CCO PERFORMANCE SNAPSHOT

Individual Profile

Advanced Health

OREGON HEALTH AUTHORITY

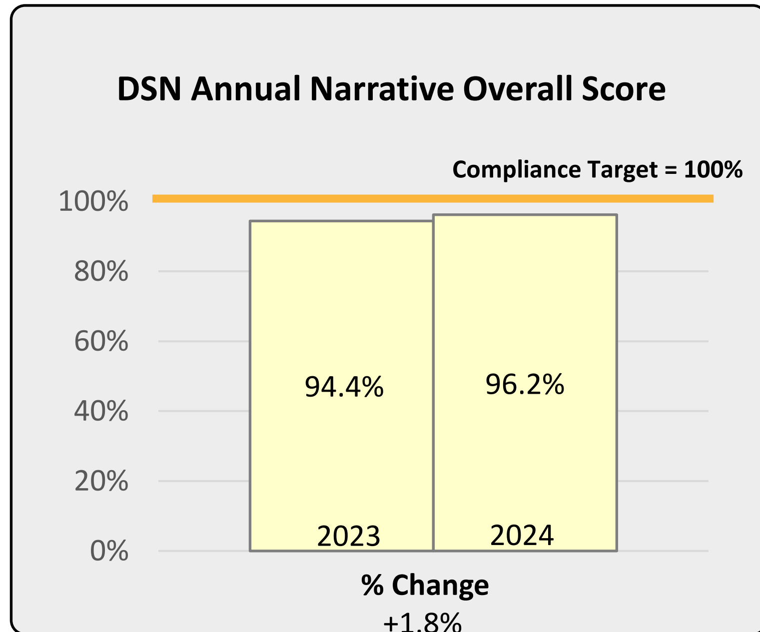
ACCESS TO CARE

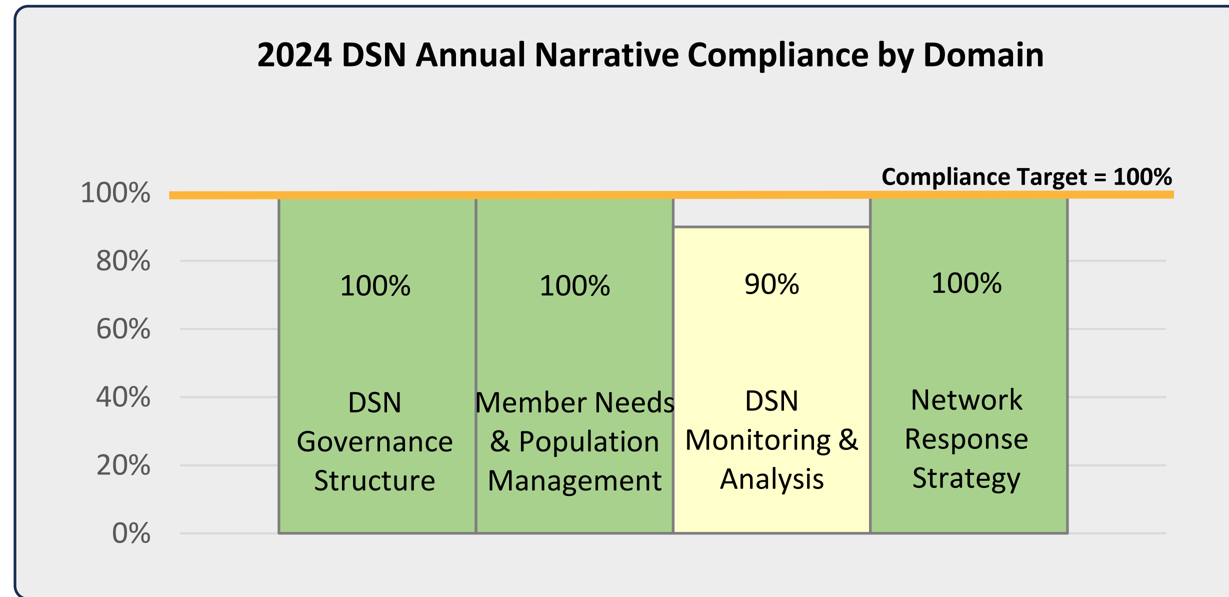
OREGON HEALTH AUTHORITY

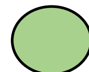
Recommendations:

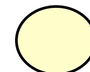
Address the findings issued in the 2024 DSN Annual Narrative Evaluation DSN Monitoring and Analysis domain:

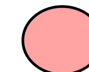
- Ensure collection of usable data from its providers and subcontractors on a regular basis sufficient to effectively monitor the ability of its network and individual providers to offer appointments that are compliant with timeliness standards. The CCO should explain and demonstrate how the information is used to support network adequacy monitoring and decision-making.
- Assess the availability of physical accessibility accommodations across its network (e.g., via information collected at credentialing/recredentialing) and provide aggregate data to relevant staff, departments, or committees to help inform network adequacy decision-making (e.g., assessing the percentage of PCPs within its network that meet ADA requirements). This is the same required action as given in 2023.





 High Performance (100%)

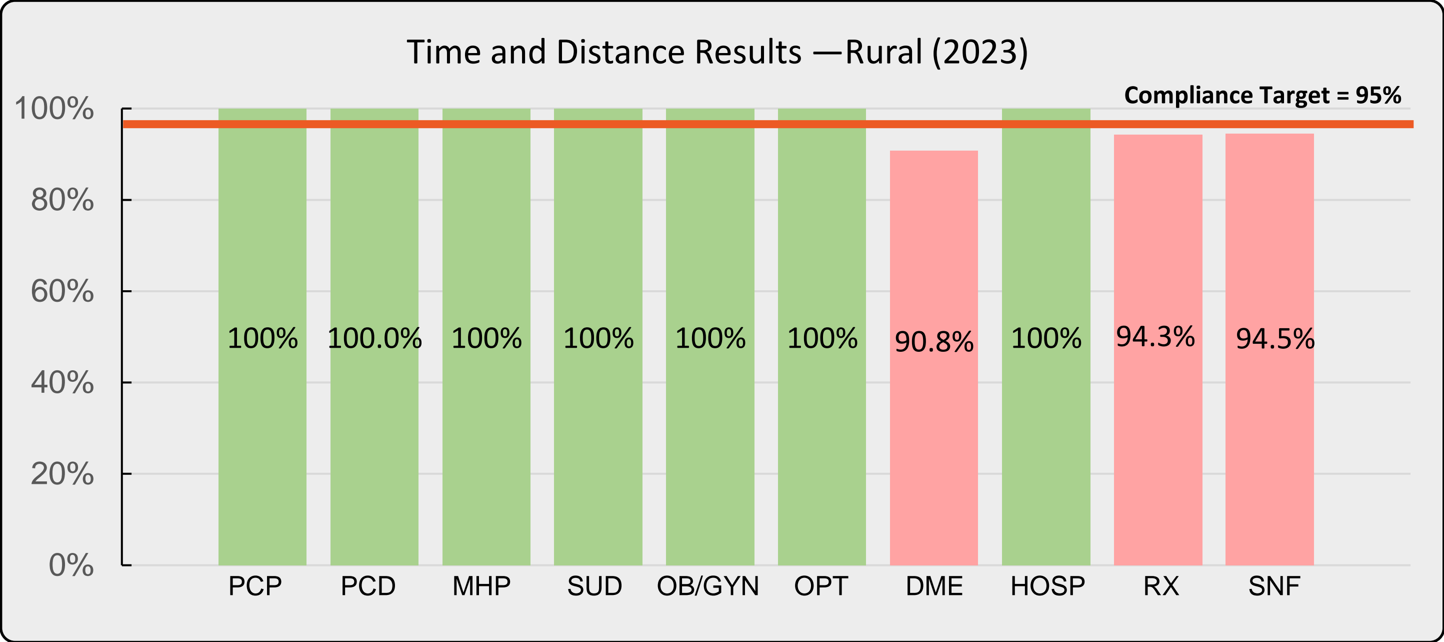
 Moderate Performance (75-99.9%)

