. Why the weakness exists: In addition to limitations related to the revealed survey approach, inaccuracies found in TCHP-TC's provider data may have contributed to the low response rate and accuracy results. Recommendations: TCHP-TC should use the case-level analytic data files to address the data deficiencies identified during the survey calls (e.g., incorrect or disconnected telephone numbers; incorrect location; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	 
	Weakness: Among the total PCP and OP SUD cases reached, 41.7 percent accepted new patients. In addition, appointment availability was only offered for less than 44.0 percent of PCP cases and 41.0 percent of OP SUD cases. Of the PCP cases that offered an appointment, all compliance rates, except for existing patient urgent visits, resulted in low rates, which ranged from 64.3 percent (new patient routine visits) to 83.7 percent (existing patient routine visits). Of the OP SUD cases that offered an appointment, all compliance rates, except for urgent visits, resulted in low rates, which ranged from 61.9 percent (opioid use disorder visits) to 88.9 percent (routine visits). Why the weakness exists: In addition to limitations related to the revealed survey approach, inaccuracies found in TCHP-TC's provider data and insufficient provider panel capacity may have contributed to low access and availability rates (i.e., new patient acceptance, appointment availability, and wait times). Also, internal office staffing structures and procedures may have contributed to the long wait times. Recommendations: TCHP-TC should confirm appointment availability with providers, including panel capacity to accept new patients. Further, TCHP-TC should use the case-level analytic data files to address data deficiencies identified during the survey calls.	  
Encounter Data Validation		
Since EDV results were not available for inclusion in the 2024 EQR technical report, the strengths and weaknesses for each CCO could not be assessed. The findings will be incorporated in next year's EQR technical report.		
Mental Health Parity Evaluation		
	Weakness: TCHP-TC demonstrated 100 percent of MH/SUD Rx denial decisions were overturned at the appeal level.	 

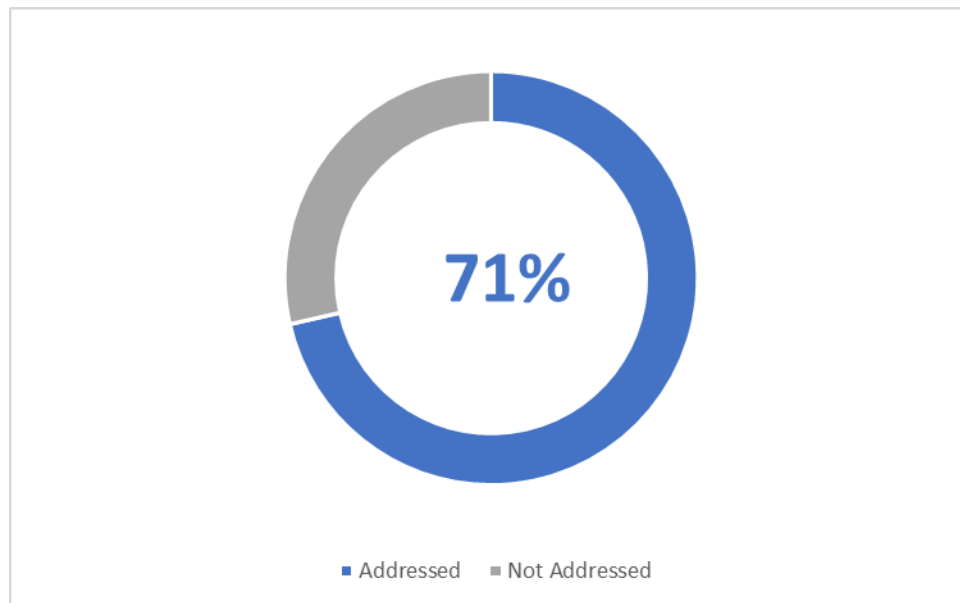
Strength/ Weakness	Description	Domain(s) ⁷³
	Why the weakness exists: Although the total number of appeals was low (i.e., four), the fact that 100 percent of the denial decisions were overturned at the appeal level may highlight issues with potentially ineffective PA processes and/or individuals making inappropriate decisions. Recommendations: TCHP-TC should review the MH/SUD Rx appeals to understand the factors affecting the 100 percent overturn rate. The CCO should review PA criteria and/or decision-making processes and make appropriate changes to ensure appropriate access to MH/SUD Rx services.	

Follow-Up on Prior Year Recommendations

HSAG evaluated TCHP-TC's approach to addressing the recommendations related to findings issued during CY 2023 and unresolved findings from CY 2020, CY 2021, and CY 2022 while conducting the CY 2024 EQR activities. The CCOs not addressing recommendations are at risk of being out of compliance with their contracts.

Figure 5-28 illustrates the degree in which the CCO sufficiently addressed the recommendations for QI made by HSAG during the CY 2023 EQR.

Figure 5-28—Percentage of CY 2023 EQR Recommendations Addressed by TCHP-TC



TCHP-TC-specific CY 2023 recommendations and follow-up CY 2024 assessments are summarized in Table 5-28.

Table 5-28—Assessment of TCHP-TC’s Approach to Addressing Previous Annual Recommendations

CY 2023 Recommendation	CY 2024 Assessment
Compliance Monitoring Review	
Standard I—Assurance of Adequate Capacity and Availability of Services*	
This recommendation was initially given during the CY 2021 EQR. TCHP-TC should ensure processes include ongoing monitoring of provider network compliance against all network access standards and taking corrective actions when providers fail to meet network access requirements. In addition, TCHP-TC should ensure its GeoAccess monitoring includes individual provider specialties and revise its policies and procedures to align with current monitoring practices.	TCHP-TC did not sufficiently address the recommendation. TCHP-TC demonstrated appropriate monitoring of providers against the quantitative standards including individual provider specialties. The CCO also demonstrated taking corrective action when providers failed to meet network access requirements. However, TCHP-TC did not fully demonstrate the appropriate mechanisms to assess compliance with timely access to services standards required by the State. Note: Standard I—Assurance of Adequate Capacity and Availability of Services was comprehensively reviewed during the CY 2024 CMR cycle, and recommendations addressing all findings related to this standard are included in the CCO’s individual Results and Conclusions section.
Standard III—Coordination and Continuity of Care	
TCHP-TC should demonstrate implementation of appropriate assessments and reassessments, according to federal and State requirements. TCHP-TC should also demonstrate compliance with its policies, specifically for outreach attempts to members for care coordination services.	TCHP-TC sufficiently addressed the recommendation.
Standard IV—Coverage and Authorization of Services	
TCHP-TC should revise its policies and procedures to align with federal and State requirements. TCHP-TC should also demonstrate the implementation of appropriate service offerings. TCHP-TC should also demonstrate proper outreach to retrieve the information needed to process service authorization requests.	TCHP-TC did not sufficiently address the recommendation. TCHP-TC subcontractors could not demonstrate processes that fully aligned with the State’s requirements for processing PA requests. Also, the CCO had not finalized its internal process to address the practice of reconsiderations following the issuance of an NOABD and having a peer-to-peer consultation. Additionally, the CCO’s policies continued to be noncompliant with the State requirements for follow-up attempts to obtain the additional information. TCHP-TC should revise its policies and procedures to align with federal and State requirements and ensure that its subcontractors’ processes are in alignment. TCHP-TC should also

CY 2023 Recommendation	CY 2024 Assessment
	demonstrate processes for the proper outreach to retrieve the information needed to process service authorization requests.
Standard V—Provider Selection	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard VI—Subcontractual Relationships and Delegation	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard VII—Member Rights and Protections	
TCHP-TC should revise its policies and procedures and member- and provider-facing materials to align with federal and State requirements.	TCHP-TC sufficiently addressed the recommendation.
Standard VIII—Confidentiality	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard IX—Enrollment and Disenrollment	
This recommendation was initially given during the CY 2022 EQR. TCHP-TC should revise all applicable documents to include all discrimination reasons required by State and federal regulations.	TCHP-TC did not sufficiently address the recommendation. Although TCHP-TC revised its provider manual, participating provider contract template, and disclosure form to include the discrimination reasons required by State and federal regulations, the CCO did not demonstrate revising its employee training material to include these reasons. TCHP-TC should revise all applicable documents to include all discrimination reasons required by State and federal regulations.
Standard X—Grievance and Appeal Systems	
TCHP-TC should revise its policies and procedures to align with federal and State requirements. TCHP-TC should adhere to federal and State requirements for content in resolution notices and time frames for acknowledging and resolving grievances and appeals. TCHP-TC should also demonstrate implementation of federal and State requirements within communications to staff, members, providers, and subcontractors.	TCHP-TC sufficiently addressed the recommendation.

CY 2023 Recommendation	CY 2024 Assessment
Standard XI—Practice Guidelines	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard XII—Quality Assessment and Performance Improvement	
This recommendation was initially given during the CY 2022 EQR. The CCO should revise its QAPI program structure to align with federal and State requirements for assessing the quality and appropriateness of care.	TCHP-TC sufficiently addressed the recommendation.
Standard XIII—Health Information Systems, including ISCA	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Standard XIV—Member Information	
TCHP-TC should revise its policies, procedures, and member-facing materials to align with federal and State requirements. Additionally, TCHP-TC should track and monitor the timely provision of required member information.	TCHP-TC did not sufficiently address the recommendation. TCHP-TC demonstrated revising its policies, procedures, and some of its member-facing materials to align with federal and State requirements. Additionally, TCHP-TC demonstrated the appropriate mechanisms to monitor the timely provision of required member information. However, the CCO did not demonstrate its printed provider directory fully aligned with State requirements. HSAG recommends that TCHP-TC revise its provider directory to fully align with federal and State requirements.
Standard XVI—Emergency and Poststabilization Services	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Performance Improvement Projects	
Statewide Mental Health Service Access Monitoring PIP	
TCHP-TC should revisit root cause analyses identifying barriers to improving access to MH services to determine which barriers to improvement were not effectively addressed. TCHP-TC should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to improve indicator results.	TCHP-TC sufficiently addressed the recommendation. The CCO revisited barrier analyses and revised improvement strategies in response to prior indicator and intervention evaluation results; however, the most recent remeasurement results for the overall performance did not demonstrate improvement. The CCO should continue efforts toward refining improvement strategies to address high-impact

CY 2023 Recommendation	CY 2024 Assessment
	barriers and drive improvement in overall indicator results.
Statewide Substance Use Disorder PIP	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Performance Measure Validation	
TCHP-TC should conduct root cause analyses to identify specific factors affecting performance on this measure and develop, implement, and evaluate targeted interventions to ensure improvement strategies are adopted. Additionally, TCHP-TC should monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches for ensuring the timeliness and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	TCHP-TC sufficiently addressed the recommendation. TCHP-TC reported that it had initiated a weekly gap review meeting to review existing and potential gaps in the network for access to care and to identify potential solutions to close those identified gaps. Additionally, TCHP-TC provided outreach to targeted practitioners from the access and availability survey to educate staff on required time frames for care and potential alternative solutions, such as telehealth and after-hours care.
Validation of Network Adequacy	
Delivery System Network Evaluation	
This recommendation was initially given during the CY 2021 EQR. TCHP-TC should ensure that it reports DSN Provider Capacity Reporting data values, specifically for the <i>Credentialing Date</i> data field, and seek technical assistance from OHA as needed.	TCHP-TC sufficiently addressed the recommendation.
TCHP-TC should seek technical assistance with OHA to determine the nature of the provider capacity data issues, including but not limited to provider counts and acceptance of new patients, and correct them.	TCHP-TC sufficiently addressed the recommendation.
TCHP-TC should seek technical assistance with OHA to determine the nature of the provider capacity data issues, related to primary dental and BH services, and correct them.	TCHP-TC sufficiently addressed the recommendation.
Secret Shopper Survey	
This recommendation was initially given during the CY 2021 EQR. HSAG recommends that TCHP-TC use the case-level analytic data files to address the data deficiencies identified during the secret shopper survey calls (e.g., incorrect or disconnected telephone numbers;	TCHP-TC sufficiently addressed the recommendation.

