March 2025

CCO PERFORMANCE SNAPSHOT

Individual Profile

AllCare

OREGON HEALTH AUTHORITY

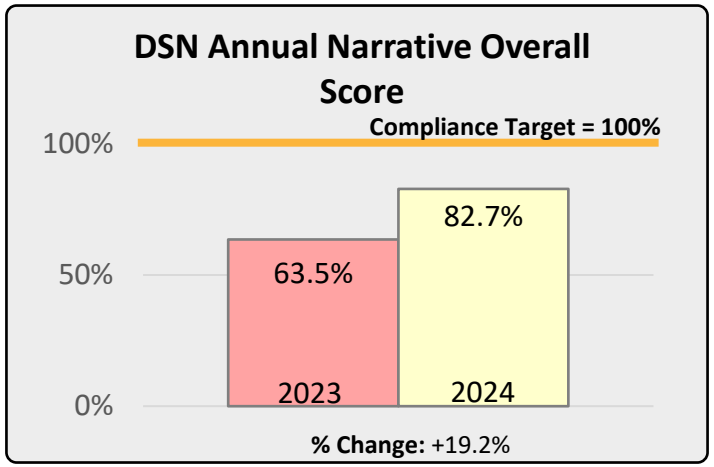
ACCESS TO CARE

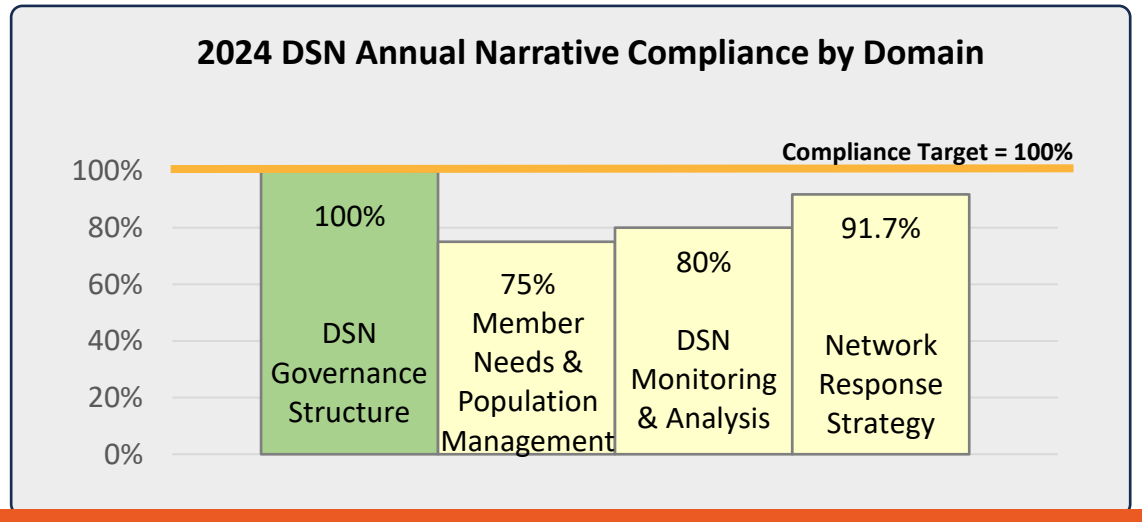
Network Development and Monitoring

Recommendations:

Address the findings issued in the 2024 DSN Annual Narrative Evaluation Member Needs and Population Management, DSN Monitoring and Analysis, and Network Response domains:

- Demonstrate how it uses population-level data on physical, intellectual, and developmental disabilities to inform network adequacy decision-making beyond care coordination and LTSS member tracking.
- Demonstrate the use of utilization trend data by decision-making bodies (e.g., DSN Oversight Committee, etc.) to inform network adequacy monitoring and decision-making.
- Demonstrate how it monitors its full member population for prevalence of diseases (i.e., the total number of cases of any given disease existing in a population divided by the total population) and use the results to drive network adequacy decision-making to ensure that the provider network is adequate for offering services to match the prevalence of a given disease.
- Implement a process for monitoring wait time to appointment availability across its provider network (e.g., provider self-attestation surveys for physical, specialty, behavioral, and oral health providers–pregnant and children/non-pregnant individuals) to evaluate compliance with State-determined time frames for emergent, urgent, and standard appointments, and use such information in the context of other data (e.g., subdivision by provider, service type, etc.) to inform network adequacy decision-making by its DSN Oversight Committee.
- Develop processes for and demonstrate consistent collection of data on availability and use of telehealth modalities to inform and support network adequacy monitoring and decision-making.
- Demonstrate how it uses network-level data on availability of accessibility accommodations to inform and support network adequacy monitoring and decision-making.
- Ensure that it deliberates on and describes anticipated changes to future network capacity needs, potentially including, but not limited to, significant membership change forecasts, upcoming OHP benefit changes, changing member population demographics, or critical provider or facility terminations.





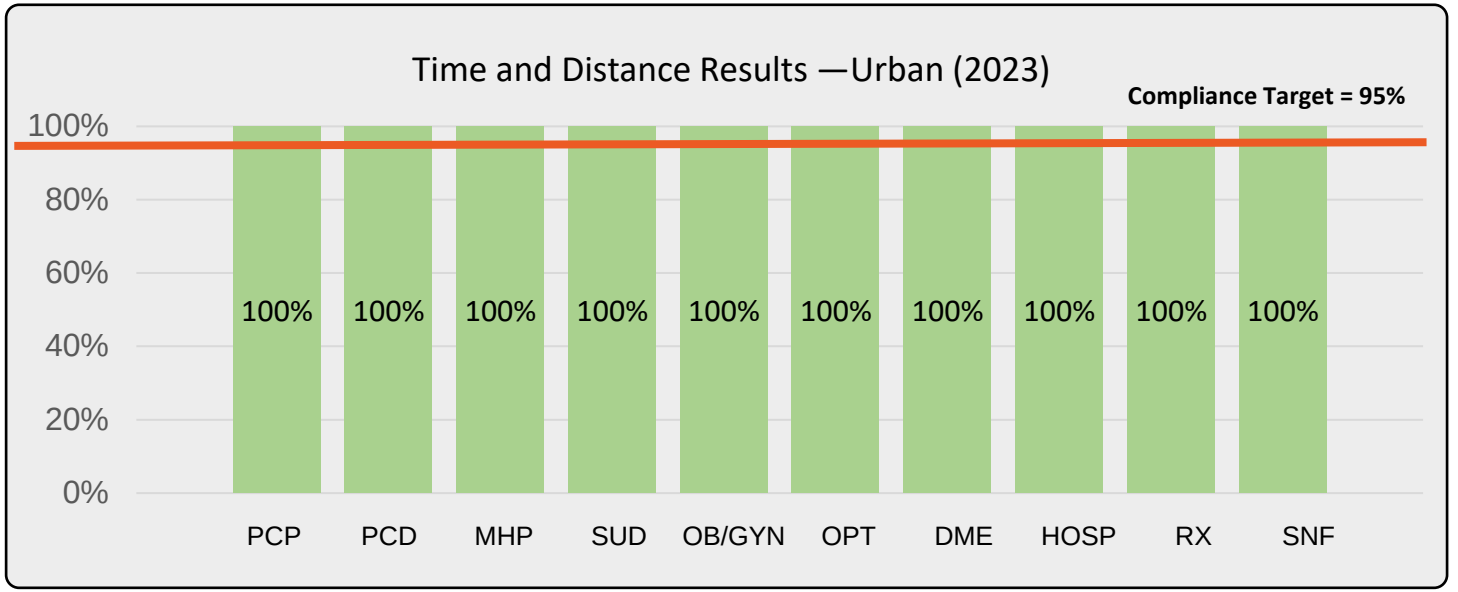
High Performance (100%)