 Low Performance (<75%)

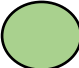
OREGON HEALTH AUTHORITY

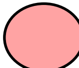
Recommendations:

- Approximately 50 percent of specialty providers and facilities were noncompliant (i.e., less than 95 percent of members with access) with time and distance access standards. For most specialty providers and facilities, more than 90 percent of the CCO's members were within the time and distance standards, with many results being within 1 percent of the standard except Durable Medical Equipment. Most members lacking access resided in southwestern and central Curry County.
- Review Q3 2024 DSN Provider Capacity Report and identified gaps in time and distance and address any gaps in areas that do not have an approved time and distance exception.
- AH has the following exceptions: Allergy & Immunology, Cardiology, Dermatology, Endocrinology, Gastroenterology, Hematology, Medical Oncology, Mental Health Provider, Methadone Clinic, Nephrology, Neurology, Pulmonology, Radiation Oncology, Rheumatology, Speech Language Pathology, and Substance Use Disorder.



Note: The CCO did not have any urban settings within its service area.


High Performance (≥ 95%)

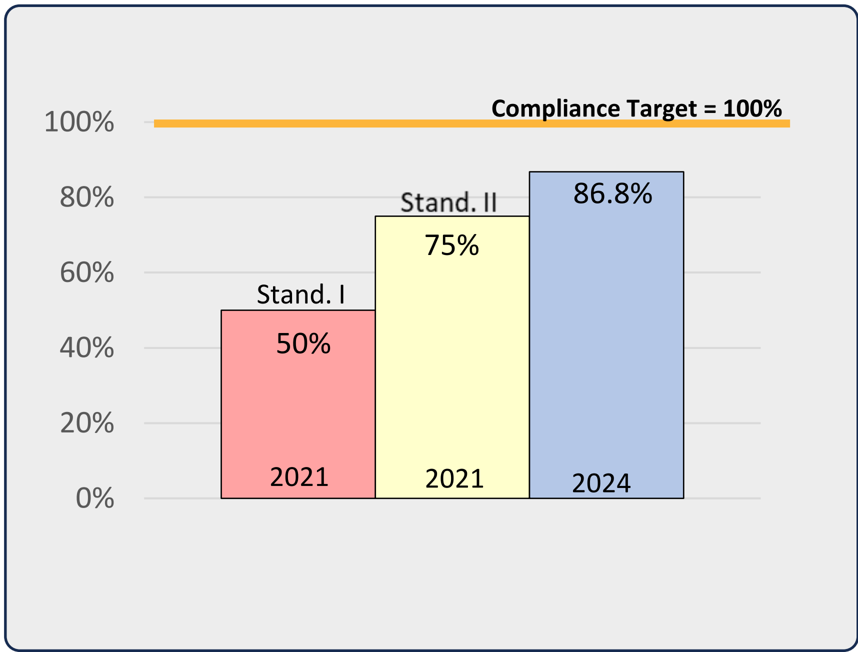

Low Performance (<95%)

Managed Care Compliance

OREGON HEALTH AUTHORITY

Compliance Monitoring Review

Standard I: Assurance of Adequate Capacity and Availability of Services



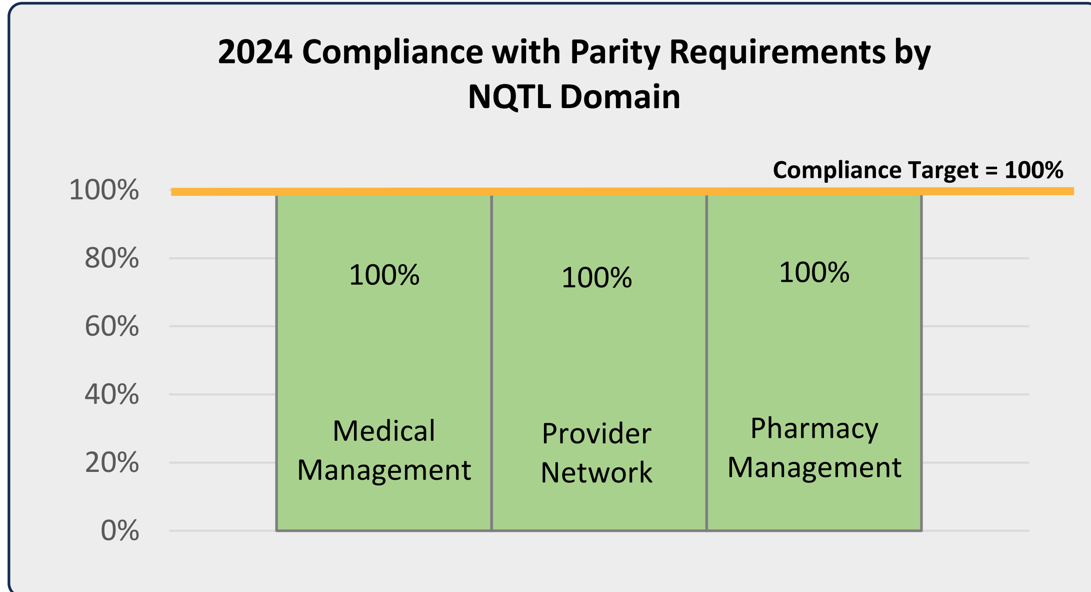
- High Confidence ≥95%
- Moderate Confidence ≥85% - <95%
- Low Confidence ≥75% - <85%
- No Confidence <75%

Note: In 2024, the two standards reviewed separately in 2021 were combined.

Recommendations:

- AH received a score of 86.8 percent 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.
- Address five findings for this standard.
- Revise policies and procedures to align with State-established requirements for timely access to care and services and demonstrate implementation.
- Demonstrate corrective action when providers fail to meet appointment standards.

