REVISED APRIL 11, 2025

CCO OPERATIONAL SNAPSHOT

OREGON HEALTH AUTHORITY

Executive summary

This report is a point-in-time review of how well coordinated care organizations (CCOs) perform on measures in five key operational areas demonstrating CCO compliance and performance: Access to Care, Service Delivery, Member Rights and Health Equity, Program Integrity, and Financial Performance. These results assess CCO performance individually and collectively. This report aims to provide an objective assessment of CCO compliance with selected federal, state and contractual requirements that are vital to operational success. The report does not reflect the full extent of CCO responsibilities nor evaluate all aspects of CCO performance in addressing the needs of their members. Utilizing results from recent evaluations, this report seeks to illustrate CCO capabilities in critical areas in a new, comprehensive format.

In Access to Care, CCOs improved provider network capacity, ensuring provision of services to their members. CCOs also improved oversight of their network providers. CCOs exhibit greater compliance with federal and state requirements for network adequacy. While most CCOs have programs to monitor and align network capacity to the demand of their members, some CCO networks are more limited in scope, which limits access to care for some members. More specific requirements for CCO network adequacy have both improved CCO network capacity and enhanced Oregon Health Authority (OHA) oversight. With more refined monitoring, reporting and evaluation, both CCOs and OHA can better pinpoint network vulnerabilities and resolve gaps in access.

CCOs showed limited performance improvement in Service Delivery, with some CCOs exhibiting a decline in certain areas. Assessments of CCO care coordination, authorization of benefits, quality improvement and member grievances and appeals exposed several gaps in compliance. A lack of operational structures and the failure to effectively enforce CCO policies were the most common reasons for non-compliance. Limited CCO oversight of subcontractors coupled with subcontractor inability to demonstrate adherence to requirements resulted in frequent failures in meeting federal and state requirements. CCOs have shown incremental improvement in meeting quality of care measures, yet there are several opportunities for improvement.

While significant progress occurred in Member Rights and Health Equity, substantial improvement is still needed. CCOs performed better at meeting requirements for notifying members when they deny a service. However, CCOs also saw a decline in providing adequate member information and meeting requirements for member rights and protections. For health equity, most CCOs boosted the use of interpreters and showed continued progress toward meeting health equity plan focus

area requirements. CCOs made gains increasing the supply of Traditional Health Workers available to members, but faced challenges with specific THW provider types.

CCO Fraud, Waste and Abuse performance across specific deliverables has been mixed. In 2024, most CCOs achieved compliance with specific federal and state fraud, waste and abuse requirements, previously not achieved by any CCOs. At the same time, OHA found deficiencies in the implementation of these processes through the monitoring of assessments, as well as extensive subcontractor non-compliance. Further examination of both CCOs and their subcontractors revealed inconsistent and even absent CCO monitoring of subcontractors.

As stewards of billions in state and federal funding, strong Financial Performance is imperative for CCOs. While the negative impacts of the pandemic caused most CCOs to face some financial challenges, in recent years most CCOs have maintained compliance with federal and state financial requirements.

CCOs have implemented improvement plans to mitigate non-compliance for most of the deficiencies in this report. OHA will continue to support CCOs in their efforts to adhere to federal and state requirements. This report does not incorporate all contractual requirements or evaluate all federal and state managed care rules. However, it is extensive enough to indicate how well CCOs have met core operational requirements. For both CCOs and OHA, this report can be a tool to highlight where to do more work to meet the needs of CCO members.

The next CCO contract procurement process will result in OHA selecting CCOs entrusted with health care for more than 1.4 million people in Oregon. OHA will use the findings in this report highlighting the strengths and shortcomings of the current contract to develop the evaluation criteria and selection process for the upcoming procurement.

What's inside

Introduction

The CCO Operational Snapshot assesses Oregon's 16 coordinated care organizations (CCOs). The report focuses on effectiveness in delivering equitable, accessible, and high-quality care to more than 1.4 million Oregon Health Plan (OHP) members.

This report covers five key operational areas — Access to Care, Service Delivery, Member Rights and Health Equity, Program Integrity and Financial Performance — that are critical to achieving systemwide improvements in care delivery and population health outcomes, as well as reaching OHA's goal of eliminating health disparities by 2030. Each operational area section has subsections highlighting the selected criteria, measures and corresponding data.