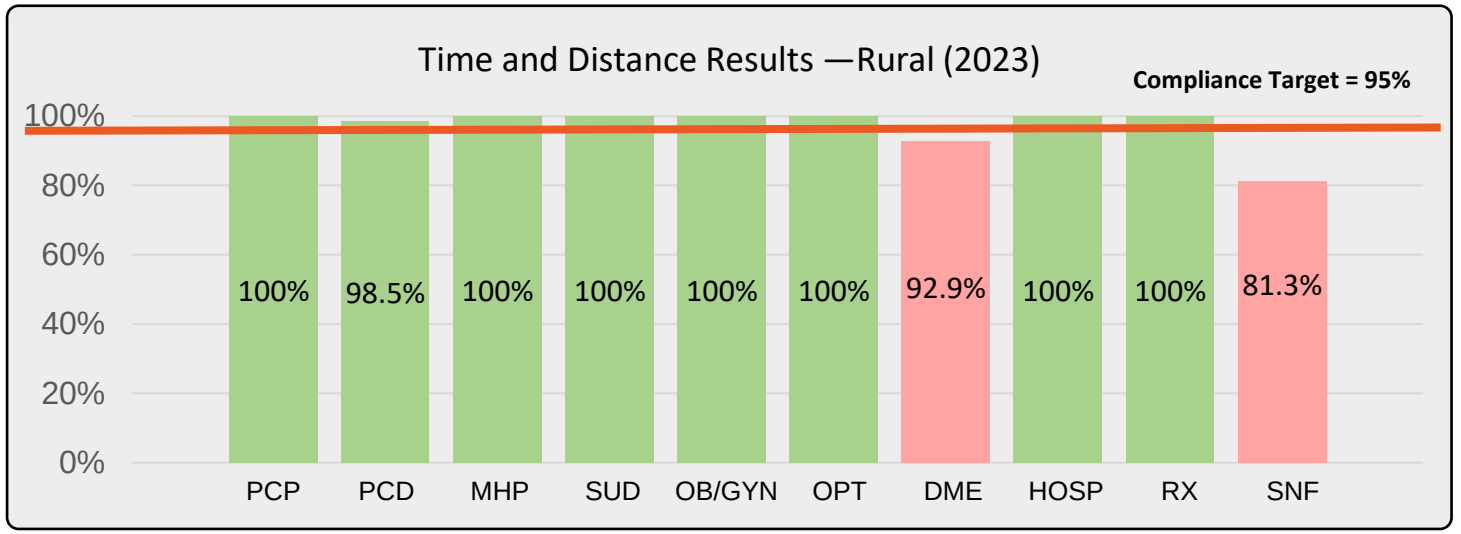
Moderate Performance (75-99.9%)

Low Performance (<75%)

Recommendations:

- AC lacked access to certain specialty providers which may represent potential barriers to access to care, particularly for rural settings within Curry County.
- Review Q3 2024 DSN Provider Capacity Report to identify gaps in time and distance and address if the CCO does not have an approved time and distance exception.
- AC has approved exceptions for Gastroenterology, Hematology, Nephrology, Rheumatology, Cardiology, Radiation Oncology, Psychiatry, and Primary Care Dentists.





High Performance (≥ 95%)

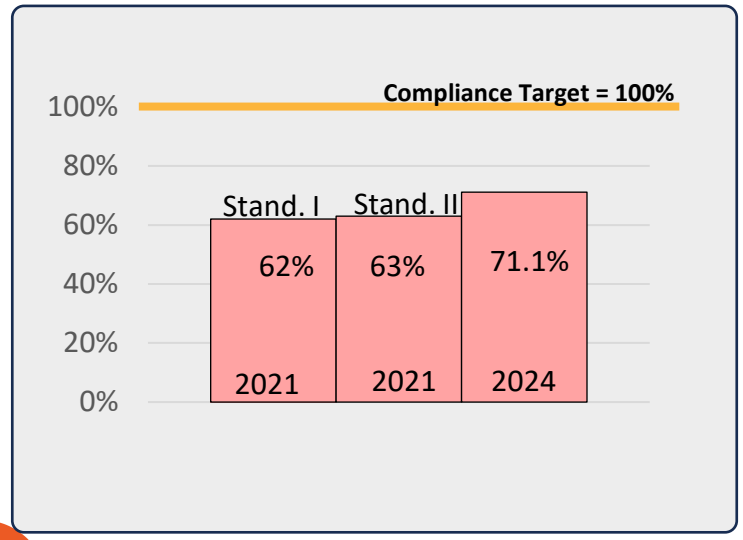
Low Performance (<95%)

Compliance Monitoring Review

Standard I: Assurance of Adequate Capacity and Availability of Services

Strengths:

- Demonstrated best practices with the diverse and robust nature of its health equity training curriculum.
- Demonstrated best practices by employing dedicated staff to assist members with physical and mental disabilities with navigating care.
- Demonstrated best practices in including LGBTQIA and disabled population representation on the Community Advisory Council (CAC).