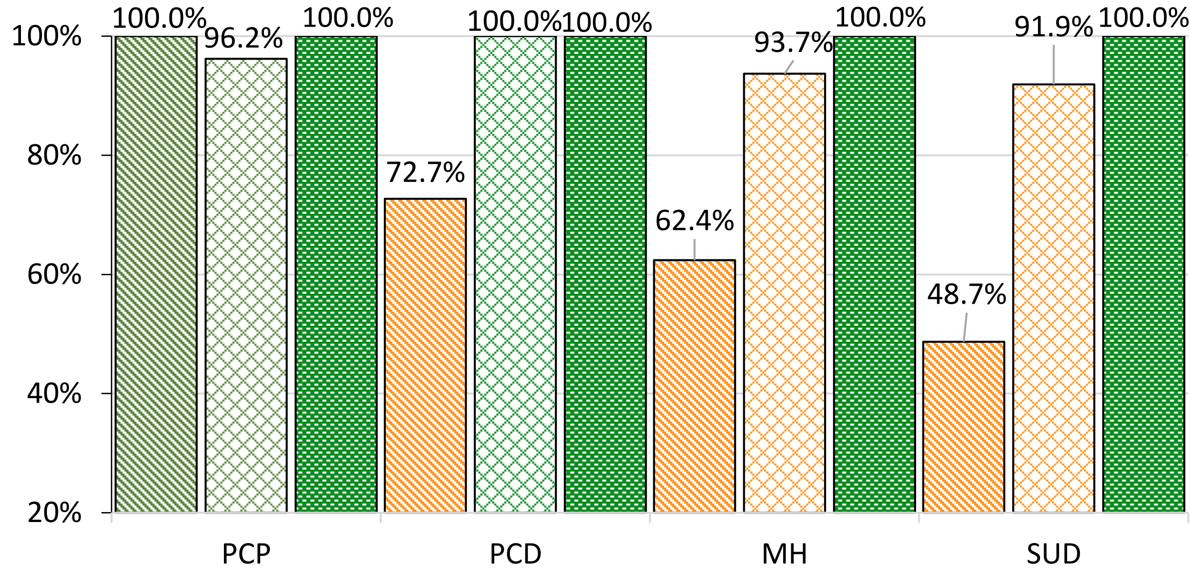
Mental Health Parity

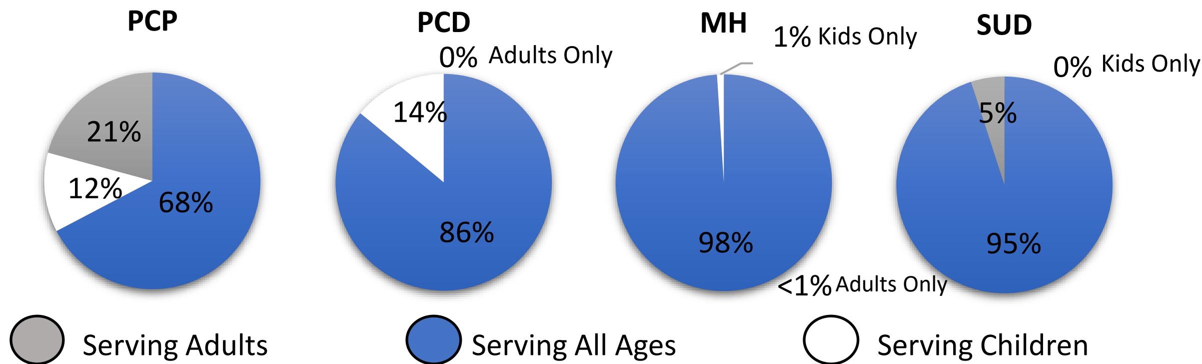


Compliant   Partially Compliant

- AH addressed findings received in calendar year (CY) 2023 related to concurrent review and retrospective review. AH provided supporting documentation that demonstrated the process and requirements used to apply concurrent review and retrospective review NQTLs to MH/SUD benefits were applied with no more stringency than to M/S benefits in the same classification.
- Pharmacy Management domain: Addressed findings received in CY 2023 related to formulary design for pharmacy services. AH provided additional documentation to sufficiently address its formulary design NQTL. The rationale used to determine assignment of the formulary design NQTL was consistent between MH/SUD and M/S benefits, and the evidentiary standards used in administering the NQTL to MH/SUD benefits were comparable to the evidentiary standards used in administering the NQTL to M/S benefits. The CCO used evidence-based criteria for MH/SUD and M/S benefits to administer its processes with equivalent stringency.
- Continue to maintain parity across NQTL domains.

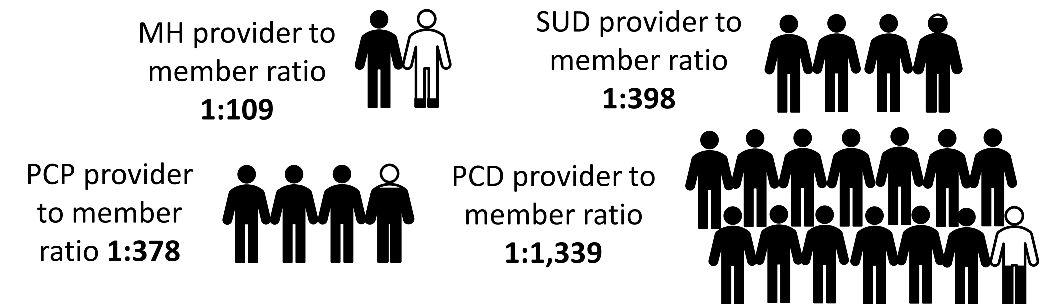
Network Adequacy





Recommendations:

- Identify available primary care dentists, mental health providers, substance use disorder providers within service area that are not contracted. Contract with any interested providers and consider other solutions outside of contracting.
- Monitor number of SUD providers serving OHP patients to assess if providers are regularly seeing CCO members.
- Determine member need for providers serving specific age-groups (e.g., adults only, children only) and identify strategies to improve the rate of providers.