CY 2023 Recommendation	CY 2024 Assessment
incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
HSAG recommends that TCHP-TC confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. TCHP-TC should use the case-level analytic data files containing data deficiencies identified during the secret shopper survey calls.	TCHP-TC sufficiently addressed the recommendation. TCHP-TC reported that it had conducted routine outreach and monitoring activities to confirm provider data and appointment availability. TCHP-TC should continue to monitor and improve any efforts in maintaining accurate provider data and compliance with wait time standards.
Revealed Telephone Survey	
HSAG recommends that TCHP-TC use the case-level analytic data files to address the data deficiencies identified during the revealed telephone survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, program information, and translation/interpreter services offered).	TCHP-TC sufficiently addressed the recommendation. TCHP-TC reported that it had validated and updated provider data files. TCHP-TC should continue to monitor and improve any efforts in maintaining accurate provider data (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).
HSAG recommends that TCHP-TC confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. TCHP-TC should use the case-level analytic data files containing data deficiencies identified during the revealed telephone survey calls and work with BH outpatient offices to identify the root cause for delays in appointment availability.	TCHP-TC sufficiently addressed the recommendation. TCHP-TC reported that it had conducted routine outreach and monitoring activities to confirm provider data and appointment availability. TCHP-TC should continue to monitor and improve any efforts in maintaining accurate provider data and compliance with wait time standards.
Encounter Data Validation	
This recommendation was initially given during the CY 2022 EQR. TCHP-TC should investigate and follow up with its providers to determine why encounters were submitted to OHA, but no medical records or documentation were available for the member and/or the requested dates of service, or the member was not a patient of the practice.	TCHP-TC sufficiently addressed the recommendation. TCHP-TC implemented robust communication, training, and audit practices to ensure compliance and documentation accuracy. Continuous updates to the provider manual and resources further strengthen its approach.
This recommendation was initially given during the CY 2022 EQR. TCHP-TC should	TCHP-TC sufficiently addressed the recommendation. TCHP-TC implemented

CY 2023 Recommendation	CY 2024 Assessment
investigate the root cause for the omissions and consider performing periodic MRRs of submitted claims to verify appropriate coding and data completeness, where appropriate. Any findings from these reviews would then be provided to providers through periodic education and training regarding encounter data submissions, medical record documentation, and coding practices.	regular reviews, audits, and education initiatives. Continued evaluation of progress and tailored recommendations for providers will further enhance its compliance and effectiveness.
While encounter submission to OHA did not require the inclusion of the <i>Rendering Provider NPI</i> value if it matched the <i>Billing Provider NPI</i> value, the data request for the EDV comparative analysis had different requirements. To address this, HSAG recommends that TCHP-TC and its subcontractor(s) ensure that values for both <i>Billing Provider NPI</i> and <i>Rendering Provider NPI</i> are included in the data submission, irrespective of their equivalence. This adjustment will enhance the accuracy and completeness of the comparative analysis data. Additionally, it will provide HSAG with the means to verify and ensure the accuracy of the MMIS' process of populating the <i>Rendering Provider NPI</i> with the <i>Billing Provider NPI</i> .	TCHP-TC did not sufficiently address the recommendation. TCHP-TC has partially addressed the recommendation. While the commitment to updating internal policies is a positive step, the response does not provide evidence of current implementation or measures to ensure compliance. Demonstrating these updates in future submissions will fully address the recommendation.
HSAG recommends that TCHP-TC implement standardized quality controls to ensure data are accurately aligned in its data extracts from their encounter data system(s). However, it is also important to note that in the data requirements document, HSAG requested data to be extracted from the CCOs' subcontractors' data systems and was anticipating three distinct data extracts from TCHP-TC's subcontractors. Instead, TCHP-TC stacked all data extracts before submission to HSAG, rather than submitting the raw data extracts directly received from the subcontractors. The stacking of the data caused the misalignment observed in Capitol Dental Care's data. To address this, HSAG suggests submitting the raw data extracts separately, maintaining the integrity of the original data and avoiding misalignments during the stacking process.	TCHP-TC did not sufficiently address the recommendation. TCHP-TC has partially addressed the recommendation. While the planned updates to internal policies are a step forward, the response lacks details on current quality controls or measures to ensure compliance. Demonstrating these improvements and submitting raw data extracts in future submissions will fully address the recommendation.

CY 2023 Recommendation	CY 2024 Assessment
Mental Health Parity Evaluation	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.

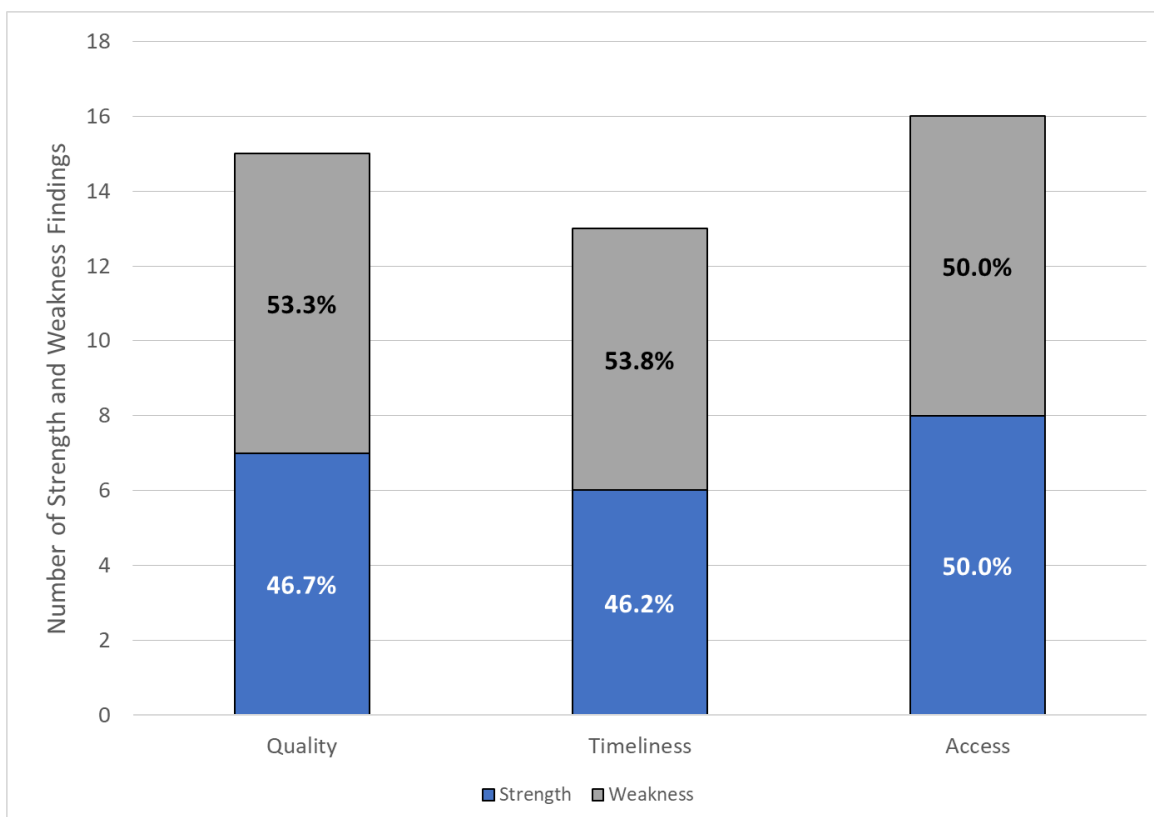
*Standard I—Availability of Services and Standard II—Assurances of Adequate Capacity and Services were combined, and all elements required by 42 CFR §438.206 and §438.207 were assessed under the combined Standard I—Assurance of Adequate Capacity and Availability of Services during the CY 2024 CMR activity.

Umpqua Health Alliance, LLC

Results and Conclusions

HSAG assessed the strengths and weaknesses of each CCO with respect to the quality, timeliness, and accessibility of health care services. Figure 5-29 illustrates the number of strengths exhibited by UHA relative to the number of weaknesses identified during the CY 2024 EQR activities across the three domains. The greater the proportion of weaknesses, the greater opportunities for improvement.

Figure 5-29—UHA Overall Number of Findings (Strengths and Weaknesses) by Domain



Detailed results from the EQR’s substantive findings are summarized in Table 5-29 for each activity. This table highlights the extent to which UHA furnishes high quality, timely, and appropriate access to health care services, and recommendations for how UHA can best address issues identified for each activity.⁷⁴

⁷⁴ See Section 4—Comparative Statewide Results for detailed, CCO-specific scores associated with EQR activity.