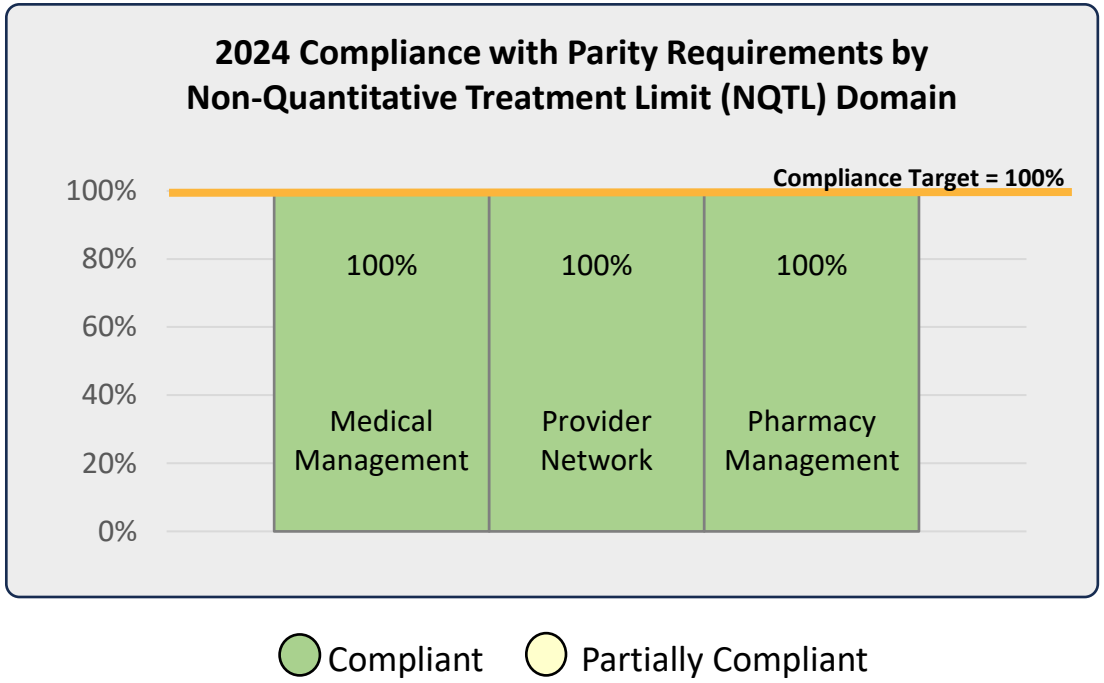


Note: In 2024, the two separate standards reviewed in 2021 were combined.

Recommendations:

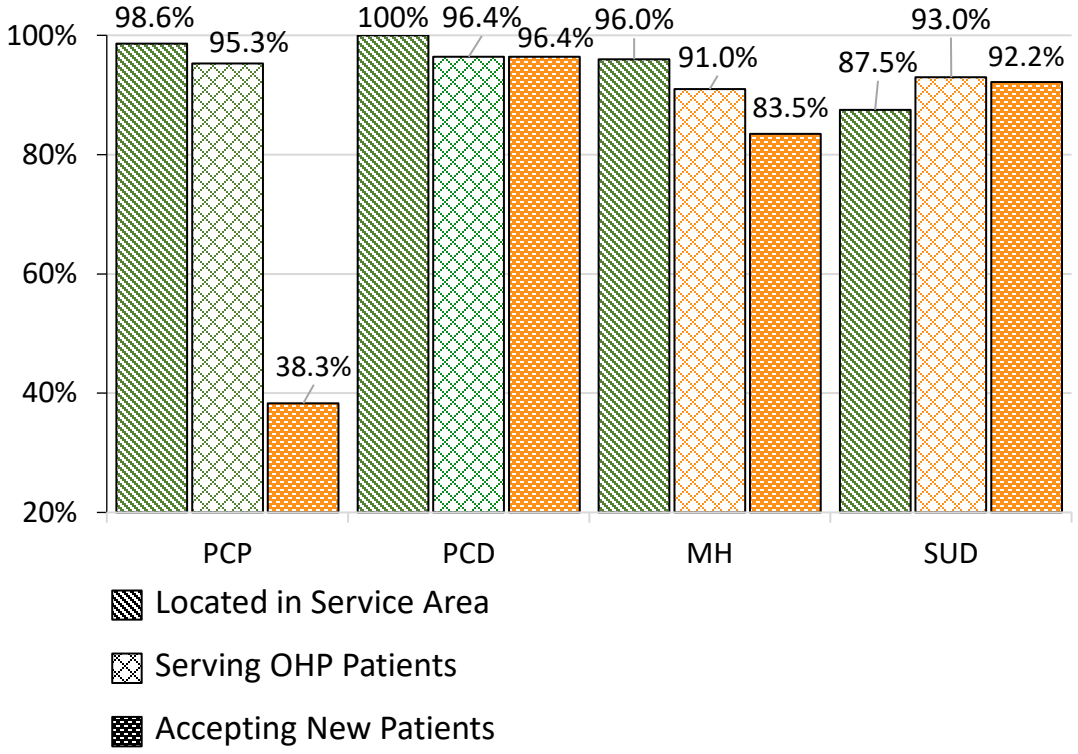
- AC received a score of 71.1 percent due to insufficient documentation to support operations and ensure compliance with federal and State requirements, the inability to demonstrate sufficient implementation of established processes, and deficiencies within its monitoring activities impacting the CCO's ability to ensure timely access to care and services.
- Address eleven findings for this standard.
- Develop and implement a methodology for monitoring and maintaining its provider network for the federal and State-required components.
- Revise its policies and procedures to align with State-established requirements for time and distance and appointment standards, reporting requirements, and provision of access, accommodations, and equipment for members with physical and mental disabilities and demonstrate implementation.
- Demonstrate corrective action when providers fail to meet appointment standards.
- Revise its provider and member communications to include the appropriate access to care and service requirements.

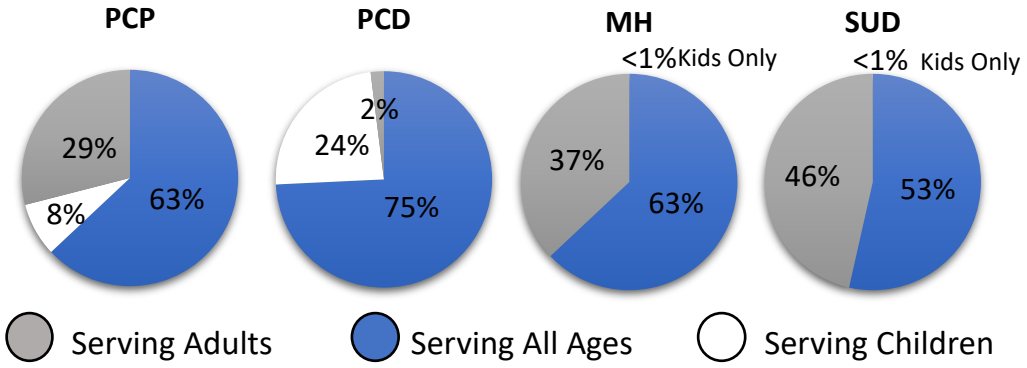
Mental Health Parity



- Medical Management domain: Addressed less than Compliant ratings received in calendar year (CY) 2023 related to Prior Authorization (PA), concurrent review (CR), and medical necessity criteria. The rationale used to determine assignment of the PA, CR, and medical necessity criteria NQTLs 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. AC also indicated they were not used to manage the administration of MH/SUD or M/S services: retrospective review, fail-first requirements, requirements that lower cost therapies be tried first, and failure to complete exclusions requirements.
- Pharmacy Management domain: Addressed less than Compliant ratings received in CY 2023 related to formulary design for pharmacy services. AC 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. AC also addressed the methods for the determining reasonable charges NQTL by indicating the NQTL is not used to manage MH/SUD or M/S benefit coverage, and the CCO confirmed the prescription drug benefit tiers NQTL is used to support internal classification of prescription drugs and not used as an NQTL to manage MH/SUD and M/S Rx services.
- Continue to maintain parity across NQTL domains.