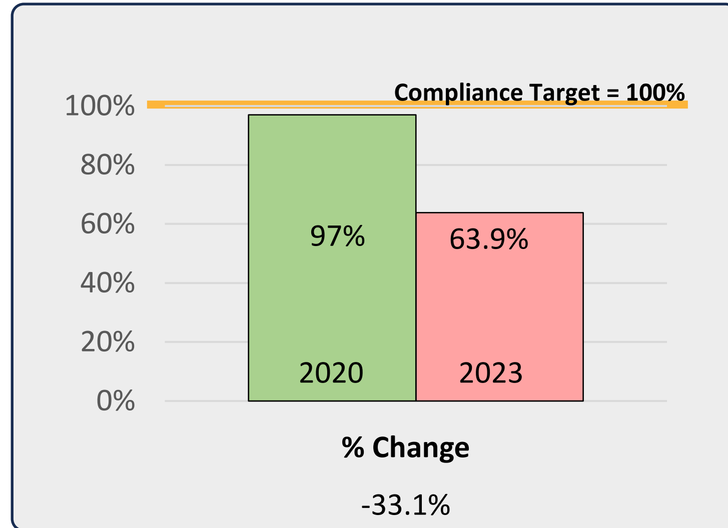
= 100 people

ACCESS TO CARE

SERVICE DELIVERY

Compliance Monitoring Review

Standard IV: Coverage and Authorization of Services

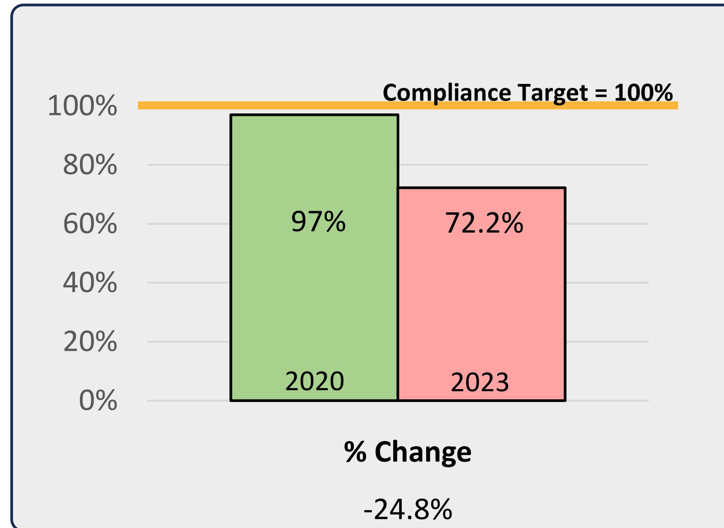


Recommendations:

- AH received a score of 63.9 percent in the Coverage and Authorization of Services standard due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting the CCO's ability to adhere to federal and State requirements for authorizing services and to ensure proper and timely notification of adverse benefit determinations.
- Revise policies and procedures and member- and provider-facing materials to align with federal and State requirements.
- Demonstrate adherence to federal and State requirements for authorization of services and required content and time frames for notifications of adverse benefit determination.
- Address nine unresolved findings for this standard.

Compliance Monitoring Review

Standard III: Coordination and Continuity of Care

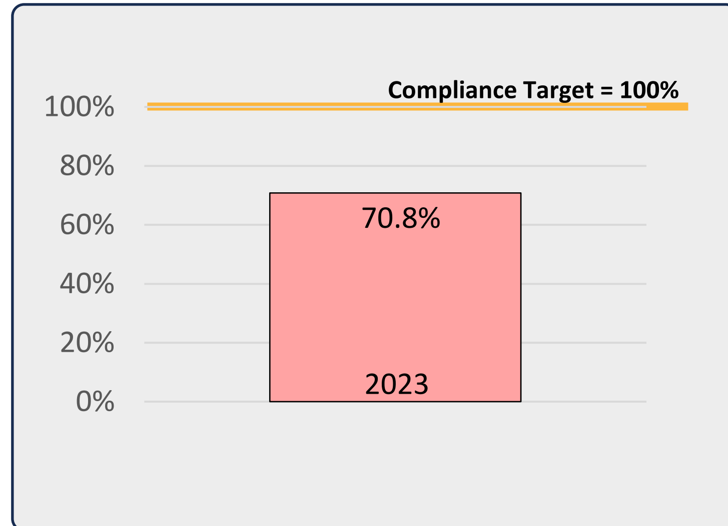


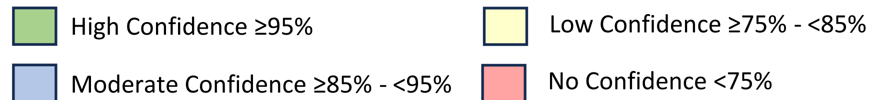
Recommendations:

- AH received a score of 72.2 percent in the Coordination and Continuity of Care standard due to a lack of operational structure and failure to appropriately screen and assess/reassess members for care management and ICC services.
- Revise policies and procedures and member- and provider-facing materials to align with federal and State requirements.
- Demonstrate notification to members at all levels of the person formally designated as primarily responsible for coordinating the services accessed by the member.
- Demonstrate implementation of appropriate assessments, reassessments, and revision of treatment plans according to federal and State requirements.
- The findings referenced above were previously resolved in the annual Compliance Monitoring Review.

Compliance Monitoring Review

Standard XVI: Emergency and Post-stabilization Services



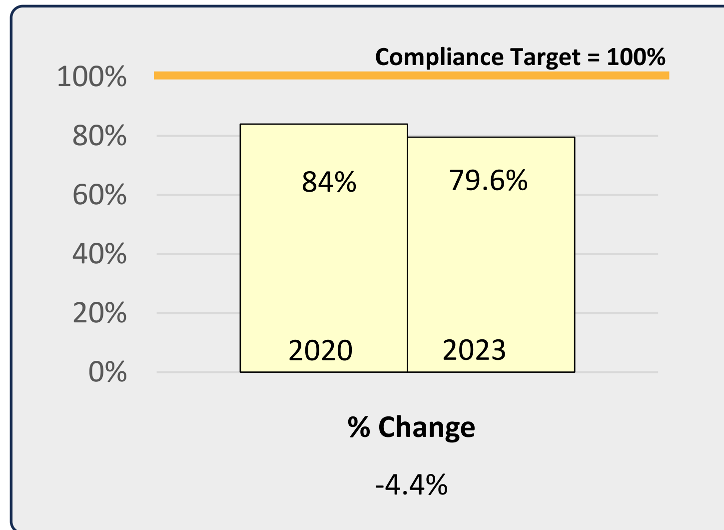


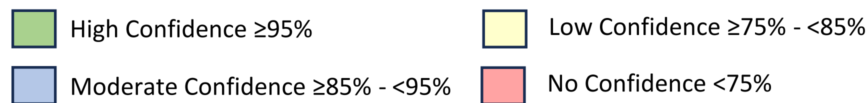
Recommendations:

- AH received a score of 70.8 percent due to a lack of operational structure to ensure poststabilization services are covered appropriately.
- Revise the applicable plan documents to define “emergency and poststabilization services” and communicate the appropriate requirements.
- The findings referenced above were previously resolved in the annual Compliance Monitoring Review.