Table 5-29—UHA Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s) ⁷⁵
Compliance Monitoring Review		
	Strength: UHA demonstrated best practices by becoming NCQA accredited in Health Equity.	 
	Strength: UHA achieved full compliance with the <i>Practice Guidelines</i> standard, demonstrating that the CCO had established policies and procedures, along with the appropriate structure, to ensure that clinical practice guidelines were adopted, reviewed, updated, and disseminated. These guidelines took into account the needs of members and were based on evidence or on a consensus among providers in the relevant field. Additionally, decision-making was aligned with these guidelines.	 
	Weakness: UHA received a score of 78.9 percent in the <i>Assurance of Adequate Capacity and Availability of Services</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements, the inability to demonstrate sufficient implementation of established processes, and deficiencies within its monitoring activities impacting the CCO's ability to ensure timely access to care and services. Why the weakness exists: UHA lacked a methodology for monitoring and maintaining its provider network for the federal and state-required components. Additionally, the policies and procedures implemented did not fully align with state-established time and distance standards, appointment standards, and reporting requirements. Also, the CCO failed to demonstrate the appropriate monitoring of its provider network against state-established time and distance and appointment standards, and evidence of taking corrective action when providers failed to meet appointment standards. Recommendations: UHA should develop and implement a methodology for monitoring and maintaining its provider network for the federal and state-required components. Additionally, the CCO should revise its policies and procedures to align with state-established requirements for timely access to care and services and reporting and demonstrate implementation. The CCO should also demonstrate corrective action when providers fail to meet appointment standards.	  
	Weakness: UHA received a score of 66.7 percent in the <i>Provider Selection</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements and the inability to demonstrate sufficient implementation of	 

⁷⁵  = Quality,  = Timeliness,  = Access

Strength/ Weakness	Description	Domain(s) ⁷⁵
	established processes, impacting the CCO's ability to meet federal and State requirements for retaining and credentialing network providers. Why the weakness exists: UHA lacked policies and procedures for retaining network providers. Additionally, the CCO did not follow its policy or the State requirements for credentialing providers, including collecting the required credentialing documentation. Also, the CCO did not have a mechanism to ensure its provider selection processes did not inadvertently discriminate against providers. Recommendations: UHA should develop written policies and procedures for retaining providers. Additionally, the CCO should adhere to its policy and State requirements for credentialing providers, including collecting the required credentialing documentation. The CCO should also ensure its provider selection processes do not inadvertently discriminate against providers.	
	Weakness: UHA received a score of 87.5 percent in the <i>Subcontractual Relationships and Delegation</i> standard due to insufficient documentation to support operations and ensure compliance with federal requirements for written agreements between the CCO and its subcontractors. Why the weakness exists: UHA's contracts with the subcontractors failed to include federally required language for written agreements with subcontractors. Recommendations: UHA should revise its written agreements to align with federally required language for written agreements with subcontractors.	
Performance Improvement Projects		
Statewide Mental Health Service Access Monitoring PIP		
	Strength: UHA successfully continued the Implementation stage for the PIP, receiving a <i>Met</i> score for 100 percent of applicable evaluation elements in the PIP Validation Tool. In the Implementation stage, UHA accurately reported baseline and RY 2 performance indicator data, identified and analyzed barriers to improving MH service access, carried out interventions to address those barriers, and refined interventions based on intervention evaluation results.	
	Strength: UHA's RY 2 performance indicator results demonstrated sustained improvement in MH service access compared to baseline indicator results.	
Statewide Substance Use Disorder PIP		
	Strength: UHA accurately reported baseline and RY 1 performance indicator data; identified and analyzed barriers for initiation,	

Strength/ Weakness	Description	Domain(s) ⁷⁵
	engagement, and treatment of alcohol and other drug use disorders; and began to carry out interventions to address those barriers.	
	Weakness: UHA received a <i>No Confidence</i> rating for overall confidence that the <i>Substance Use Disorder</i> PIP achieved significant improvement. Why the weakness exists: UHA demonstrated a decline in performance from baseline to RY 1 for both Indicator 1 (<i>Percentage of new SUD episodes that result in treatment and initiation within 14 days</i>) and Indicator 2 (<i>Percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation</i>) results Recommendations: UHA should revisit root cause analyses identifying barriers to improving initiation, engagement, and treatment of alcohol and other drug use disorders to determine which barriers to improvement were not effectively addressed. UHA should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to further improve the percentage of new SUD episodes that result in treatment and initiation within 14 days and the percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation indicator results.	
Performance Measure Validation		
	Strength: UHA's MY 2023 performance on the <i>Child and Adolescent Well-Care Visits—Ages 3 to 6 Years</i> measure indicator exceeded the statewide aggregate for MY 2023 by 5 percentage points or more (5.3 percentage points).	
	Strength: UHA's MY 2023 performance on the <i>Members Receiving Preventive Dental or Oral Health Services—Ages 1 to 5 Years and Ages 6 to 14 Years</i> measure indicators improved by more than 5 percentage points compared to MY 2022; a 6.7 percentage point increase for members ages 1 to 5 years and a 5.4 percentage point increase for members ages 6 to 14 years. In addition, the CCO's performance on the <i>Members Receiving Preventive Dental or Oral Health Services—Ages 1 to 5 Years and Ages 6 to 14 Years</i> measure indicators demonstrated ongoing improvement since MY 2021. UHA's MY 2023 performance among members ages 6 to 14 years exceeded the benchmark set by OHA by 5 or more percentage points (6.7 percentage points).	
	Strength: UHA's MY 2023 performance on the <i>Oral Evaluation for Adults With Diabetes</i> measure demonstrated ongoing improvement since MY 2021. In addition, UHA's performance measure rate increased by 5 or more percentage points from MY 2022 to MY 2023 (6.1 percentage points).	

Strength/ Weakness	Description	Domain(s) ⁷⁵
	Weakness: UHA’s MY 2023 performance on the <i>Initiation of SUD Treatment</i> measure indicator for members ages 18 years and older decreased from the prior year and did not meet the statewide aggregate rate nor the OHA benchmark for MY 2023. Why the weakness exists: In response to EQR recommendations, UHA developed and implemented interventions to ensure the quality, timeliness, and accessibility of SUD treatment. UHA implemented these interventions starting Q3 2022, though has noted improvement was slow due to ongoing barriers, including transportation challenges, limitations of culturally specific resources and immediate interpretive services, limited communication pathways and tools to identify patients with a new SUD diagnosis, and insufficient coordinated care and communication between providers and agencies. Recommendations: UHA has already begun performance improvement initiatives based on prior year recommendations. UHA developed SUD resources for care coordination, shared workflows with the Quality Metrics Subcommittee, integrated care plans into PointClickCare, engaged providers through Tiger Team meetings, optimized member identification and IET cohort activation with PointClickCare, and worked with its CMHPs to enhance rapid access and service referrals. UHA is working to expand interpretive services for its members through interpreter training and scholarship programs, as well as increasing outreach initiatives for members who have not initiated SUD treatment. UHA should continue implementing these efforts to raise its performance rate for the <i>Initiation of SUD Treatment</i> measure indicator for members ages 18 years and older to the level of the benchmarks set by OHA. The CCO should ensure interventions are specific to “initiation of SUD treatment” and the specific 18 years and older age group.	
	Weakness: Though not incentivized for MY 2023, UHA’s MY 2023 performance rates declined more than 5 percentage points for both <i>Initiation and Engagement of SUD Treatment</i> measure indicators (a 9.5 percentage point decrease for initiation and a 12.9 percentage point decrease for engagement). In addition to the decline in performance, the rate for the <i>Engagement of SUD Treatment</i> measure indicator fell below the statewide aggregate. Why the weakness exists: UHA noted improvement was slow due to ongoing barriers, including transportation challenges, limitations of culturally specific resources and immediate interpretive services, limited communication pathways and tools to identify patients with a new SUD diagnosis, and insufficient coordinated care and communication between providers and agencies. Recommendations: UHA has already begun performance improvement initiatives based on prior year recommendations for	

Strength/ Weakness	Description	Domain(s) ⁷⁵
	members ages 18 years and older. UHA developed SUD resources for care coordination, shared workflows with the Quality Metrics Subcommittee, integrated care plans into PointClickCare, engaged providers through Tiger Team meetings, optimized member identification and IET cohort activation with PointClickCare, and worked with its CMHPs to enhance rapid access and service referrals. UHA is working to expand interpretive services for its members through interpreter training and scholarship programs, as well as increasing outreach initiatives for members who have not initiated SUD treatment. UHA should continue implementing these efforts to improve performance on the <i>Initiation and Engagement of SUD Treatment</i> measure indicators for members ages 13 to 17 years and raise the performance rate for the <i>Engagement of SUD Treatment</i> measure indicators on this measure to the level of the benchmarks set by OHA.	
Validation of Network Adequacy		
Network Adequacy Validation Audit		
The CCO met performance expectations. No significant strengths or weaknesses were noted during the review.		
Delivery System Network Evaluation		
	Weakness: UHA did not meet the time and distance standards for OT, PT, and SLP providers serving adult members; and CRD, M-ONC, PT, GST, HEM, and PUL providers serving pediatric members. Why the weakness exists: UHA did not meet the adult (OT, PT, and SLP) and pediatric (CRD, M-ONC, PT, GST, HEM, and PUL) network adequacy standards since fewer than 95 percent of its adult and pediatric members were within acceptable travel times or distances for these Tier 2 and Tier 3 provider types. Additionally, 0.0 percent of UHA's adult members had access to PT, OT, and SLP providers, and 0.0 percent of pediatric members had access to CRD, M-ONC, GST, HEM, and PUL providers since UHA's provider network had not contracted with providers in these specialties. Finally, UHA had not engaged in OHA's time and distance exception request process for any noncompliant provider types. It is expected that the CCO have at least one provider of all monitored types within its network, regardless of time and distance standard compliance, rather than rely on single case agreements or similar methods. Recommendations: UHA should ensure that it takes the necessary steps to maintain an adequate network that can provide all covered and necessary care. The CCO should work to contract with at least one provider of each missing type that can supply such services as part of the CCO's network, even if that provider is not within the service region. Such providers should still be meaningfully accessible through regional transportation (e.g., driving to a nearby population center). The	

Strength/ Weakness	Description	Domain(s) ⁷⁵
	CCO should engage with OHA on potential solutions for these needs, including engagement in OHA's time and distance exception request process for noncompliant provider types and populations.	
Revealed Telephone Survey		
	Strength: Of the OP SUD cases that offered an appointment, 100 percent of urgent visits were compliant with the wait time standard.	
	Strength: Of the total PCP and OP SUD cases that accepted the CCO, 95.2 percent of cases offered translation or interpreter services.	
	Weakness: Overall, 78.7 percent of the total PCP and OP SUD sampled cases were reached. Among the cases reached, 89.2 percent confirmed the correct location, 78.4 percent offered the requested services, 70.3 percent accepted OHP Medicaid, and 56.8 percent accepted UHA. Why the weakness exists: In addition to limitations related to the revealed survey approach, inaccuracies found in UHA's provider data may have contributed to the low response rate and accuracy results. Recommendations: UHA should use the case-level analytic data files to address the data deficiencies identified during the survey calls (e.g., incorrect or disconnected telephone numbers; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
	Weakness: Among the total PCP and OP SUD cases reached, 51.4 percent accepted new patients. In addition, appointment availability was only offered for less than 58.0 percent of PCP cases and 44.0 percent of OP SUD cases. Of the PCP cases that offered an appointment, compliance rates ranged from 0.0 percent (new patient urgent visits) to 75.0 percent (existing patient routine visits). Of the OP SUD cases that offered an appointment, all compliance rates, except for urgent visits, resulted in low rates, which ranged from 57.1 percent (opioid use disorder visits) to 83.3 percent (routine visits). Why the weakness exists: In addition to limitations related to the revealed survey approach, inaccuracies found in UHA's provider data and insufficient provider panel capacity may have contributed to low access and availability rates (i.e., new patient acceptance, appointment availability, and wait times). Also, internal office staffing structures and procedures may have contributed to the long wait times. Recommendations: UHA should confirm appointment availability with providers, including panel capacity to accept new patients. Further, UHA should use the case-level analytic data files to address data deficiencies identified during the survey calls.	