Network Adequacy





Recommendations:

- Improve rate of primary care providers accepting new patients to improve access.
- Monitor number of mental health providers accepting new patients to determine opportunities for improvement.
- Review contracted primary care dentists, mental health providers, and substance use providers to determine if provider quantity meets the needs of members.
- Identify available primary care dentists and mental health providers within service area that are not contracted. Contract with interested providers.
- Assess if the composition of providers serving adults only and children only are enough to meet the specific needs of each population group.

PCP provider to member ratio **1:188**

MH provider to member ratio **1:125**

SUD provider to member ratio **1:533**

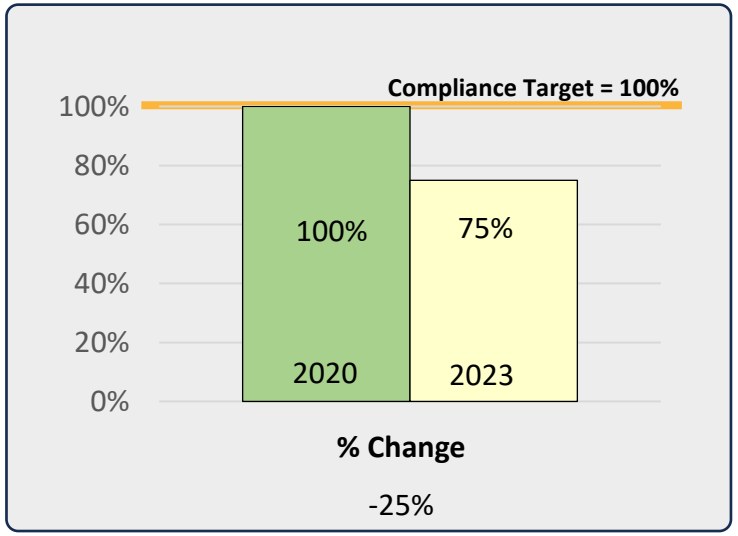
PCD provider to member ratio **1:1,239**

= 100 people

SERVICE DELIVERY

Compliance Monitoring Review

Standard IV: Coverage and Authorization of Services



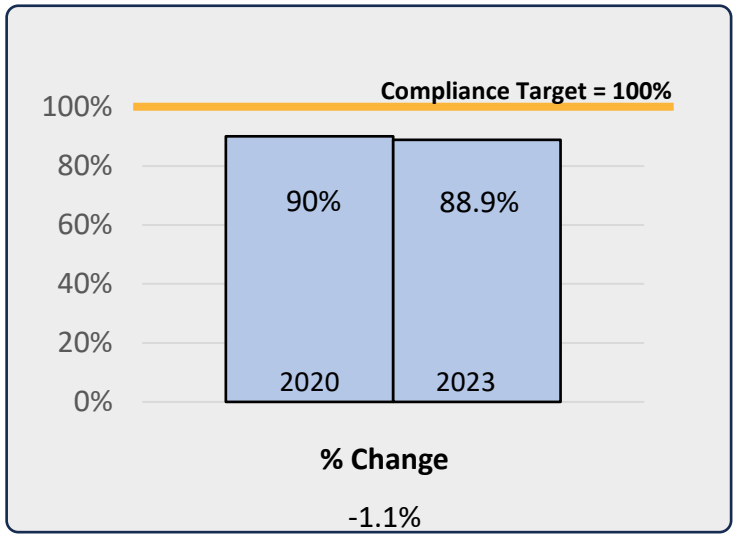
High Confidence ≥95%
Low Confidence ≥75% - <85%
Moderate Confidence ≥85% - <95%
No Confidence <75%

Recommendations:

- AC received a score of 75.0 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 ensure it offers the appropriate services, appropriate and consistent coverage determinations, and proper and timely notification of adverse benefit determinations to members.
- Revise policies and procedures to align with federal and State requirements.
- Demonstrate implementation of appropriate service offerings and consistent application of medical necessity criteria according to federal and State requirements.
- Demonstrate adherence to federal and State required time frames for notification of adverse benefit determinations.
- Address two unresolved findings for this standard.

Compliance Monitoring Review

Standard III: Coordination and Continuity of Care

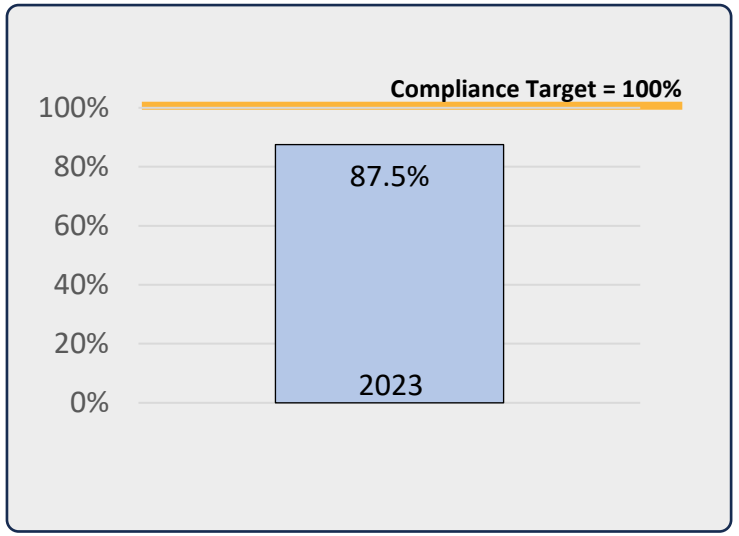


Recommendations:

- AC received a score of 88.9 percent in the Coordination and Continuity of Care standard due to a lack of operational structure and failure to appropriately assess/reassess members of prioritized populations and members with SHCN for intensive care coordination services.
- Revise CCO policies and procedures to align with State requirements.
- 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