OREGON HEALTH AUTHORITY

Compliance Monitoring Review
Standard X: Grievance and Appeal Systems



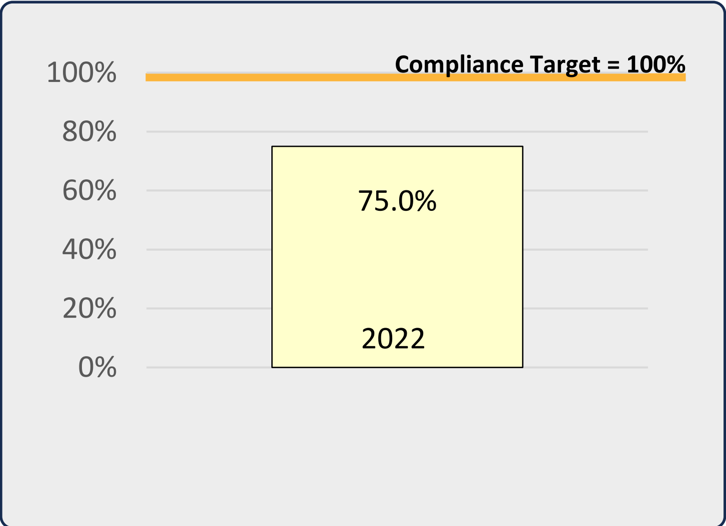


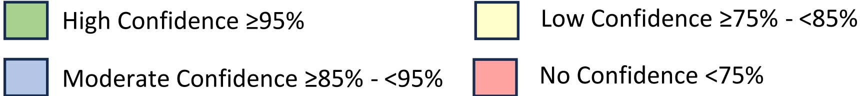
Recommendations:

- AH received a score of 79.6 percent in the Grievance and Appeal Systems standard due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting the CCO's ability to ensure member grievances and appeals are addressed and responded to appropriately.
- Revise its policies and procedures to align with federal and State requirements.
- Must demonstrate adherence to requirements for appropriate decision-makers; time frames for acknowledging and responding to grievances and/or appeals; readability of notices; and implementation of federal and State requirements within communications to members, providers, and subcontractors.
- Must demonstrate maintaining one level of appeal, being the final adjudicator on appeals, and adherence to federal and State appeal extension requirements.
- The findings referenced above were previously resolved in the annual Compliance Monitoring Review.

Compliance Monitoring Review

Standard XII: Quality Assessment and Performance Improvement



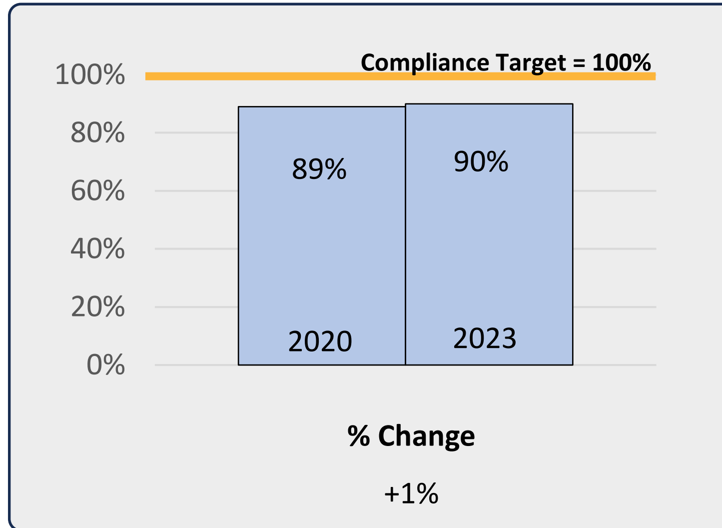


Recommendations:

- AH received a score of 75 percent in the QAPI standard due to failure to establish and implement a comprehensive and descriptive program description and workplan that met applicable federal, State, and contractual requirements. In addition, AH failed to demonstrate appropriate oversight of its QAPI program, which impacted the MCE's ability to monitor and evaluate the quality and appropriateness of services furnished to its members consistent with the needs and priorities of the MCE's member population.
- Revise its QAPI program structure to align with federal and State requirements for a QAPI program.
- Demonstrate implementation and appropriate oversight of its QAPI program.
- The findings referenced above were previously resolved in the annual Compliance Monitoring Review.

MEMBER RIGHTS & HEALTH EQUITY

Compliance Monitoring Review
Standard VII: Member Rights and Protections



High Confidence ≥95%

Moderate Confidence ≥85% - <95%

Low Confidence ≥75% - <85%

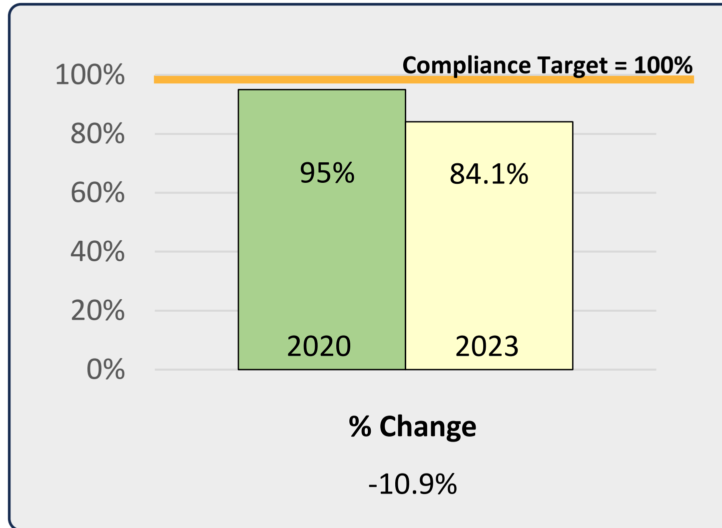
No Confidence <75%

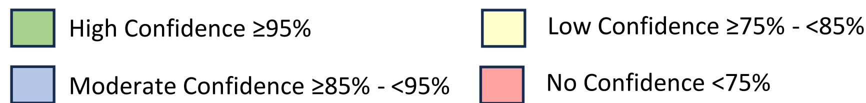
Recommendations:

- AH received a score of 90.0 percent due to deficits in its operational structure, impacting the CCO's ability to ensure that member rights are respected and members are notified of their rights as required by federal and State requirements.
- Revise policies and procedures and member- and provider-facing materials to align with federal and State requirements.
- The findings referenced above were previously resolved in the annual Compliance Monitoring Review.