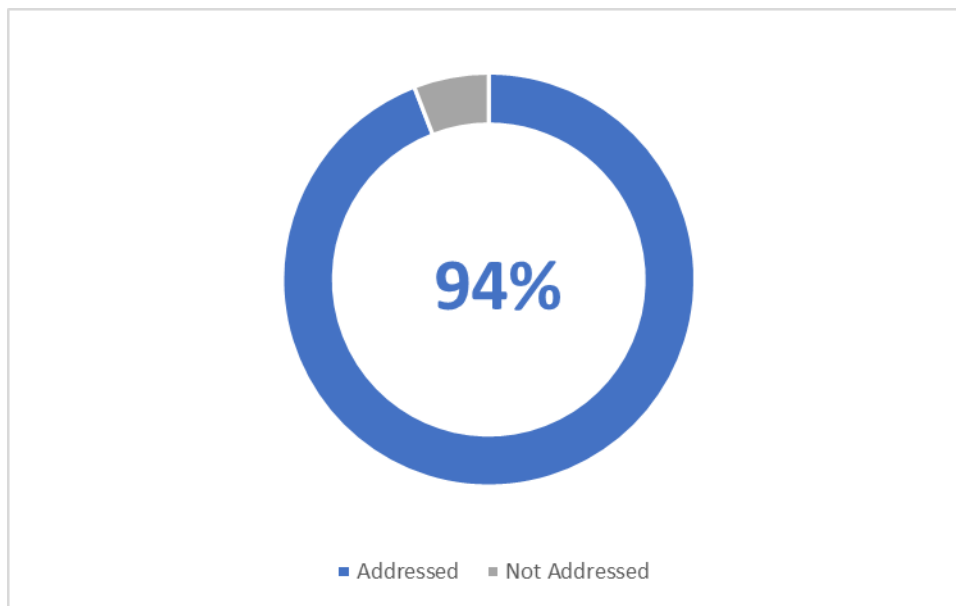
Strength/ Weakness	Description	Domain(s) ⁷⁵
Encounter Data Validation		
Since EDV results were not available for inclusion in the 2024 EQR technical report, the strengths and weaknesses for each CCO could not be assessed. The findings will be incorporated in next year's EQR technical report.		
Mental Health Parity Evaluation		
	Strength: UHA provided a detailed summary and sufficiently addressed pharmacy management NQTLs as required from the previous year's MHP Evaluation. The information provided was clearly communicated in the narrative and was accompanied by supporting documentation.	
	Weakness: UHA demonstrated that 66.0 percent of the MH/SUD grievances received were related to access issues. Why the weakness exists: Although the total number of MH/SUD grievances was low and represented only 10.2 percent of all grievances, more than half were related to access, which may highlight that the CCO has challenges ensuring timely access to MH/SUD covered services. Recommendations: UHA should review the access-related MH/SUD grievances to understand the factors that triggered the grievances and assess whether barriers exist for members accessing MH/SUD services (e.g., finding qualified in-network providers, excessive travel, or appointment availability).	

Follow-Up on Prior Year Recommendations

HSAG evaluated UHA's approach to addressing the recommendations related to findings issued during CY 2023 and unresolved findings from CY 2020, CY 2021, and CY 2022 while conducting the CY 2024 EQR activities. The CCOs not addressing recommendations are at risk of being out of compliance with their contracts.

Figure 5-30 illustrates the degree in which the CCO sufficiently addressed the recommendations for QI made by HSAG during the CY 2023 EQR.

Figure 5-30—Percentage of CY 2023 EQR Recommendations Addressed by UHA



UHA-specific CY 2023 recommendations and follow-up CY 2024 assessments are summarized in Table 5-30.

Table 5-30—Assessment of UHA’s Approach to Addressing Previous Annual Recommendations

CY 2023 Recommendation	CY 2024 Assessment
Compliance Monitoring Review	
Standard I—Assurance of Adequate Capacity and Availability of Services*	
This recommendation was initially given during the CY 2021 EQR. UHA should continue to develop processes to ensure the CCO is monitoring compliance of its provider network and corrective actions when providers fail to meet network access requirements.	UHA did not sufficiently address the recommendation. Although UHA had a process in place to monitor compliance against its provider network, the CCO did not demonstrate assessing providers’ compliance with the emergency care appointment standard for physical health providers. The CCO also did not demonstrate the appropriate corrective action when providers failed to meet network access requirements. Note: Standard I—Assurance of Adequate Capacity and Availability of Services was comprehensively reviewed during the CY 2024 CMR cycle, and recommendations addressing all findings related to this standard are included in the CCO’s individual Results and Conclusions section.

CY 2023 Recommendation	CY 2024 Assessment
Standard III—Coordination and Continuity of Care	
UHA should demonstrate assessments and reassessments, and development and revision of treatment plans according to federal and State requirements.	UHA sufficiently addressed the recommendation.
Standard IV—Coverage and Authorization of Services	
UHA should revise its policies and procedures to align with federal and State requirements. UHA should demonstrate adherence to federal and State requirements for authorization of services, and required content and time frames for providing NOABDs.	UHA sufficiently addressed the recommendation.
Standard V—Provider Selection	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard VI—Subcontractual Relationships and Delegation	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard VII—Member Rights and Protections	
UHA should revise its policies and procedures and provider-facing materials to align with federal and State requirements.	UHA sufficiently addressed the recommendation.
Standard VIII—Confidentiality	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard IX—Enrollment and Disenrollment	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Standard X—Grievance and Appeal Systems	
UHA should demonstrate adherence to federal and State requirements for time frames for acknowledging and responding to grievances and appeals and the readability of notices. UHA should also demonstrate implementation of federal and State requirements within communications to providers and subcontractors.	UHA sufficiently addressed the recommendation.

CY 2023 Recommendation	CY 2024 Assessment
Standard XI—Practice Guidelines	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard XII—Quality Assessment and Performance Improvement	
This recommendation was initially given during the CY 2022 EQR. UHA should conduct an annual assessment of activities outlined in the QAPI program description or policies, including background and rationale. This should include a discussion of goals and objectives. At a minimum, it should address key priority areas and the elements outlined in the QAPI standard.	UHA sufficiently addressed the recommendation.
Standard XIII—Health Information Systems, including ISCA	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard XIV—Member Information	
UHA should revise its member-facing materials to align with federal and State requirements.	UHA sufficiently addressed the recommendation.
Standard XVI—Emergency and Poststabilization Services	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Performance Improvement Projects	
Statewide Mental Health Service Access Monitoring PIP	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Statewide Substance Use Disorder PIP	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Performance Measure Validation	
UHA should continue efforts to raise its rate on the <i>Initiation of SUD Treatment</i> measure indicator for members ages 18 years and older to the level of the benchmark set by OHA.	UHA sufficiently addressed the recommendation. UHA reported implementing several performance improvement initiatives to improve performance. UHA developed SUD resources for care coordination, shared workflows with the Quality Metrics Subcommittee, integrated care plans into PointClickCare, engaged providers through Tiger Team meetings, optimized member identification and IET cohort

CY 2023 Recommendation	CY 2024 Assessment
	activation with PointClickCare, and worked with its CMHPs to enhance rapid access and service referrals. UHA is working to expand interpretive services for its members through interpreter training and scholarship programs, as well as increasing outreach initiatives for members who have not initiated SUD treatment. UHA should continue implementing these efforts to raise its rates on this measure to the level of the benchmarks set by OHA.
Validation of Network Adequacy	
<i>Delivery System Network Evaluation</i>	
UHA should seek technical assistance with OHA to determine the nature of the provider capacity data issues and correct them.	UHA sufficiently addressed the recommendation.
<i>Secret Shopper Survey</i>	
This recommendation was initially given during the CY 2021 EQR. HSAG recommends that UHA use the case-level analytic data files to address the data deficiencies identified during the secret shopper survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	UHA sufficiently addressed the recommendation. UHA reviewed the case-level analytic data files and directory information and addressed the data deficiencies. UHA should continue to monitor and improve any efforts in maintaining accurate provider data (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).
HSAG recommends that UHA confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. UHA should use the case-level analytic data files containing data deficiencies identified during the secret shopper survey calls.	UHA sufficiently addressed the recommendation. UHA reviewed the case-level analytic data files and addressed the data deficiencies. UHA also followed up with offices to ensure requirements and staff education are met. UHA should continue to monitor and improve any efforts in maintaining accurate provider data and compliance with wait time standards.
<i>Revealed Telephone Survey</i>	
HSAG recommends that UHA use the case-level analytic data files to address the data deficiencies identified during the revealed telephone survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, program	UHA sufficiently addressed the recommendation. UHA reviewed the case-level analytic data files and directory information and addressed the data deficiencies. UHA should continue to monitor and improve any efforts in maintaining accurate provider data (e.g., incorrect or disconnected telephone numbers; incorrect

CY 2023 Recommendation	CY 2024 Assessment
information, and translation/interpreter services offered).	addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).
HSAG recommends that UHA confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. UHA should use the case-level analytic data files containing data deficiencies identified during the revealed telephone survey calls and work with BH outpatient offices to identify the root cause for delays in appointment availability.	UHA sufficiently addressed the recommendation. UHA reviewed the case-level analytic data files and addressed the data deficiencies. UHA also followed up with offices to identify root causes of appointment delays, and provide targeted training as needed. UHA should continue to monitor and improve any efforts in maintaining accurate provider data and compliance with wait time standards.
Encounter Data Validation	
This recommendation was initially given during the CY 2021 EQR. UHA should provide more specific information on how the additional data feed and reporting have directly contributed to reducing errors associated with extracted data. Additionally, detailing any quantifiable improvements in accuracy, completeness, or timeliness of encounter data submissions would provide a clearer picture of the outcomes of the implemented initiatives. Lastly, UHA should develop a more explicit strategy for continued improvement, such as plans for addressing the identified barrier of the absence of ICNs on National Council for Prescription Drug Programs response files.	UHA sufficiently addressed the recommendation. UHA's targeted adjustments to file generation processes resolved the issue of missing ICNs, and its commitment to collaboration supports continued improvement. Quantifying the impact of these changes would further strengthen its response.
This recommendation was initially given during the CY 2022 EQR. UHA should provide more detail on the frequency and scope of the periodic MRRs. UHA should include information on the expected outcomes or goals of these reviews to help demonstrate the effectiveness of the implemented initiatives. Additionally, UHA should provide a clearer statement on the proactive measures or ongoing plans for continued improvement, even in the absence of identified barriers, to strengthen the response.	UHA sufficiently addressed the recommendation. UHA implemented structured MRR processes, hiring specialized staff, and providing education based on findings. To fully demonstrate effectiveness, UHA should conduct follow-up reviews and assess the impact of its initiatives on performance improvement.