OHA identified specific criteria for each performance area. These criteria represent key operational and compliance measures. The report summarizes several years of operational and compliance monitoring and reporting, bringing together audit findings from contract deliverable evaluations, external quality reports, and actuarial and fiscal analyses. The report highlights CCO performance for the selected criteria and measures. Evaluations carried out by the External Quality Review Organization rated CCO performance using a scale of High Confidence, Moderate Confidence, Low Confidence, and No Confidence, based on the overall compliance score achieved by the CCO. External Quality Review activities also compare CCO performance to the statewide CCO compliance average. A subset of deliverables uses an OHA-developed performance scale that evaluates performance in comparison to the compliance standard (100%) in assigning a high, moderate, or low performance level. The remaining deliverables use an OHA-developed scale that evaluates performance in comparison to the CCO average assigning a high, moderate, or low performance level.

In advance of the next CCO procurement, CCOs can use the Operational Snapshot to identify areas requiring operational and performance improvement and the deficiencies to address. In some areas, CCOs may need to further evaluate and assess their operational infrastructure, membership needs and member demographics to determine how to address the root cause of the performance gaps.

Although this report is intended to address a broad scope of CCO requirements, it does not comprehensively reflect the full extent of CCO responsibilities or evaluate all aspects of the CCO model. It is critical to understand the contents of this report, but also its limitations in capturing all aspects of the CCO model. This report seeks to provide an objective assessment of CCO compliance with federal, state and contractual requirements. While these are vital to the success of the CCO model, the expectation of a CCO is ultimately to ensure their members can access quality healthcare services in a manner that will result in intended health outcomes. A complete evaluation of a CCO's ability to meet the needs of their members requires an extensive and complex analysis incorporating a variety of CCO attributes and activities that extend beyond the scope of this report. It should also be noted that over the life of the current CCO contract, the eligibility of members served by the CCOs was expanded, as well as the benefits package, introducing new and modified expectations for CCOs. The measures included in this report should be taken with these changes in mind offering a recognition that the CCO model represents a continuing journey of progress.

Here are a few of the key CCO attributes, activities and changes that contribute to overall CCO quality and outcomes not captured in this report.

1. Community Investment - Through the utilization of community investments, CCOs work to address challenges faced by the local healthcare system.
2. Community Engagement & Partnership - CCOs take a leadership role in the communities through collaboration with key community partners in the healthcare system, as well as governmental agencies, elected officials, the business community and the general public.
3. COVID-19 Pandemic – It should be noted that the current CCO contract began on January 1, 2020. During the first several years of the contract, CCOs were consumed with the overwhelming challenges of a worldwide virus and a significant expansion in membership. The pandemic caused a delay in the implementation of many anticipated elements of the new contract, including some compliance requirements.
4. 1115 Waiver Benefits – Through the 1115 Waiver Demonstration, approved by the Centers for Medicare & Medicaid Services (CMS) in September 2022, benefits for CCO members were expanded significantly in the last few years to include Early & Periodic Screening, Diagnostic and Treatment (EPSDT) and Health-Related Social Needs (HRSN) services including climate, housing and nutrition.
5. Expanded Eligibility – CCOs now provide coverage for two new plans that expanded those eligible for healthcare benefits. The Healthier Oregon Program was established in 2023 and

expanded in 2024. Also in 2024, the Basic Health Plan was established. Both of these programs required new contractual relationships between OHA and CCOs.

6. Community Health Assessment (CHA) & Community Health Improvement Plan (CHP) – CCOs lead a community effort to assess the health of their community and develop a plan to meet their healthcare needs. This extensive effort results in the development of the CHA and the CHP. These documents, and the community's progress in meeting identified objectives, is a significant responsibility for all CCOs.
7. Health Equity – While a few of the measures provide some insight into a CCO's efforts to ensure equity in their members' access to care and quality of service delivery, as well as the extensive efforts undertaken by CCOs to mitigate inequities, are not fully addressed.

Operational areas

Access to Care

This area assesses the CCOs' ability to maintain an adequate network of appropriate health care providers to ensure all services are available and accessible to members in a timely manner. The information in this area is in three subsections: network development and monitoring; managed care compliance; and network adequacy.

Service Delivery

This area assesses the CCOs' ability to ensure quality and appropriateness of care and availability of OHP-covered benefits that are medically necessary and appropriate. The information in this area is in three subsections: coverage of services; grievance and appeal system; and quality assessment and performance improvement.

Member Rights and Health Equity

This area assesses the CCOs' commitment to provide information to members in an accessible and easily understood format and develop a health equity infrastructure that ensures services are tailored to the members' cultural, linguistic, and health needs. The information in this area is in two subsections: health equity and member rights and information.