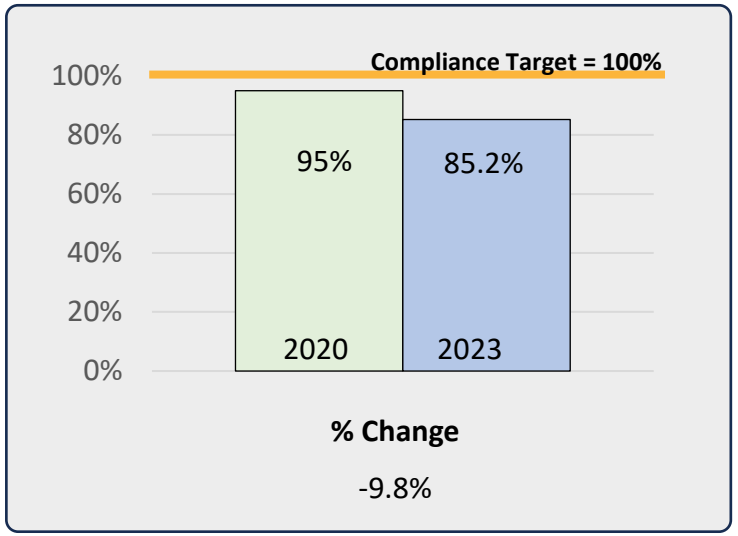
Standard XVI: Emergency and Post-stabilization Services



Recommendations:

- AC received a score of 87.5 percent due to failure to demonstrate implementation of appropriate processes and workflows, impacting the CCO's ability to ensure emergency and post-stabilization services are covered appropriately.
- Demonstrate evidence of processes to ensure payment of emergency and post-stabilization services.
- The findings referenced above were previously resolved in the annual Compliance Monitoring Review.

Compliance Monitoring Review
Standard X: Grievance and Appeal Systems

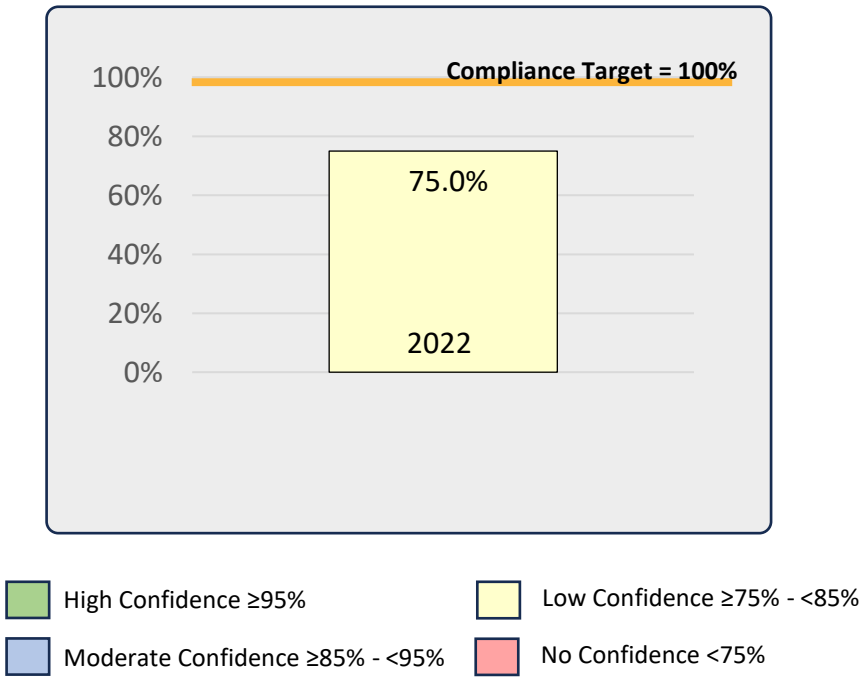


Recommendations:

- AC received a score of 85.2 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 policies and procedures to align with federal and State requirements.
- Demonstrate implementation of federal and State requirements within staff messaging.
- Demonstrate adherence to federal and State requirements for decision-makers on clinically-related grievances, time frames for acknowledging receipt of grievances, and readability of notices.
- Demonstrate implementation of federal and State requirements within communications to members, providers, and subcontractors.
- The findings referenced above were previously resolved in the annual Compliance Monitoring Review.

Compliance Monitoring Review

Standard XII: Quality Assessment and Performance Improvement

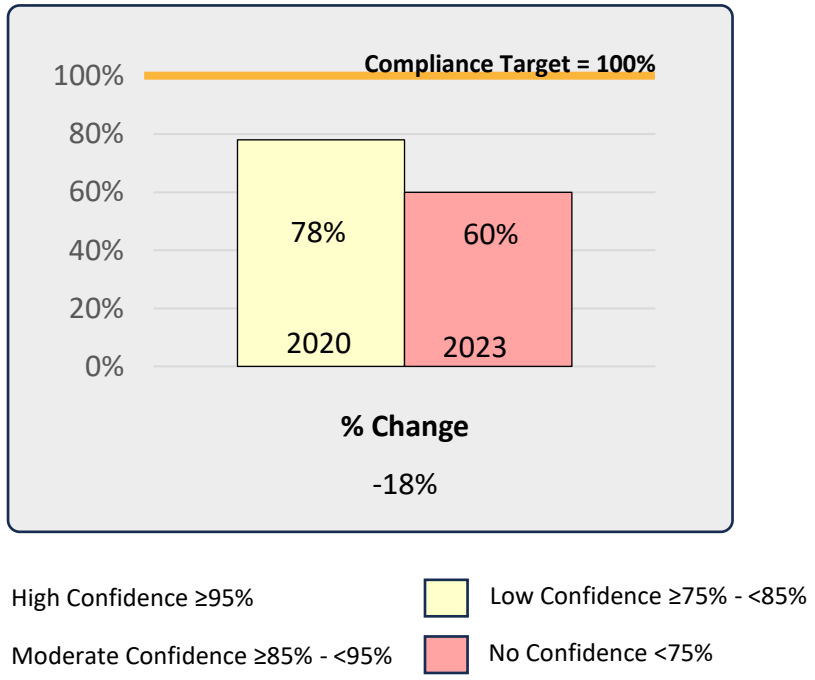


Recommendations:

- AC received a score of 75 percent in the QAPI standard due to deficiencies in its QAPI program structure and failure to demonstrate appropriate oversight of its QAPI program, which impacted the CCO's ability to monitor and evaluate the quality and appropriateness of services furnished to its members consistent with the needs and priorities of the CCO's member population.
- QAPI program structure, including submission of performance measure data, mechanisms to assess the quality and appropriateness of the care provided to members with SHCN and members using LTSS, and proper components of a Quality Improvement Committee (QIC), did not fully comply with federal and State requirements for a QAPI program.
- Demonstrate appropriate oversight of its QAPI program.
- The findings referenced above were previously resolved in the annual Compliance Monitoring Review.