CY 2023 Recommendation	CY 2024 Assessment
Mental Health Parity Evaluation	
UHA should identify processes, strategies, evidentiary standards, and other factors used in formulary design and the application for prescription drugs.	UHA sufficiently addressed the recommendation.
UHA should review out-of-network claim denials to understand the factors affecting the lower percentage of paid MH/SUD OP claims compared to M/S OP claims. UHA should assess whether any barriers exist for members accessing MH/SUD services, including the need to seek services outside the CCO's network (e.g., appointment availability).	UHA sufficiently addressed the recommendation.

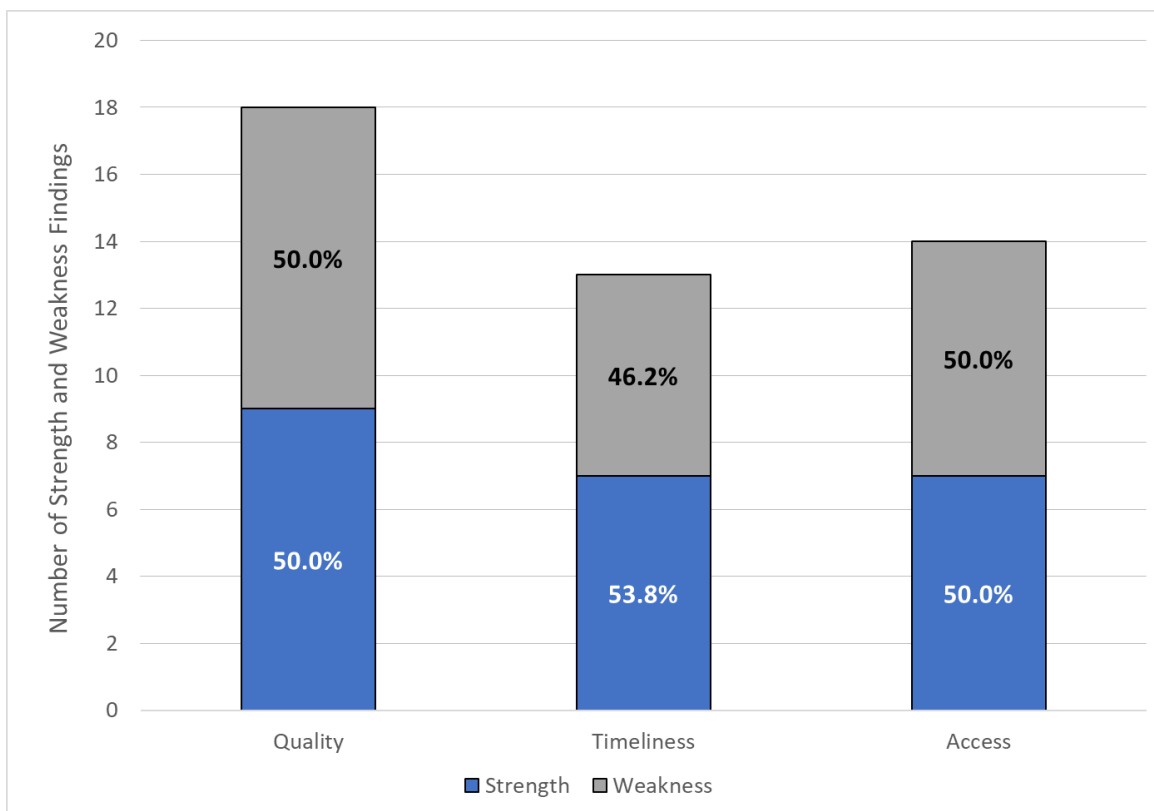
*Standard I—Availability of Services and Standard II—Assurances of Adequate Capacity and Services were combined, and all elements required by 42 CFR §438.206 and §438.207 were assessed under the combined Standard I—Assurance of Adequate Capacity and Availability of Services during the CY 2024 CMR activity.

Yamhill Community Care Organization

Results and Conclusions

HSAG assessed the strengths and weaknesses of each CCO with respect to the quality, timeliness, and accessibility of health care services. Figure 5-31 illustrates the number of strengths exhibited by YCCO relative to the number of weaknesses identified during the CY 2024 EQR activities across the three domains. The greater the proportion of weaknesses, the greater opportunities for improvement.

Figure 5-31—YCCO Overall Number of Findings (Strengths and Weaknesses) by Domain



Detailed results from the EQR’s substantive findings are summarized in Table 5-31 for each activity. This table highlights the extent to which YCCO furnishes high quality, timely, and appropriate access to health care services, and recommendations for how YCCO can best address issues identified for each activity.⁷⁶

⁷⁶ See Section 4—Comparative Statewide Results for detailed, CCO-specific scores associated with EQR activity.

Table 5-31—YCCO Substantive Findings Impacting Quality, Timeliness, and Access to Care and Services

Strength/ Weakness	Description	Domain(s) ⁷⁷
Compliance Monitoring Review		
	Strength: YCCO demonstrated best practices with its family planning, women’s health access efforts and outreach materials, which were tailored to the CCO’s population.	
	Strength: YCCO demonstrated best practices with its retention efforts through expansion of training, implementation of value-based contracts with birth doulas, pilot programs to engage and expand the workforce, and mobile dental services.	
	Strength: YCCO achieved full compliance for the <i>Practice Guidelines</i> standard, demonstrating that the CCO had established policies and procedures, along with the appropriate structure, to ensure that clinical practice guidelines were adopted, reviewed, updated, and disseminated. These guidelines took into account the needs of members and were based on evidence or on a consensus among providers in the relevant field. Additionally, decision-making was aligned with these guidelines.	
	Weakness: YCCO received a score of 84.2 percent in the <i>Assurance of Adequate Capacity and Availability of Services</i> due to insufficient documentation to support operations and ensure compliance with federal and State requirements, the inability to demonstrate sufficient implementation of established processes, and deficiencies within its monitoring activities impacting the CCO’s ability to ensure timely access to care and services. Why the weakness exists: YCCO lacked a methodology for monitoring and maintaining its provider network for the federal and State required components. Additionally, the policies and procedures implemented did not fully align with state-established time and distance monitoring requirements, provision of services in a culturally and linguistically appropriate manner, and provision of access, accommodations, and equipment for members with physical and mental disabilities. The CCO also failed to demonstrate a process for appropriate monitoring of state-established appointment standards and taking corrective action when providers fail to meet appointment standards. Recommendations: YCCO should develop and implement a methodology for monitoring and maintaining its provider network for the federal and state-required components. Additionally, the CCO should revise its policies and procedures to align with state-established requirements for timely access to care and services and demonstrate	

⁷⁷  = Quality,  = Timeliness,  = Access

Strength/ Weakness	Description	Domain(s) ⁷⁷
	implementation. The CCO should also demonstrate corrective action when providers fail to meet appointment standards.	
—	Weakness: YCCO received a score of 91.7 percent in the <i>Provider Selection</i> standard due to insufficient documentation to support operations and ensure compliance with federal and State requirements, impacting the CCO’s ability to meet federal and State requirements for retention of providers. Why the weakness exists: Although YCCO demonstrated implementing retention efforts, the CCO lacked written policies and procedures for retaining network providers. Recommendations: The CCO should develop written policies and procedures for retaining providers.	 
—	Weakness: YCCO received a score of 87.5 percent in the <i>Subcontractual Relationships and Delegation</i> standard due to insufficient documentation to support operations and ensure compliance with federal requirements for written agreements between the CCO and its subcontractors. Why the weakness exists: YCCO’s contracts with the subcontractors failed to include federally required language for written agreements with subcontractors. Recommendations: YCCO should revise its written agreements to align with federally required language for written agreements with subcontractors.	
Performance Improvement Projects		
Statewide Mental Health Service Access Monitoring PIP		
+	Strength: YCCO identified and analyzed barriers to improving MH service access, carried out interventions to address those barriers, and refined interventions based on intervention evaluation results.	
+	Strength: YCCO’s RY 2 performance indicator results demonstrated statistically significant improvement in MH service access compared to baseline indicator results.	 
—	Weakness: YCCO’s narrative interpretation of indicator results lacked clarity and accuracy. Why the weakness exists: YCCO did not address all feedback on the narrative interpretation of results that HSAG provided in the initial validation tool. Recommendations: YCCO should correct and simplify the narrative interpretation of results for each measurement period to align with the corrected data in the indicator results table prior to next year’s annual PIP validation.	

Strength/ Weakness	Description	Domain(s) ⁷⁷
Statewide Substance Use Disorder PIP		
	Strength: YCCO accurately reported baseline and RY 1 performance indicator data; identified and analyzed barriers for initiation, engagement, and treatment of alcohol and other drug use disorders; and began to carry out interventions to address those barriers.	
	Weakness: YCCO received a <i>Low Confidence</i> rating for overall confidence that the <i>Substance Use Disorder</i> PIP achieved significant improvement. Why the weakness exists: YCCO's improvement in Indicator 1 (<i>Percentage of new SUD episodes that result in treatment and initiation within 14 days</i>) result from baseline to RY 1 was not statistically significant. In addition, the CCO's performance for Indicator 2 (<i>Percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation</i>) declined from BY to RY 1. Recommendations: YCCO should revisit root cause analyses identifying barriers to improving initiation, engagement, and treatment of alcohol and other drug use disorders to determine which barriers to improvement were not effectively addressed. YCCO should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to further improve the percentage of new SUD episodes that result in treatment and initiation within 14 days and the percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation indicator results.	
Performance Measure Validation		
	Strength: YCCO's MY 2023 performance on the <i>Child and Adolescent Well-Care Visits—Ages 3 to 6 Years</i> measure indicator demonstrated ongoing improvement since MY 2021. YCCO's performance measure rate increased by 5 percentage points or more from the prior year (5.1 percentage points). In addition, the CCO's MY 2023 rate for this measure exceeded the statewide aggregate set by OHA for MY 2023 by 5 percentage points or more.	
	Strength: YCCO's MY 2023 rate on the <i>Initiation of SUD Treatment</i> measure indicator for members ages 13 to 17 years increased by 5 percentage points or more (11.1 percentage points). Though no benchmark was set for this age group, YCCO exceeded the statewide aggregate by 5 percentage points or more for MY 2023 (8.1 percentage points).	
	Strength: YCCO's MY 2023 performance on the <i>Members Receiving Preventive Dental or Oral Health Services—Ages 6 to 14 Years</i> measure indicator demonstrated ongoing improvement since MY 2021. The performance on the <i>Members Receiving Preventive Dental or Oral</i>	