Program Integrity

This area assesses the CCOs' oversight and reporting processes to ensure compliance with state and federal requirements. The information in this area is in three subsections: fraud, waste and abuse; subcontracting and delegation; and unresolved Compliance Monitoring Review findings.

Financial Performance

This area assesses the CCOs' financial stability to support increased risks, utilization, and higher acuity members.

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ACCESS TO CARE

About this operational area

Access to care means Oregon Health Plan members can get the care they need when, where, and how they need it. CCOs must maintain a network of health care providers so members have timely access to quality services. To ensure CCOs are meeting these standards, OHA monitors their compliance with state and federal requirements, such as provider-to-member ratios and the time or distance it takes to get to providers.

What does access to care compliance look like?

Network Development & Monitoring

This section focuses on monitoring CCO performance and capacity as they build, maintain, and improve upon their networks of Oregon Health Plan providers.

Managed Care Compliance

This measures CCO adherence to rules and requirements, such as federal regulations, Oregon Administrative Rules, and CCO Contract requirements.

Network Adequacy

Network adequacy means making sure people have access to health care providers. The heart of network adequacy is this one question: Is the care you need available where and when you need it?

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NETWORK DEVELOPMENT & MONITORING

Successfully building and maintaining an adequate network of providers within a CCO's service area means that the CCO is ensuring its members have access to quality care and services whenever they need them. OHA is tasked with implementing checks and balances to make sure CCOs are doing just that, utilizing delivery system network reporting and analysis to monitor performance and adequacy of CCO networks, and bring focus to any gaps or issues before they affect the care and services members receive.

Statewide Compliance with Time & Distance Standards

Urban areas:
9 CCOs had full compliance in 2023 for all provider types

Rural areas:
10 CCOs had full compliance in 2023 for all provider types

Statewide Compliance with Delivery System Network Annual Narrative Evaluations

Domain 1: DSN Governance Structure

(Statewide average)

2023	98.5%
2024	100%

Domain 2: Member Needs and Population Management

(Statewide average)

2023	88.7%
2024	96.1%

Domain 3: DSN Monitoring and Analysis

(Statewide average)

2023	82.8%
2024	93.4%

Domain 4: Network Response Strategy

(Statewide average)

2023	85.5%
2024	90.5%

Delivery System Network (DSN) Annual Narrative Report

The DSN Annual Narrative Report evaluates CCO processes and infrastructure for managing and monitoring their provider networks to ensure they meet member needs. This includes oversight structures, membership monitoring, network analysis, and strategies to address findings.

Table 1: DSN Annual Narrative Report Evaluation Results – 2023, 2024

	Overall Score		Domain 1: DSN Governance Structure		Domain 2: Member Needs and Population Management		Domain 3: DSN Monitoring and Analysis		Domain 4: Network Response Strategy	
	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024
AH	94.4%	96.2%	100%	100%	100%	100%	85.00%	90%	100%	100%
AC	63.5%	82.7%	75.0%	100%	56.3%	75.0%	50.0%	80%	91.7%	91.7%
CHA	73.1%	92.3%	100%	100%	81.3%	100%	70.0%	90%	58.3%	83.3%
CPCCO	80.8%	88.5%	100%	100%	93.8%	100%	60.0%	75%	91.7%	91.7%
EOCCO	90.4%	96.2%	100%	100%	87.5%	93.8%	95.00%	100%	83.3%	91.7%
HSO	90.0%	92.0%	100%	100%	100%	87.5%	80.00%	90%	90.0%	100%
IHN	65.4%	94.2%	100%	100%	81.3%	87.5%	55.0%	95%	50.0%	100%
JCC	80.8%	88.5%	100%	100%	93.8%	100%	60.0%	75%	91.7%	91.7%
PCS-CO	100%	96.2%	100%	100%	100%	100%	100%	100%	100%	83.3%
PCS-CG	100%	96.2%	100%	100%	100%	100%	100%	100%	100%	83.3%
PCS-LN	100%	96.2%	100%	100%	100%	100%	100%	100%	100%	83.3%
PCS-MP	100%	96.2%	100%	100%	100%	100%	100%	100%	100%	83.3%
TCHP-N	86.5%	96.2%	100%	100%	87.5%	100%	100%	100%	58.3%	83.3%
TCHP-S	86.5%	96.2%	100%	100%	87.5%	100%	100%	100%	58.3%	83.3%
UHA	96.0%	100%	100%	100%	93.8%	100%	95.00%	100%	100%	100%
YCCO	76.0%	98.1%	100%	100%	56.3%	93.8%	75.0%	100%	100%	100%
Average Rate	86.5%	94.1%	98.5%	100%	88.7%	96.1%	82.8%	93.4%	85.5%	90.5%