OREGON HEALTH AUTHORITY

Compliance Monitoring Review
Standard XIV: Member Information

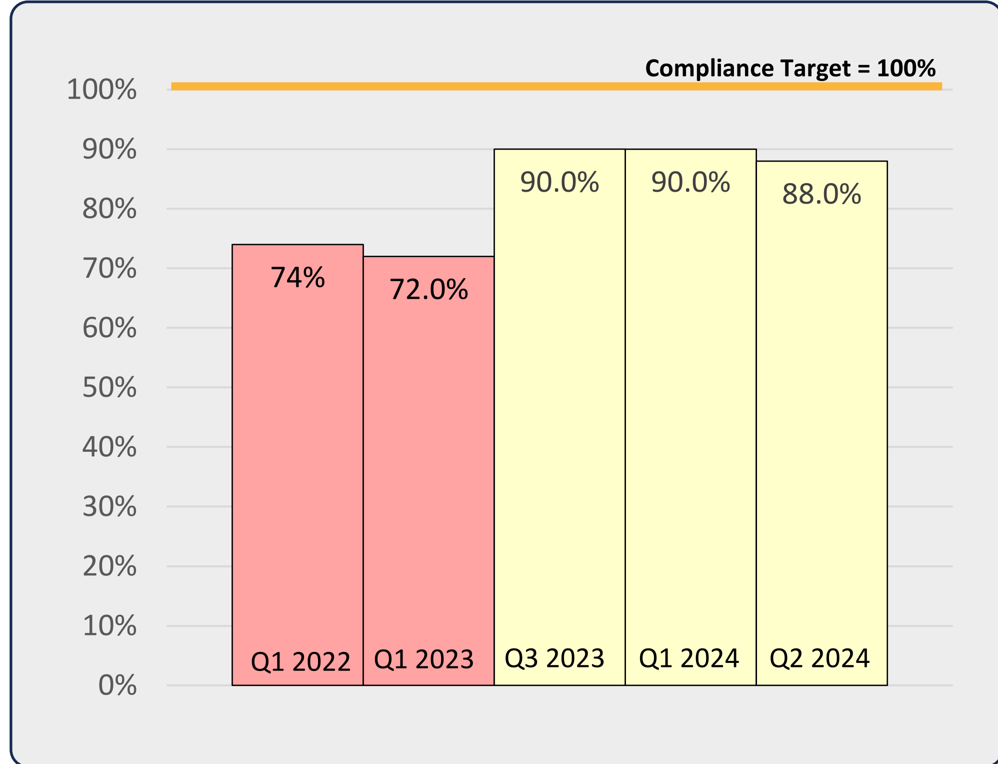




Recommendations:

- AH received a score of 84.1 percent due to deficits in its operational structure and failure to demonstrate implementation of an established process, impacting the CCO's ability to ensure timely and proper member communication.
- Revise its policies, procedures, and member-facing materials to align with federal and State requirements.
- Address one unresolved findings for this standard.

Notice of Adverse Benefit Determination Requirements

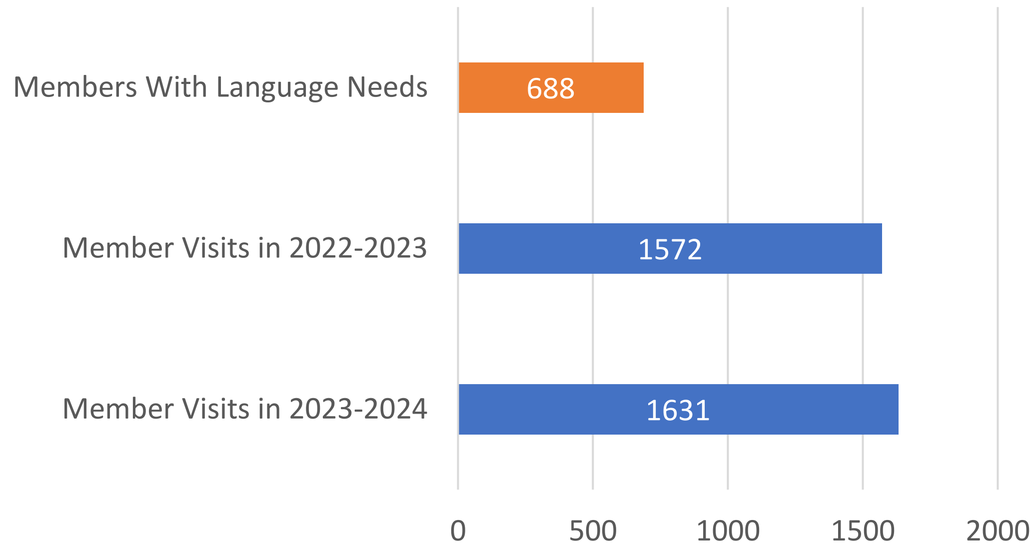


Recommendations:

- Improve internal processes to update NOABD requirements on an annual basis upon release of Member Notice Template Evaluation Criteria.
- Ensure clinical reviewers consider medical necessity and medical appropriateness in the evaluation of the authorization request.
- Work with vendors to reduce the amount of time it takes to make system changes upon release of the evaluation criteria.
- Provide additional support to subcontracted entities that have been delegated the requirement to send NOABDs to members.
- Ensure the current OHA NOABD model template is adopted and implemented by the CCO and subcontractors.
- Implement stronger oversight mechanisms to regularly audit NOABDs sent by the CCO and subcontractors.
- Establish or improve subcontractor reporting to help improve adherence to NOABD requirements.

OREGON HEALTH AUTHORITY

Language Access Interpreter Utilization



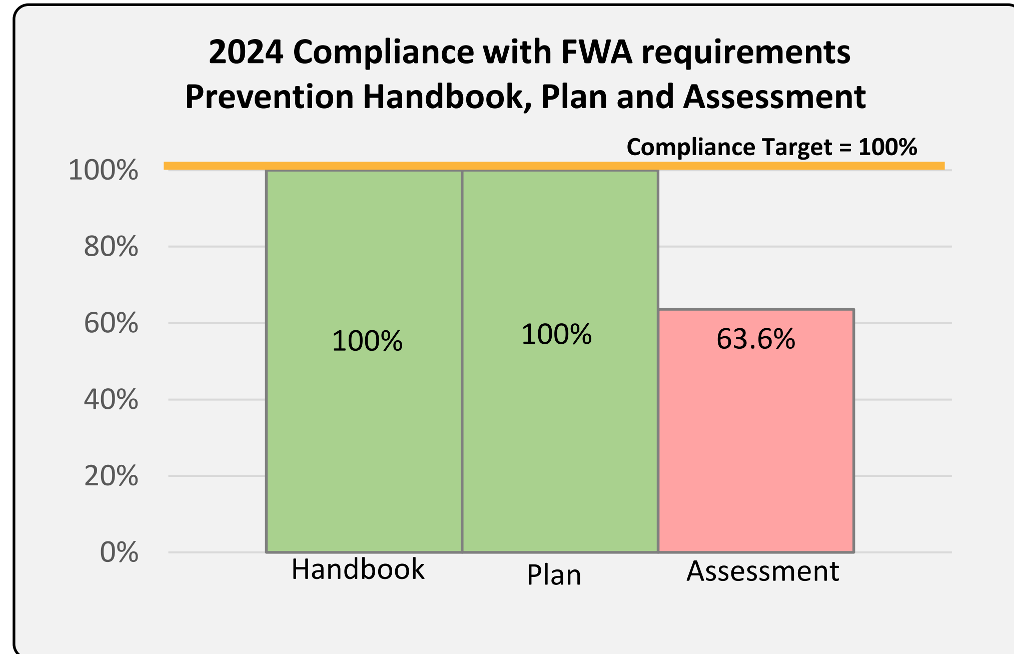
Note: This chart shows a current average of 2.37 visits per member.