Strength/ Weakness	Description	Domain(s) ⁷⁷
	<i>Health Services—Ages 1 to 5 Years</i> measure indicator improved by 5 percentage points or more (8.4 percentage points) from MY 2022. In addition, the CCO’s MY 2023 rate for both age groups exceeded the benchmarks set by OHA for MY 2023 by 5 percentage points or more; 9.5 percentage points for members ages 1 to 5 years and 5.1 percentage points for members ages 6 to 14 years.	
	Strength: YCCO’s MY 2023 performance on the <i>Oral Evaluation for Adults With Diabetes</i> measure demonstrated ongoing improvement since MY 2021 with a percentage increase of 5 percentage points or more (5.6 percentage points) since MY 2022.	
	Weakness: YCCO’s MY 2023 rate on the <i>Initiation and Engagement of SUD Treatment</i> for both measure indicators for members ages 18 years and older fell below the benchmark set by OHA for MY 2023. Why the weakness exists: In response to EQR recommendations, YCCO noted several barriers in meeting performance measure benchmarks for this metric. Challenges noted include ongoing impact from the COVID-19 PHE, delays in notification of initial SUD diagnosis, geographic disparities (i.e., transportation limitations and limited access to care in rural areas), and staffing shortages in provider clinics. Recommendations: YCCO reported performing a root cause analysis which identified many potential barriers to improving the <i>Initiation and Engagement of SUD Treatment</i> measure. YCCO prioritized barriers based on impact and inclusion with PIP initiatives. YCCO reported refining the Service Directory to ensure information more effectively connected members to SUD services. YCCO updated the Contract Request form to increase its ability to gather critical information to inform the decision-making for adding new SUD and co-occurring providers to the network. Additionally, YCCO created <i>Initiation and Engagement of SUD Treatment</i> project educational materials for providers to increase awareness and understanding. On a larger scale, YCCO participated in state-level activities to expand telehealth services in the State of Oregon. YCCO should continue implementing these efforts to continue raising its rates on this measure to the benchmarks set by OHA.	
Validation of Network Adequacy		
Network Adequacy Validation Audit		
The CCO met performance expectations. No significant strengths or weaknesses were noted during the review.		

Strength/ Weakness	Description	Domain(s) ⁷⁷
Delivery System Network Evaluation		
	Strength: YCCO demonstrated substantial annual improvements to its <i>DSN Provider Narrative Template</i> submission since 2022, both in terms of the overall quality of submitted documentation and the implementation of fundamental operations reforms. YCCO has shown strong commitment to improvement and responds quickly and well to feedback. As a result, in a few years YCCO has moved from the bottom quartile of overall <i>DSN Provider Narrative Template</i> scores to the top quartile.	
	Weakness: YCCO showed potential issues within its provider data, including but not limited to provider counts, service area operations, and status of accepting new patients. Why the weakness exists: YCCO's provider data showed substantial changes in basic data elements, including but not limited to provider counts, location of operations, and new patient acceptance rates. These issues were also identified in CY 2023, and were identified by the CCO as having a root cause in subcontractor data quality issues. Recommendations: YCCO should implement its plan to bring all data management in house by 2025, and should contact OHA for technical assistance, as necessary.	
	Weakness: YCCO did not meet the facility network adequacy standard for MTD providers. Why the weakness exists: YCCO did not meet the facility network adequacy standards for MTD providers since it did not have any contracted MTD providers within its network. Additionally, YCCO did not engage in OHA's time and distance exception request process. It is expected that the CCO have at least one provider of all monitored types within its network, regardless of compliance with time and distance standard compliance, rather than rely on single case agreements or similar methods. Recommendations: YCCO should ensure that it takes the necessary steps to maintain an adequate network that can provide all covered and necessary care. The CCO should work to contract with at least one provider or facility of each missing type that can supply such services as part of the CCO's network, even if that provider is not within the service region. Such providers should still be meaningfully accessible through regional transportation (e.g., driving to a nearby population center). The CCO should engage with OHA on potential solutions for these needs via the time and distance exception request process.	
Revealed Telephone Survey		
	Strength: Of the total PCP and OP SUD cases that accepted the CCO, 97.4 percent of cases offered translation or interpreter services.	

Strength/ Weakness	Description	Domain(s) ⁷⁷
	Weakness: Overall, 59.3 percent of the total PCP and OP SUD sampled cases were reached. Among the cases reached, 81.4 percent confirmed the correct location, 62.8 percent offered the requested services, 54.3 percent accepted OHP Medicaid, and 20.7 percent accepted YCCO. Why the weakness exists: In addition to limitations related to the revealed survey approach, inaccuracies found in YCCO's provider data may have contributed to the low response rate and accuracy results. Recommendations: YCCO should use the case-level analytic data files to address the data deficiencies identified during the survey calls (e.g., incorrect or disconnected telephone numbers; incorrect location; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	
	Weakness: Among the total PCP and OP SUD cases reached, only 15.4 percent accepted new patients. In addition, appointment availability was only offered for less than 12.0 percent of PCP cases and 13.0 percent of OP SUD cases. Of the PCP appointments that were offered, compliance rates ranged from 28.6 percent (new patient urgent visits) to 76.9 percent (existing patient urgent visits). Also, of the OP SUD appointments that were offered, compliance rates ranged from 62.5 percent (routine visits) to 75.0 percent (urgent and opioid use disorder visits). Why the weakness exists: In addition to limitations related to the revealed survey approach, inaccuracies found in YCCO's provider data and insufficient provider panel capacity may have contributed to low access and availability rates (i.e., new patient acceptance, appointment availability, and wait times). Also, internal office staffing structures and procedures may have contributed to the long wait times. Recommendations: YCCO should confirm appointment availability with providers, including panel capacity to accept new patients. Further, YCCO should use the case-level analytic data files to address data deficiencies identified during the survey calls.	
Encounter Data Validation		
Since EDV results were not available for inclusion in the 2024 EQR technical report, the strengths and weaknesses for each CCO could not be assessed. The findings will be incorporated in next year's EQR technical report.		
Mental Health Parity Evaluation		
	Weakness: YCCO demonstrated 100 percent of MH/SUD Rx denial decisions were overturned at the appeal level. Why the weakness exists: Although the total number of appeals was low (i.e., seven), the fact that 100 percent of the denial decisions were overturned at the appeal level may highlight issues with potentially	

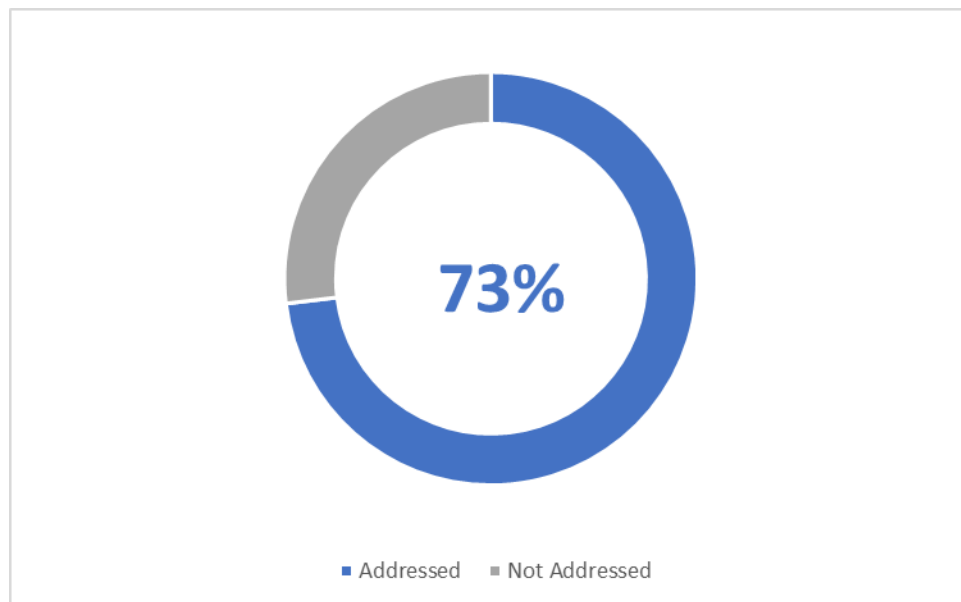
Strength/ Weakness	Description	Domain(s) ⁷⁷
	ineffective PA processes and/or individuals making inappropriate decisions. Recommendations: YCCO should review MH/SUD Rx appeals to understand the factors affecting the 100 percent overturn rate. The CCO should review PA criteria and/or decision-making processes and make appropriate changes to ensure appropriate access to MH/SUD Rx services.	

Follow-Up on Prior Year Recommendations

HSAG evaluated YCCO’s approach to addressing the recommendations related to findings issued during CY 2023 and unresolved findings from CY 2020, CY 2021, and CY 2022 while conducting the CY 2024 EQR activities. The CCOs not addressing recommendations are at risk of being out of compliance with their contracts.

Figure 5-32 illustrates the degree in which the CCO sufficiently addressed the recommendations for QI made by HSAG during the CY 2023 EQR.

Figure 5-32—Percentage of CY 2023 EQR Recommendations Addressed by YCCO



YCCO-specific CY 2023 recommendations and follow-up CY 2024 assessments are summarized in Table 5-32.

Table 5-32—Assessment of YCCO’s Approach to Addressing Previous Annual Recommendations

CY 2023 Recommendation	CY 2024 Assessment
Compliance Monitoring Review	
Standard I—Assurance of Adequate Capacity and Availability of Services*	
This recommendation was initially given during the CY 2021 EQR. YCCO should continue to develop processes to ensure the CCO is monitoring compliance of its provider network and corrective actions when providers fail to meet network access requirements.	YCCO did not sufficiently address the recommendation. YCCO did not demonstrate a process to assess compliance with standards for timeliness of appointment availability, nor did the CCO demonstrate a process for corrective action when providers failed to meet standards. Note: Standard I—Assurance of Adequate Capacity and Availability of Services was comprehensively reviewed during the CY 2024 CMR cycle, and recommendations addressing all findings related to this standard are included in the CCO’s individual Results and Conclusions section.
Standard III—Coordination and Continuity of Care	
YCCO should demonstrate implementation of appropriate assessments, reassessments, and revision of treatment plans according to federal and State requirements. YCCO should also implement mechanisms to ensure the appropriate maintenance of medical records in accordance with professional standards.	YCCO did not sufficiently address the recommendation. YCCO demonstrated efforts to communicate its standards for medical record maintenance and sharing for its BH providers; however, the CCO could not demonstrate this occurred for all providers. Additionally, the CCO has begun developing workflows for conducting the appropriate assessments, reassessments, and treatment plans; however, the CCO could not demonstrate policies and procedures that aligned with the federal and State requirements. YCCO should demonstrate implementation of appropriate assessments, reassessments, and revision of treatment plans according to federal and State requirements. YCCO should also implement mechanisms to ensure the appropriate maintenance of medical records in accordance with professional standards for all providers.
Standard IV—Coverage and Authorization of Services	
This recommendation was initially given during the CY 2020 EQR. YCCO should revise its policies to specify the appropriate time frames for processing PA requests. In addition, YCCO should revise its policies and procedures to align with federal and State requirements. YCCO should demonstrate adherence to federal and State requirements for authorization of services and	YCCO did not sufficiently address the recommendation. YCCO’s policies and procedures continued to be out of alignment with federal and State requirements, and YCCO did not demonstrate sufficient action to ensure compliance with requirements for processing PA requests. YCCO should revise its policies and procedures to align with State and federal PA