MEMBER RIGHTS & HEALTH EQUITY

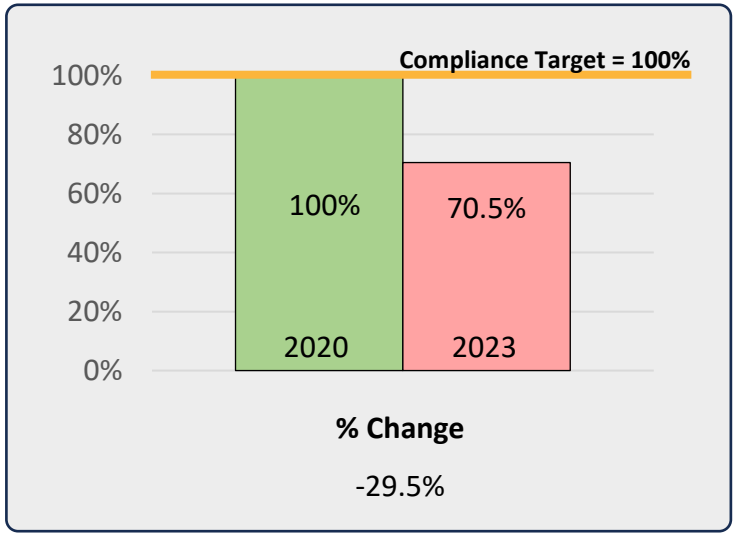
Compliance Monitoring Review
Standard VII: Member Rights and Protections



Recommendations:

- The CCO received a score of 60.0 percent due to a lack of operational structure and failure to demonstrate implementation of an established process, impacting the CCO's ability to ensure that member rights are respected and allowed to be exercised freely without affecting the treatment of members, advance directive requirements are met, and members are notified of their rights as required by federal and State requirements.
- Revise policies and procedures and member- and provider-facing materials to align with federal and State requirements.
- Address one unresolved findings for this standard.

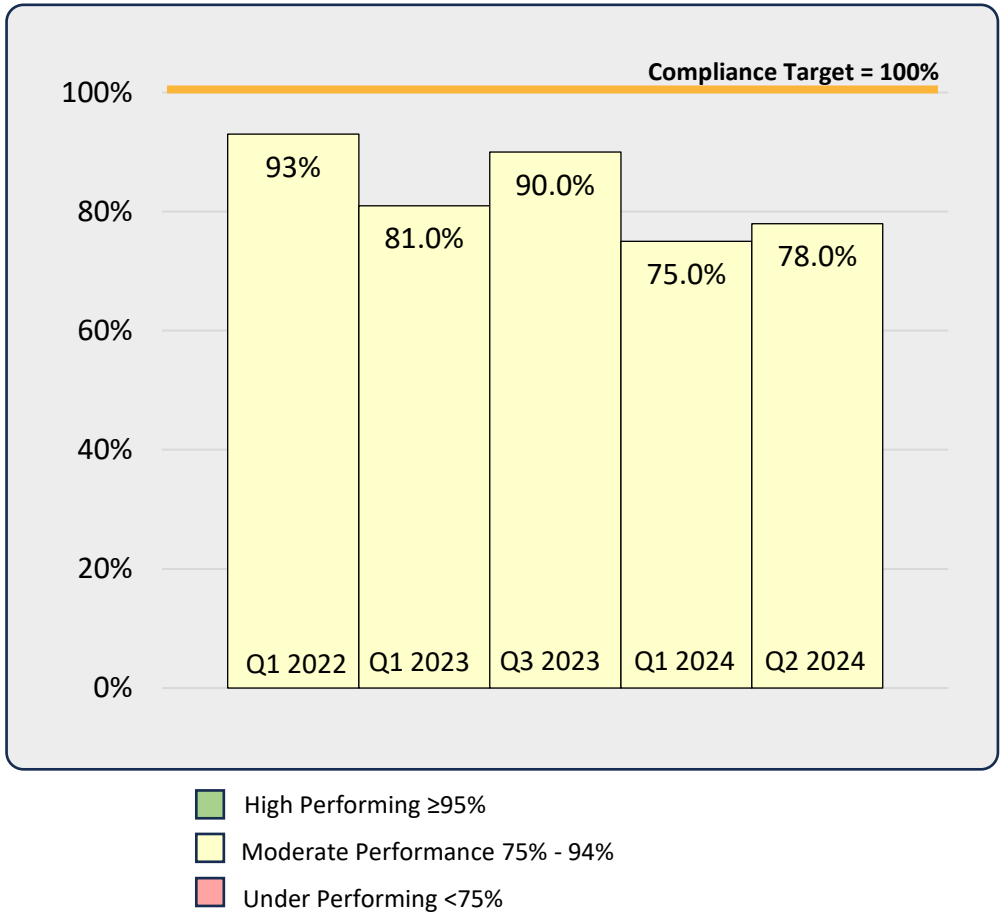
Compliance Monitoring Review
Standard XIV: Member Information



Recommendations:

- AC received a score of 70.5 percent due to a lack of operational structure and failure to demonstrate implementation of an established process, impacting the CCO's ability to ensure timely and proper member communication.
- Revise policies, procedures, and member-facing materials (e.g., member handbook, member notices, CCO formulary, and provider directory) to align with federal and State requirements.
- Demonstrate monitoring of timeliness of notification to members of significant information changes and provide proper notification to members of the availability of member information.
- Address two unresolved findings for this standard.

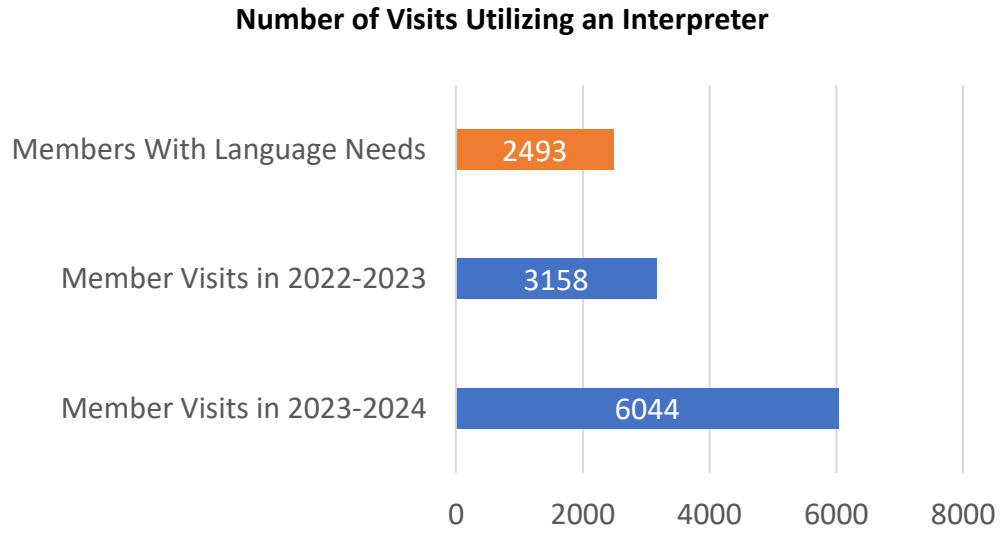
Notice of Adverse Benefit Determination Requirements



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.