Sources: 2023 and 2024 DSN Delivery System Network Annual Reports and DSN Annual Narrative Report

Description	Overall Score		Domain 1		Domain 2		Domain 3		Domain 4	
	2023	2024	2023	2024	2023	2024	2023	2024	2023	2024
High performance	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Moderate performance	75.0-99.9%	75.0-99.9%	97.0-99.9%	97.0-99.9%	75.0-99.9%	75.0-99.9%	75.0-99.9%	75.0-99.9%	75.0-99.9%	75.0-99.9%
Low performance	< 75%	< 75%	< 97%	< 97%	< 75%	< 75%	< 75%	< 75%	< 75%	< 75%

Why this matters to members

A high-performing CCO can more likely develop and maintain a provider network that is responsive to the health care needs, utilization, and demographic composition of its members. Network gaps are identified proactively, limiting the impact on members, and the CCO can implement clear strategies to address those gaps, facilitating access to care.

What this tells us about performance

Overall, CCOs have made progress in managing provider networks, with improved monitoring programs aligning network adequacy with member needs. However, some programs remain limited in scope, requiring further refinement. Only one CCO achieved full compliance, as reflected by an overall score of 100 percent, but nearly all CCOs exhibited improvement. CCOs are encouraged to continue developing their processes and infrastructure to monitor and manage their provider networks in meeting member needs.

In 2024, CCOs showed smaller range and higher overall compliance scores than in prior DSN Annual Narrative Report evaluations (2022-2023). CCO-specific compliance scores ranged from 82.7 percent (AC) to 100 percent (UHA). Eleven CCOs had overall compliance scores equal to or above the CCO average of 94.1 percent in 2024. This exhibited an overall high level of compliance. Only three CCOs (AC, CPCCO, and JCC) exhibited overall compliance of less than 90 percent.

Between 2022 and 2023, domain requirements were updated to better reflect CCO contract and Oregon Administrative Rule (OAR) requirements, as well as address redundancy across deliverables.

Domain 1: DSN Governance Structure

This domain required CCOs to provide documentation of their operational infrastructure for overseeing and monitoring provider network adequacy, including policies, procedures and data systems.

All CCOs achieved full compliance with most reporting no substantive changes to governance structures or sub-contractual relationships since 2023.

Domain 2: Member Needs and Population Management

This domain required CCOs to document processes for monitoring current and anticipated membership and service needs, supported by policies, procedures, and data reports.

Eleven CCOs achieved full compliance, indicating significant improvement in resolving findings from the previous years' reviews. Nearly all CCOs demonstrated improvement in 2024 as compared to 2023. Observations from the 2024 evaluation include the following:

- Most CCOs reported implementation or planned implementation of frequently updated dashboards rather than periodic manual reporting for monitoring member needs and conducting population management.
- Findings of noncompliance and scores below the CCO aggregate were typically related to operational practices of monitoring and reporting on individual members (e.g., case management for members with disabilities) rather than member populations, or only assessing OHA-determined CCO performance metrics (e.g., preventive screening rates) rather than the actual needs or utilization patterns of the member population.

Domain 3: DSN Monitoring and Analysis

This domain assessed CCO processes for monitoring and analyzing their provider networks, including performance measures and reporting. While OHA has not established contractual standards for some elements related to DSN monitoring and analysis, OHA has consistently conveyed expectations that CCOs collect, analyze, and consider data associated with the elements in this domain through written guidance, individual technical assistance sessions and large group discussions.

Nine CCOs achieved full compliance. CPCCO and JCC had the lowest compliance score at 75 percent. Observations from the 2024 evaluation include the following:

- All CCOs complied with OHA's 2024 provider monitoring requirements by provider types, tiers, and urbanicities. Implementation of these standards was essential to the CCOs' overall compliance with OHA's quantitative network adequacy requirements.
- Several CCOs identified the expansion of traditional health worker (THW) providers as critical to their monitoring of and network capacity for the provision of culturally and linguistically appropriate care. These CCOs allocated funding toward the training, recruitment, retention, and expansion of their THW provider network.
- Most deficiencies in this domain were related to weak data collection and lack of consideration of available data to support network adequacy monitoring and decision making. CCOs were least compliant with time to appointment availability, use of telehealth modalities, and availability of physical accessibility accommodations.