CY 2023 Recommendation	CY 2024 Assessment
required content and time frames for providing NOABDs.	processing requirements and implement sufficient oversight mechanisms to ensure CCO and subcontractor adherence with all requirements.
Standard V—Provider Selection	
This recommendation was initially given during the CY 2021 EQR. YCCO should ensure its credentialing program complies with requirements for credentialing THWs; adequate oversight of its credentialing subcontractors; and appropriate training of CCO staff and participating providers and their staff regarding the delivery of covered services, applicable administrative rules, and the CCO’s administrative policies.	Not Applicable. The recommendation was tied to a state-specific element that was removed from HSAG’s review.
Standard VI—Subcontractual Relationships and Delegation	
This recommendation was initially given during the CY 2021 EQR. YCCO should ensure compliance with contractual requirements to implement corrective action for subcontractors when deficiencies are identified as part of the annual audit and report corrective actions within the annual Subcontractor Performance Report.	Not Applicable. The recommendation was tied to a state-specific element that was removed from HSAG’s review.
Standard VII—Member Rights and Protections	
YCCO should revise its policies and procedures to align with federal and State requirements.	YCCO sufficiently addressed the recommendation.
Standard VIII—Confidentiality	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard IX—Enrollment and Disenrollment	
This recommendation was initially given during the CY 2022 EQR. YCCO should revise its policies and procedures, member-facing documents, and training provided to staff to align with federal and State requirements. YCCO should also demonstrate oversight and monitoring of disenrollment reasons to ensure compliance with the regulatory requirements.	YCCO did not sufficiently address the recommendation. YCCO revised its internal documents to align with federal and State requirements. However, the CCO could not demonstrate oversight and monitoring of disenrollment reasons to ensure compliance with the regulatory requirements. YCCO should demonstrate oversight and monitoring of disenrollment reasons to ensure compliance with the regulatory requirements.

CY 2023 Recommendation	CY 2024 Assessment
Standard X—Grievance and Appeal Systems	
YCCO should revise its policies and procedures to align with federal and State requirements. YCCO should demonstrate adherence to federal and State requirements for time frames for acknowledging and responding to grievances and appeals and the readability of notices. YCCO should also demonstrate implementation of federal and State requirements within communications to providers and subcontractors.	YCCO did not sufficiently address the recommendation. YCCO did not demonstrate communicating all federal and State requirements regarding information on the grievance, appeal, and contested case hearing system to providers and subcontractors. The CCO also could not demonstrate oversight for federal requirements for denials of expedited resolution requests. YCCO also did not demonstrate that it ensures that decision-makers on grievances and appeals are individuals with the appropriate expertise. YCCO should demonstrate implementation of federal and State requirements within communications to providers and subcontractors. YCCO should also ensure alignment with federal and State requirements within its processes for decision-makers and responding to grievances and appeals.
Standard XI—Practice Guidelines	
This standard was not assessed during the 2023 CMR.	Not applicable.
Standard XII—Quality Assessment and Performance Improvement	
This recommendation was initially given during the CY 2022 EQR. YCCO should ensure its QAPI program oversight includes ensuring corrective actions needed are addressed and documented within meeting minutes.	YCCO sufficiently addressed the recommendation.
Standard XIII—Health Information Systems, including ISCA	
This recommendation was initially given during the CY 2022 EQR. YCCO should amend or develop policies and procedures that describe the collection and reporting of required data, as well as oversight processes for monitoring data submissions from BH providers. YCCO should implement and ensure staff are trained and knowledgeable about these defined processes, including the documentation of all oversight activities and follow-up actions taken when issues are identified.	Not applicable. The recommendation was tied to a state-specific element that was removed from HSAG’s review.

CY 2023 Recommendation	CY 2024 Assessment
Standard XIV—Member Information	
This recommendation was initially given during the CY 2020 EQR. YCCO’s provider directory continued to omit required elements. YCCO should ensure both its paper and electronic versions of its provider directory include all federal and State requirements. In addition, YCCO should revise its policies, procedures, and member-facing materials to align with federal and State requirements.	YCCO did not sufficiently address the recommendation. YCCO’s policies and procedures and member materials did not align with federal and State requirements for information on the CCO’s structure, operations, and physician incentive plans; member notification of significant changes; and required format. Additionally, YCCO’s provider directory continued to omit required elements. YCCO should ensure both its paper and electronic versions of its provider directory include all federal and State requirements. In addition, YCCO should revise its policies, procedures, and member-facing materials to align with federal and State requirements.
Standard XVI—Emergency and Poststabilization Services	
YCCO should revise its policies and procedures to align with federal and State requirements.	YCCO sufficiently addressed the recommendation.
Performance Improvement Projects	
Statewide Mental Health Service Access Monitoring PIP	
This recommendation was initially given during the CY 2022 EQR. YCCO should correct the baseline indicator data and report statistical testing results, seeking additional technical assistance, if needed, prior to next year’s annual PIP validation.	YCCO sufficiently addressed the recommendation.
YCCO should ensure all indicator data and statistical testing results are accurately and consistently reported throughout the PIP documentation.	YCCO did not sufficiently address the recommendation. Although the CCO corrected reporting of the overall indicator data in the PIP submission for the most recent validation cycle, the narrative interpretation of results continued to include erroneous and unclear documentation. Prior to next year’s PIP validation, the CCO should ensure the narrative interpretation of results correctly addresses all documentation requirements identified in the final 2024 PIP Validation Tool.
YCCO should ensure statistical testing used to compare baseline and remeasurement results is appropriate and accurate.	YCCO sufficiently addressed the recommendation.

CY 2023 Recommendation	CY 2024 Assessment
In the narrative interpretation of results, YCCO should address whether factors were identified that may threaten the validity of the results or the ability to compare the baseline and remeasurement results.	YCCO sufficiently addressed the recommendation.
YCCO should revisit root cause analyses identifying barriers to improving access to MH services to determine which barriers to improvement were not effectively addressed. YCCO should use intervention-specific evaluation results and updated barrier analyses to identify new or revised interventions with the potential to improve indicator results.	YCCO sufficiently addressed the recommendation.
Statewide Substance Use Disorder PIP	
The CCO met performance expectations; no recommendations were provided in 2023.	Not applicable.
Performance Measure Validation	
YCCO should conduct root cause analyses to identify specific factors affecting performance on the <i>Initiation of SUD Treatment</i> measure indicator for members ages 18 years and older and develop, implement, and evaluate targeted interventions to ensure improvement strategies are adopted. Additionally, YCCO should monitor its provider network to identify gaps in access to care and work with providers to identify alternative approaches for ensuring the timeliness and accessibility of health care services (e.g., telehealth strategies, mobile clinics).	YCCO sufficiently addressed the recommendation. YCCO addressed the recommendations provided by HSAG and continued its efforts to improve performance in this measure, which included performing a root cause analysis that identified many potential barriers to improving the <i>Initiation and Engagement of SUD Treatment</i> measure, prioritizing barriers based on impact and inclusion with PIP initiatives, and refining the Service Directory to ensure information more effectively connects members to SUD services. YCCO also reported that it updated the Contract Request form to increase its ability to gather critical information to inform the decision-making for adding new SUD and co-occurring providers to the network. Additionally, YCCO created <i>Initiation and Engagement of SUD Treatment</i> project educational materials for providers to increase awareness and understanding. On a larger scale, YCCO participated in state-level activities to expand telehealth services in the State of Oregon. YCCO should continue implementing these efforts to continue raising its rates on this measure to the benchmarks set by OHA.

CY 2023 Recommendation	CY 2024 Assessment
Validation of Network Adequacy	
Delivery System Network Evaluation	
This recommendation was initially given during the CY 2022 EQR. YCCO should reevaluate its current mechanisms to monitor provider directory accuracy and appointment availability and implement processes to improve access to care for members.	YCCO sufficiently addressed the recommendation. YCCO demonstrated, via supporting documentation and narrative responses, that it has taken steps to improve its methods for ensuring provider directory accuracy, including but not limited to use of case-level analytic data files from the secret shopper survey. YCCO demonstrated, via its provider narrative and supporting documentation, a process for monitoring appointment availability. YCCO should continue to monitor and improve any efforts in maintaining accurate provider data and compliance with wait time standards.
YCCO should seek technical assistance with OHA to determine the nature of the provider capacity data issues and correct them.	YCCO sufficiently addressed the recommendation. YCCO described and demonstrated expansion of its network data team as well as fully moving the responsibilities of data collection, warehousing, and reporting from subcontractors to in-house operations beginning January 1, 2025. While these improvements were described in detail, YCCO should continue to ensure that implementation of its data management strategy will improve its provider data collection, monitoring, use, and reporting.
Secret Shopper Survey	
HSAG recommends that YCCO use the case-level analytic data files to address the data deficiencies identified during the secret shopper survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	YCCO sufficiently addressed the recommendation. YCCO reviewed the case-level analytic data files and addressed the data deficiencies. YCCO should continue to monitor and improve any efforts in maintaining accurate provider data (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).
HSAG recommends that YCCO confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. YCCO should use the case-level analytic data files containing data	YCCO sufficiently addressed the recommendation. YCCO reviewed the case-level analytic data files and addressed the data deficiencies. YCCO also reported that it conducted monitoring activities to track wait time compliance and provider data accuracy. YCCO

CY 2023 Recommendation	CY 2024 Assessment
deficiencies identified during the secret shopper survey calls.	should continue to monitor and improve any efforts in maintaining accurate provider data and compliance with wait time standards.
Revealed Telephone Survey	
HSAG recommends that YCCO use the case-level analytic data files to address the data deficiencies identified during the revealed telephone survey calls (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).	YCCO sufficiently addressed the recommendation. YCCO reviewed the case-level analytic data files and addressed the data deficiencies. YCCO should continue to monitor and improve any efforts in maintaining accurate provider data (e.g., incorrect or disconnected telephone numbers; incorrect addresses; and provider specialty information that does not correspond to the sampled location, plan name, and program information).
HSAG recommends that YCCO confirm appointment availability and scheduling procedures with providers, including panel capacity to accept new patients. YCCO should use the case-level analytic data files containing data deficiencies identified during the revealed telephone survey calls and work with BH outpatient offices to identify the root cause for delays in appointment availability.	YCCO sufficiently addressed the recommendation. YCCO reviewed the case-level analytic data files and addressed the data deficiencies. YCCO also reported that it conducted monitoring activities to track wait time compliance and provider data accuracy. YCCO should continue to monitor and improve any efforts in maintaining accurate provider data and compliance with wait time standards.
Encounter Data Validation	
This recommendation was initially given during the CY 2021 EQR. YCCO should provide more details on the specific procedures implemented for monitoring and validation. YCCO should include information on the accuracy and completeness rates achieved through these initiatives to help demonstrate their effectiveness. Additionally, YCCO should provide a more explicit statement on the ongoing commitment to improvement, perhaps outlining specific areas of focus or key performance indicators for monitoring to strengthen the response.	YCCO sufficiently addressed the recommendation. YCCO implemented detailed monitoring and validation procedures. Demonstrating specific accuracy and completeness rates and assessing the effectiveness of its initiatives in future submissions would further strengthen its response.
This recommendation was initially given during the CY 2022 EQR. YCCO should consider providing additional details on how it plans to monitor and evaluate the effectiveness of these contractual provisions once they become effective in 2024. YCCO should include specific metrics or indicators related to compliance and	YCCO sufficiently addressed the recommendation. YCCO implemented a clear policy, effective resolution strategies, and proactive support for providers. Including specific metrics or indicators to evaluate the effectiveness of these initiatives would further strengthen its response.