Language Access Interpreter Utilization



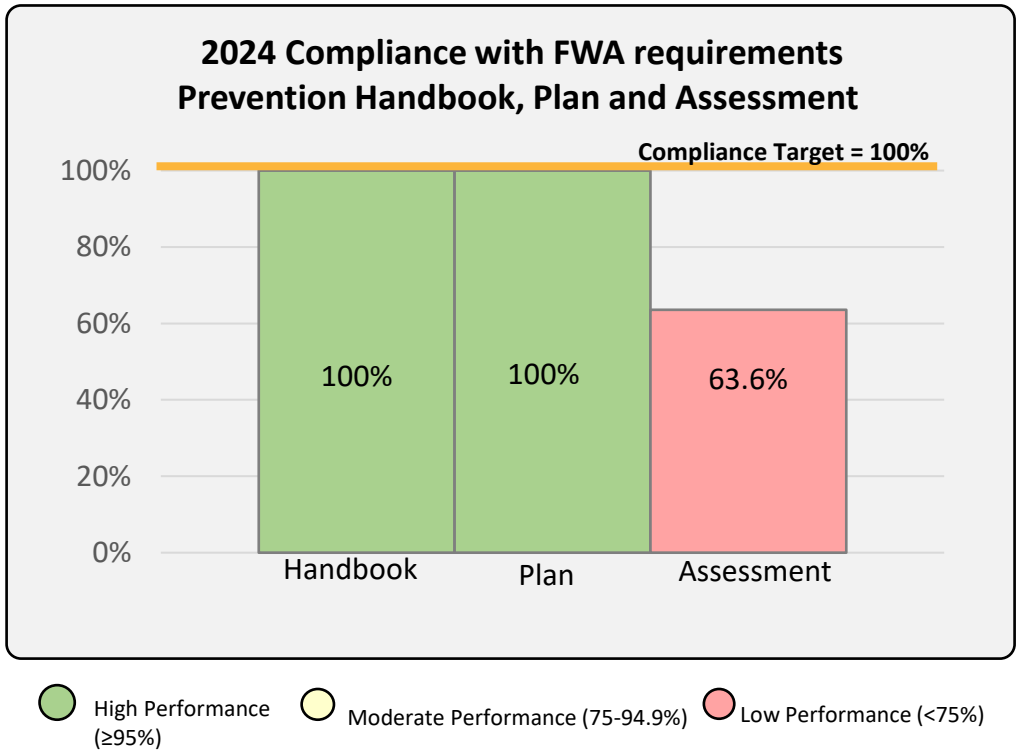
Note: This chart shows a current average of 2.42 visits per member

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

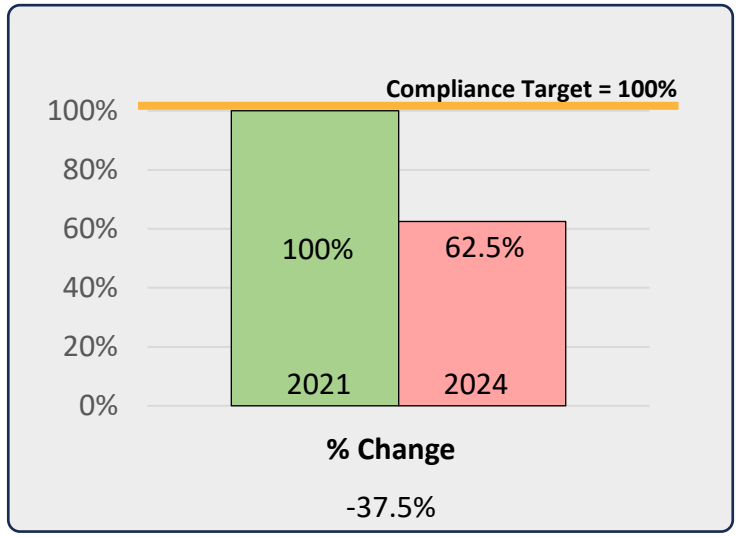
FWA Prevention Handbook, Prevention Plan, and Assessment Requirements



Recommendations:

- Indicate whether Linguava's audit was performed onsite or by a review of documentation.
- Ensure that training is provided, training completions are documented for all employees, and there is alignment between the training logs and the information reported in the annual FWA assessment.
- Demonstrate that employees who are responsible for credentialing receive the additional annual training.
- Demonstrate training completion by providers.
- Demonstrate the CCO's assessment of the subcontractor's training materials and completion of training.
- Annual FWA assessment must include whether PI audit activities were in accordance with the CCO's annual FWA prevention plan.
- Annual FWA assessment must include a description of the methodology used to identify the high-risk providers selected for the planned PI audits. The methodology should include a process specifically addressing how the CCO triages and selects providers and services performed by providers for PI audits or other types of internal reviews. At a minimum, it should encompass what data will be collected, source of the data, data collection and analysis.
- Annual FWA assessment must address whether the compliance review activity was in accordance with the CCO's previous year's FWA prevention plan.

Standard VI: Subcontractual and Delegation Requirements

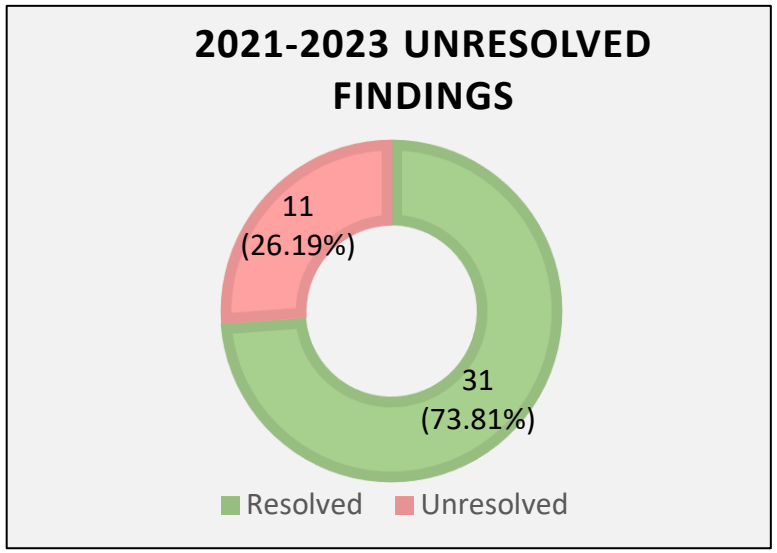


High Confidence ≥95%
Low Confidence ≥75% - <85%
Moderate Confidence ≥85% - <95%
No Confidence <75%

Recommendations:

- AllCare received a score of 62.5 percent due to insufficient documentation to support operations and ensure compliance with federal requirements for written agreements between the CCO and its subcontractors.
- Address any unresolved findings for this standard.
- The CCO must revise its written agreements to align with federally required language for written agreements with subcontractors.