Recommendations:

- Identify gaps in meeting language access needs.
  - Determine language preferences among members.
  - Evaluate the languages spoken by the provider network.
  - Evaluate utilization of interpreter services.
- Provide meaningful access to interpreters in a variety of modes that meet the members' needs (e.g., in person, telephonic, virtual).

PROGRAM INTEGRITY

FWA Prevention Handbook, Prevention Plan, and Assessment Requirements



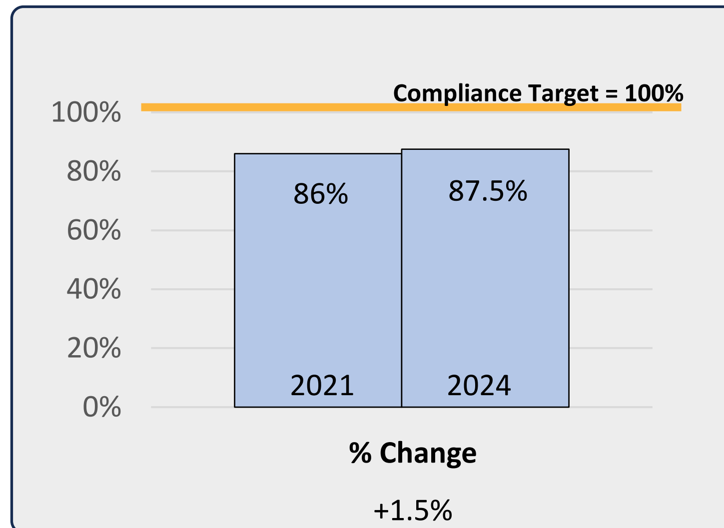
High Performance (≥95%) Moderate Performance (75-94.9%) Low Performance (<75%)

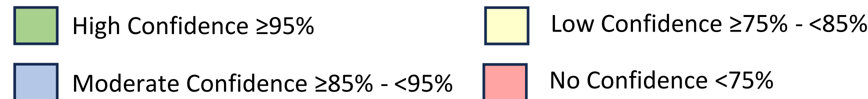
Recommendations:

- Clearly present the following information:
  - Summary and outcomes of preliminary investigations;
  - Summary of PI audits conducted as a result of referrals and investigations;
  - Planned provider PI audits conducted during the previous year;
  - Whether the PI audits were conducted in accordance with the CCO's FWA prevention plan from the prior contract year, meaning the FWA assessment should include information regarding PI audits conducted for each provider identified on the previous year's prevention audit work plan; and
  - Findings from the PI audits and corrective actions taken.
- Demonstrate training completion for all BOD members. In addition, the CCO must address credentialing-specific training in the annual FWA assessment and provide training logs to demonstrate training completion.
- Demonstrate provider training was conducted during onboarding and annually.
- Demonstrate training completion for all subcontractors listed on OHA's subcontractor reports.

OREGON HEALTH AUTHORITY

Standard VI: Subcontractual and Delegation Requirements

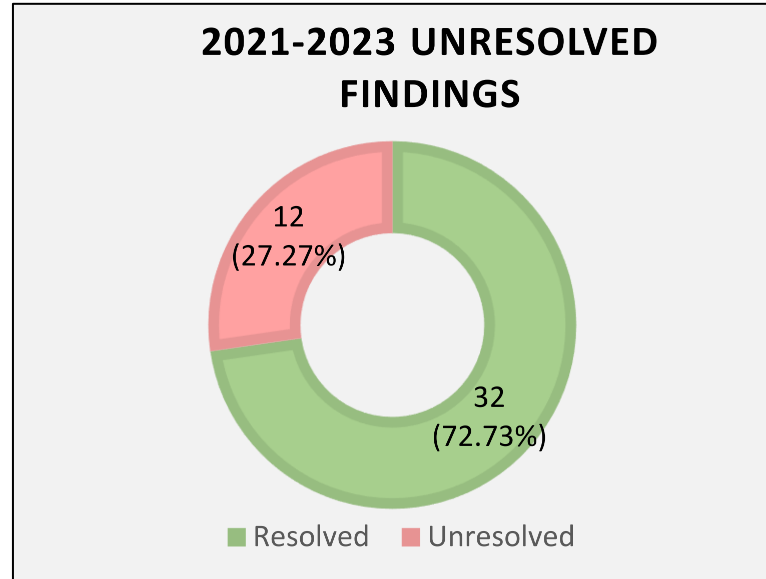




Recommendations:

- AH received a score of 87.5 percent due to insufficient documentation to support operations and ensure compliance with federal requirements for written agreements between the CCO and its subcontractors.
- Revise written agreements to align with federally required language for written agreements with subcontractors.
- Address one finding for this standard.

Unresolved Findings from Compliance Monitoring Reviews



Recommendations:

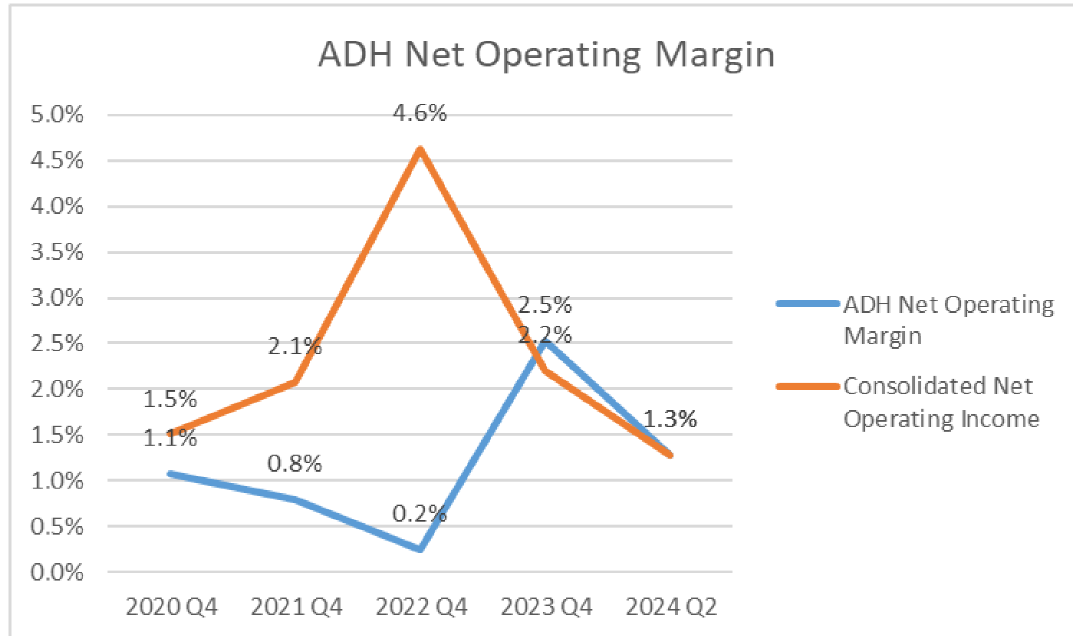
- Resolve all outstanding findings from previous cycles of Compliance Monitoring Reviews (2021-2023).
- Outstanding findings, across various years, may have a negative impact on quality of care and access to services for members. Identify operational gaps preventing the CCO from immediate resolution of audit findings and implement necessary changes to ensure findings are resolved without delay.