CY 2023 Recommendation	CY 2024 Assessment
improvements in responding to medical record requests.	
This recommendation was initially given during the CY 2022 EQR. YCCO should consider providing additional details on the specific criteria or focus areas of the MRR audits, as well as any plans for continuous monitoring and improvement based on the findings from these reviews. This could include specifying how the education and training efforts will be tailored to address identified issues.	YCCO sufficiently addressed the recommendation. YCCO implemented clear policies, effective mitigation strategies, and proactive support for providers. Tailoring education and training to audit findings would further enhance its response and continuous improvement efforts.
Mental Health Parity Evaluation	
YCCO should identify all treatment limitations applied to MH/SUD benefits.	YCCO sufficiently addressed the recommendation.
YCCO should review out-of-network claim denials to understand the factors affecting the lower percentages of paid MH/SUD IP and OP claims compared to M/S IP and OP claims. YCCO should assess whether any barriers exist for members accessing MH/SUD services, including the need to seek services outside the CCO's network (e.g., appointment availability).	YCCO sufficiently addressed the recommendation.

*Standard I—Availability of Services and Standard II—Assurances of Adequate Capacity and Services were combined, and all elements required by 42 CFR §438.206 and §438.207 were assessed under the combined Standard I—Assurance of Adequate Capacity and Availability of Services during the CY 2024 CMR activity.

Appendix A. Compliance Monitoring Review Results

Table A-1 provides a summary of the Oregon CCOs' CMR scores and the statewide CCO compliance score for 42 CFR Part 438, sections 56, 100, 114, Subpart D, and QAPI standards reviewed during the past three reporting cycles (2021–2022, 2022–2023, and 2023–2024).

Table A-1—CMR Summary of Results for the Past Three Reporting Cycles (2021–2022, 2022–2023, and 2023–2024)

Standard	Standard VIII— Confidentiality 438.224	Standard IX— Enrollment and Disenrollment 438.3; 438.56	Standard XII— Quality Assessment and Performance Improvement 438.330	Standard XIII—Health Information Systems 438.242	ISCA Review	Standard III— Coordination and Continuity of Care 438.208	Standard IV— Coverage and Authorization of Services 438.210	Standard VII— Member Rights and Protections 438.100- 438.102	Standard X— Grievance and Appeal Systems 438.228; 438.400– 438.424	Standard XIV— Member Information 438.10	Standard XVI— Emergency and Poststabilization Services 438.114	Standard I— Assurance of Adequate Capacity and Availability of Services 438.206 & 438.207	Standard V— Provider Selection 438.214	Standard VI— Subcontractual Relationships and Delegation 438.230	Standard XI—Practice Guidelines 438.236
Year of Review	2022					2023						2024			
CCOs															
AH	100%	67%	75%	94%	100%	72.2%	63.9%	90.0%	79.6%	84.1%	70.8%	86.8%	91.7%	87.5%	100%
AllCare	100%	67%	75%	89%	94.4%	88.9%	75.0%	60.0%	85.2%	70.5%	87.5%	71.7%	75.0%	62.5%	100%
CHA	100%	67%	81%	89%	100%	72.2%	86.1%	70.0%	81.5%	65.9%	83.3%	71.1%	58.3%	62.5%	83.3%
CPCCO	100%	33%	38%	89%	100%	88.9%	69.4%	50.0%	87.0%	68.2%	83.3%	76.3%	75.0%	87.5%	83.3%
EOCCO	100%	67%	88%	100%	94.4%	83.3%	77.8%	70.0%	85.2%	79.5%	83.3%	89.5%	83.3%	87.5%	16.7%
HSO	100%	58%	75%	89%	94.4%	44.4%	44.4%	60.0%	77.8%	68.2%	62.5%	55.3%	58.3%	75.0%	33.3%
IHN	100%	58%	94%	89%	100%	88.9%	61.1%	70.0%	85.2%	86.4%	66.7%	89.5%	91.7%	75.0%	100%
JCC	100%	33%	38%	89%	100%	88.9%	69.4%	50.0%	87.0%	68.2%	83.3%	76.3%	75.0%	87.5%	83.3%
PCS-CO	100%	75%	94%	100%	94.4%	94.4%	75.0%	70.0%	88.9%	90.9%	87.5%	89.5%	83.3%	75.0%	83.3%
PCS-CG	100%	75%	94%	100%	94.4%	88.9%	77.8%	70.0%	88.9%	90.9%	87.5%	89.5%	83.3%	75.0%	83.3%
PCS-LN	100%	75%	94%	100%	94.4%	88.9%	72.2%	70.0%	87.0%	90.9%	87.5%	89.5%	83.3%	75.0%	83.3%
PCS-MP	100%	75%	94%	100%	94.4%	88.9%	75.0%	70.0%	88.9%	90.9%	87.5%	89.5%	83.3%	75.0%	83.3%
TCHP-SW	100%	67%	81%	89%	100%	94.4%	61.1%	70.0%	83.3%	77.3%	100%	86.8%	75.0%	87.5%	100%
TCHP-TC	100%	67%	81%	89%	100%	94.4%	61.1%	70.0%	85.2%	77.3%	100%	86.8%	75.0%	87.5%	100%
UHA	100%	75%	69%	100%	100%	94.4%	86.1%	90.0%	92.6%	93.2%	100%	78.9%	66.7%	87.5%	100%
YCCO	100%	67%	94%	89%	100%	88.9%	66.7%	80.0%	79.6%	77.3%	95.8%	84.2%	91.7%	87.5%	100%
Statewide CCO Compliance Score	100%	64%	79%	93%	98.8%	85.1%	70.1%	69.4%	85.2%	80.0%	85.4%	81.9%	78.1%	79.7%	83.3%

Appendix B. Summary of Unresolved Compliance Review Findings

Table B-1 shows the number of unresolved compliance review findings for each CCO and overall statewide totals from the past three reporting cycles based on HSAG’s assessment of the CCOs’ improvement plans during the CY 2024 CMR activity.⁷⁸

Table B-1—CMR Summary of Unresolved Compliance Review Findings from the Past Three Reporting Cycles (2020–2021, 2021–2022, and 2022–2023)

Standard	Standard I— Availability of Services 438.206	Standard II— Assurances of Adequate Capacity and Services 438.207	Standard V—Provider Selection 438.12; 438.214	Standard VI— Subcontractual Relationships and Delegation 438.230	Standard XI— Practice Guidelines 438.236	Standard VIII— Confidentiality 438.224	Standard IX— Enrollment and Disenrollment 438.3; 438.56	Standard XII— Quality Assessment and Performance Improvement 438.330	Standard XIII—Health Information Systems 438.242	Standard III— Coordination and Continuity of Care 438.208	Standard IV— Coverage and Authoriza- tion of Services 438.210	Standard VII— Member Rights and Protections 438.100- 438.102	Standard X— Grievance and Appeal Systems 438.228; 438.400– 438.424	Standard XIV— Member Information 438.10	Standard XVI— Emergency and Poststabilization Services 438.114	Total Number of CMR Findings Remaining Unresolved
Year of Review	2021					2022				2023						2024
CCOs																
AH	1	1	NA	NA	NA	NA	0	0	NA	0	9	0	0	1	0	12
AllCare	3	NA	NA	NA	NA	NA	NA	0	NA	0	2	1	3	2	0	11
CHA	2	NA	1	NA	NA	NA	0	0	NA	1	0	0	1	4	0	9
CPCCO	1	1	NA	NA	NA	NA	0	3	NA	0	5	3	2	6	0	21
EOCCO	NA	NA	NA	NA	NA	NA	0	1	NA	1	0	0	0	4	0	6
HSO	9	2	NA	NA	NA	NA	0	1	NA	7	13	2	9	11	5	59
IHN	NA	NA	NA	NA	NA	NA	0	0	NA	0	4	0	0	1	5	10
JCC	1	1	NA	NA	NA	NA	0	3	NA	0	5	3	2	6	0	21
PCS-CO	1	NA	NA	NA	NA	NA	NA	NA	NA	0	1	0	0	1	0	3
PCS-CG	1	NA	NA	NA	NA	NA	NA	NA	NA	0	1	0	0	1	0	3
PCS-LN	1	NA	NA	NA	NA	NA	NA	NA	NA	0	1	0	0	1	0	3
PCS-MP	1	NA	NA	NA	NA	NA	NA	NA	NA	0	1	0	0	1	0	3
TCHP-SW	1	0	NA	NA	NA	NA	1	0	NA	0	3	0	0	1	NA	6
TCHP-TC	1	0	NA	NA	NA	NA	1	0	NA	0	3	0	0	1	NA	6
UHA	1	NA	NA	NA	NA	NA	NA	0	NA	0	0	0	0	0	NA	1

⁷⁸ See Section 5 CCO Individual Plan Results and Conclusions for detailed, plan-specific findings associated with each standard.

Standard	Standard I— Availability of Services 438.206	Standard II— Assurances of Adequate Capacity and Services 438.207	Standard V—Provider Selection 438.12; 438.214	Standard VI— Subcontractual Relationships and Delegation 438.230	Standard XI— Practice Guidelines 438.236	Standard VIII— Confidentiality 438.224	Standard IX— Enrollment and Disenrollment 438.3; 438.56	Standard XII— Quality Assessment and Performance Improvement 438.330	Standard XIII—Health Information Systems 438.242	Standard III— Coordination and Continuity of Care 438.208	Standard IV— Coverage and Authoriza tion of Services 438.210	Standard VII— Member Rights and Protections 438.100- 438.102	Standard X— Grievance and Appeal Systems 438.228; 438.400– 438.424	Standard XIV— Member Information 438.10	Standard XVI— Emergency and Poststabilization Services 438.114	Total Number of CMR Findings Remaining Unresolved
YCCO	1	NA	NA	NA	NA	NA	1	0	NA	2	8	0	3	5	1	21
Statewide Number of Unresolved CCO CMR Findings	25	5	1	NA	NA	NA	3	8	NA	11	56	9	20	46	11	195

NA =Not Applicable. The CCO had no unresolved findings for the standard during the CY 2024 CMR of CCO improvement plans.