Unresolved Findings from Compliance Monitoring Reviews



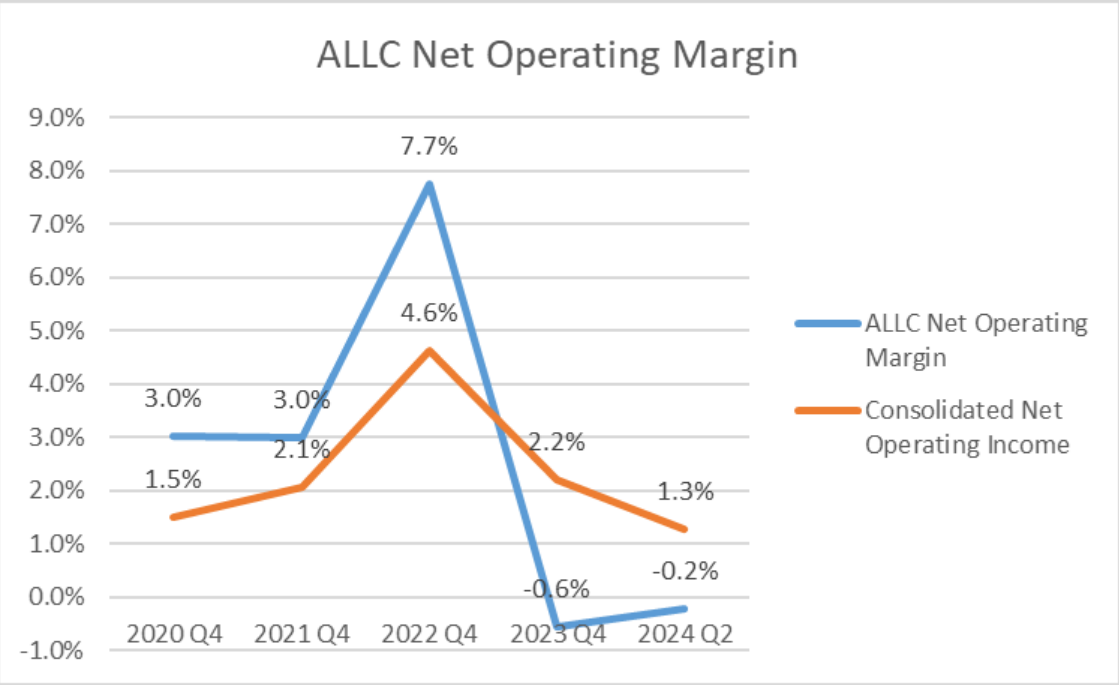
Recommendations:

- Resolve all outstanding findings from previous cycles of Compliance Monitoring Reviews (2021-2023).
- Identify operational gaps preventing the CCO from immediate resolution of audit findings.

Standard	Standard	Total # of IP Findings	Resolved IP Findings		Unresolved IP Findings	
			#	%	#	%
Standard I—Availability of Services	2021	3	0	0%	3	100.0 %
Standard IV—Coverage and Authorization of Services	2023	9	7	78%	2	22.2%
Standard VII—Member Rights and Protections	2023	4	3	75%	1	25.0%
Standard X—Grievance and Appeal Systems	2023	8	5	63%	3	37.5%
Standard XIV—Member Information	2023	11	9	82%	2	18.2%

FINANCIAL PERFORMANCE

Exhibit L: Net Operating Margin



Recommendations:

- AllCare CCO has had 2 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
AllCare CCO	16.8%	14.4%	6.4%
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
AllCare CCO	89.08%
Source: Minimum Medical Loss Ratio data	

Recommendations:

- AllCare CCO reported an MLR for 2021 – 2023 of 89.08%, 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.

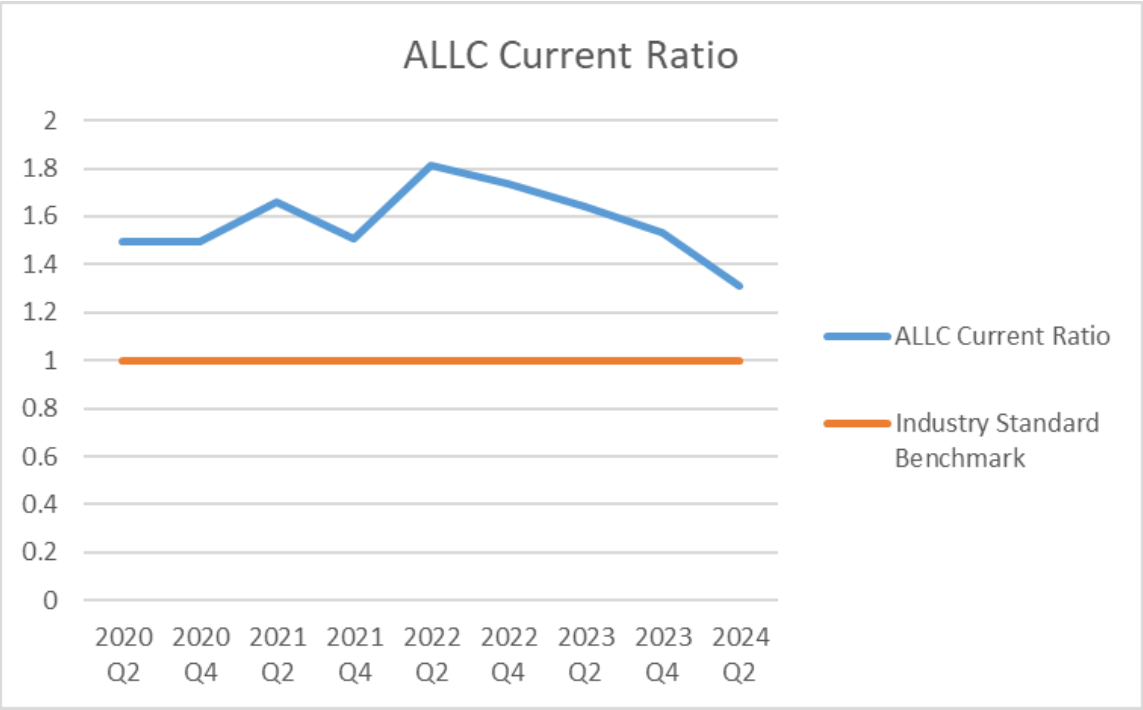
Exhibit L: Restricted Reserve

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

Recommendations:

- AllCare CCO 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 5 periods, 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:

- AllCare CCO 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.