Standard	Review Year	Total # of IP Findings	Resolved IP Findings		Unresolved IP Findings	
			#	%	#	%
Standard I—Availability of Services	2021	1	0	0.0%	1	100.0%
Standard II—Assurances of Adequate Capacity and Services	2021	1	0	0.0%	1	100.0%
Standard IV—Coverage and Authorization of Services	2023	10	1	10.0%	9	90.0%
Standard XIV—Member Information	2023	7	6	85.7%	1	14.3%

FINANCIAL PERFORMANCE

OREGON HEALTH AUTHORITY

Exhibit L: Net Operating Margin



Recommendations:

- Advanced Health has had 3 financial reporting periods in which have been at or below the CCO Consolidated Totals for Net Operating Margins. This results in an Operational Loss, meaning their Adjusted Revenues do not exceed their Medical and Administrative Expenses.
- Continued operations with a negative percentage of total revenue will result in the CCO not growing their reserves and minimize their investments in the community or reinvestment in their continued operations.

Exhibit L: Risk-Adjusted Rate of Growth

Risk-Adjusted Rate of Growth			
	Unadjusted Rate of Growth 2022-2023	**Risk-Adjusted** Rate of Growth 2022-2023	**Annualized** 2020-2023
Advanced Health	-2.5%	-3.8%	3.0%
Statewide Weighted Average	**9.5%**	**8.7%**	**5.4%**
Source: Senate Bill 1041 Report			

Recommendations:

- Rate of growth measurements look at changes in CCO spending per member. CCO capitation rates also change from year to year, but those capitation rates represent OHA spending on CCOs, or equivalently, CCO revenue. CCO spending is considered in setting capitation rates in future years, so a restrained rate of growth in CCO spending helps meet OHA goals on medical spending.
- The Unadjusted column shows the rate of growth in CCO spending per member without accounting for the health risk associated with that CCO's membership. The Risk-Adjusted column, however, shows the rate of growth considering the changes in health risk of that CCO's population. A CCO's rate of growth may be impacted and explained by growth in acuity, or health risk, in their population, such as more members with chronic disease in one year than the other. The three-year average column helps to smooth year-over-year fluctuations.
- CCOs have financial incentives for keeping their Risk-Adjusted Rate of Growth contained, including but not limited to bottom-line profitability. Annual reporting allows for CCOs to explain when growth exceeds their targets. Additionally, OHA is allowed to require a Corrective Action Plan or Sanctions for adverse Rate of Growth reporting under HB 2081 (2021).

Exhibit L: Minimum Loss Ratio

Three-year Minimum Loss Ratio	
	2021 - 2023
Advanced Health	90.67%
Source: Minimum Medical Loss Ratio data	

Recommendations:

- Advanced Health reported an MLR for 2021 – 2023 of 90.67%, this met the minimum requirement that a CCO spends at least 85% of their capitated payments on member's medical services or services that improve health care quality.

OREGON HEALTH AUTHORITY

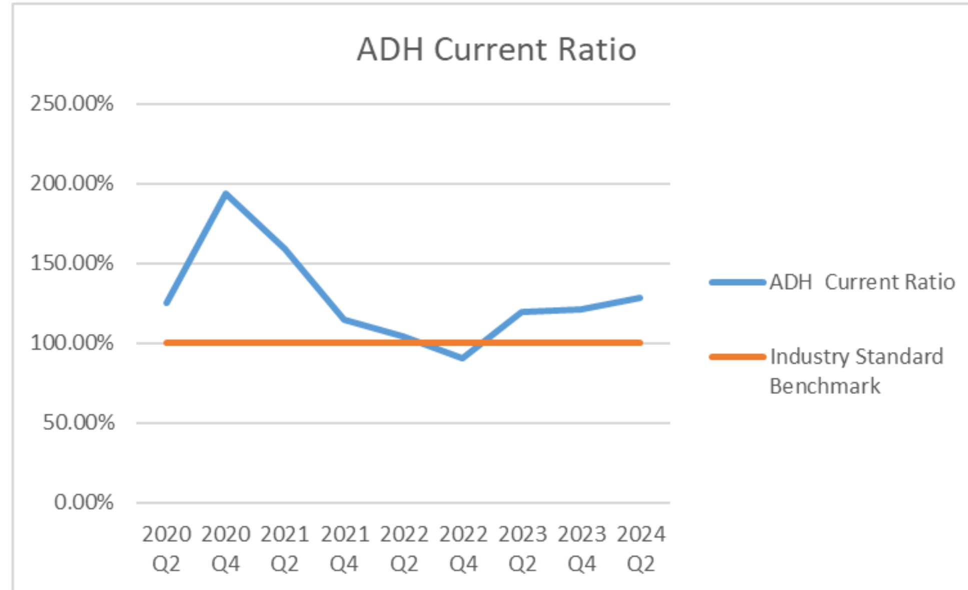
Exhibit L: Restricted Reserve

Restricted Reserve Deficit Tracking Contract Years 2020 - 2024			
	Quarter	ADH	Total Deficits by Quarter - All CCOs
2020	Q1		1
	Q2		1
	Q3		1
	Q4		7
2021	Q1		10
	Q2	Deficit	5
	Q3		6
	Q4		8
2022	Q1		8
	Q2		5
	Q3		5
	Q4		0
2023	Q1		0
	Q2		0
	Q3		4
	Q4		1
2024	Q1		3
	Q2		0
Total Deficits by CCO		1	

Recommendations:

- Advanced Health exhibited the ability to meet or exceed the minimum Restricted Reserve requirements during the contract period. Restricted Reserves are meant to safeguard approximately two weeks of CCO medical spending, in case of a rapid CCO insolvency.
- While they did report deficits in 1 period, their ability to correct the actions did not result in a high risk of non-compliance.

Exhibit L: Ratio of Current Assets to Current Liabilities



Recommendations:

- Advanced Health has consistently met or exceeded the industry standard for Current Ratio of 1. The Current Ratio is calculated by dividing the Current Assets of the CCO by the Current Liabilities. The current ratio is a measurement of how well a CCO may be able to meet its short-term obligations that are due within a year.
- The CCO consistently holds enough Current Assets to meet the obligations of the Current Liabilities as of the reporting date.