Domain 4: Network Response Strategy

This domain required documentation of actions taken to address network findings, including identifying barriers and implementing corrective actions.

Five CCOs (AH, HSO, IHN, UHA, and YCCO) achieved full compliance. TCHP-S, TCHP-N, PCS-MP, PCS-LN, PCS-CO, PCS-CG, and CHA, performed below the CCO aggregate receiving an 83.3 percent compliance score. Observations from the 2024 evaluation include the following:

- Similar to previous years, most CCOs identified a network adequacy gap around certified and qualified health care interpreters. Some CCOs described intervention plans that included funding scholarship programs for qualified and certified health care interpreters.
- Many CCOs demonstrated consideration of both their global provider network and region-specific provider networks (both at the county and city level) when assessing network adequacy gaps and planning interventions. Time and distance assessment, community feedback and provider feedback often drove these gap assessments. Several CCOs also showed proactive identification of potential gaps by cross-referencing multiple analyses, including but not limited to telehealth utilization, service trends by demographics, and out-of-network requests and authorizations.
- Most deficiencies in this domain were related to providing irrelevant or incomplete answers to elements, lack of plans (i.e., methods, metrics, and timelines) for how to monitor the

efficacy of planned network interventions and anticipated changes to future network capacity needs.

About the data

OHA's contracted External Quality Review Organization (EQRO), Health Services Advisory Group (HSAG), reviews and evaluates each CCO's narrative submission. The evaluation results are communicated back to each CCO individually and are included in the Delivery System Network Annual Report, which is posted publicly on the CCO Quality Assurance page.

CCO Compliance with time and distance standards

This section highlights the CCOs' compliance with OHA time and distance standards in 2023. In 2023, the time and distance standard required members have access to 95% of provider types within 30 miles or 30 minutes for urban settings or 60 miles and 60 minutes within rural settings. The time and distance standards were updated in 2024 to improve OHA's ability to monitor access and availability of covered services across geographic regions for pediatric and adult members.

The findings in this section are limited to a subset of core providers that represent and perform fundamental health services covered by the CCOs. The full report includes additional provider types evaluated in the review period. The tables below show the percentages of CCO members with access to core service categories by urban and rural geographic classifications.

Table 2: Time and Distance Results by Provider Type—Urban (2023)

CCO	PCP	PCD	MHP	SUD	OB/GYN	OPT	DME	HOSP	Rx	SNF
AC	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
CPCCO	100%	100%	100%	92.3%	92.5%	92.3%	100%	100%	100%	92.7%
EOCCO	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
HSO	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
IHN	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
JCC	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
PCS-CO	100%	100%	100%	100%	100%	100%	100%	95.4%	100%	98.8%
PCS-LN	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table 2: Time and Distance Results by Provider Type—Urban (2023)										
CCO	PCP	PCD	MHP	SUD	OB/GYN	OPT	DME	HOSP	Rx	SNF
PCS-MP	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TCHP-N	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TCHP-S	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
YCCO	100%	100%	100%	100%	100%	100%	99.6%	100%	100%	100%
Source: 2023 Delivery System Network Evaluation										

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

Description	Score
Full Compliance	≥ 95%
Not Meeting Compliance	< 95.0%

Table 3: Time and Distance Results by Provider Type—Rural (2023)										
CCO	PCP	PCD	MHP	SUD	OB/GYN	OPT	DME	HOSP	Rx	SNF
AH	100%	100%	100%	100%	100%	100%	90.8%	100%	94.3%	94.5%
AC	100%	98.5%	100%	100%	100%	100%	92.9%	100%	100%	81.3%
CHA	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
CPCCO	100%	100%	100%	100%	100%	100%	100%	100%	100%	93.9%
EOCCO	99.8%	99.6%	99.5%	98.5%	96.5%	98.6%	89.5%	98.5%	99.5%	75.0%
HSO	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
IHN	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
JCC	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
PCS-CG	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
PCS-CO	99.9%	99.9%	100%	>99.9%	>99.9%	100%	99.9%	98.7%	100%	99.2%
PCS-LN	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
PCS-MP	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TCHP-N	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
TCHP-S	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table 3: Time and Distance Results by Provider Type—Rural (2023)										
CCO	PCP	PCD	MHP	SUD	OB/GYN	OPT	DME	HOSP	Rx	SNF
UHA	100%	100%	100%	>99.9%	>99.9%	>99.9%	>99.9%	>99.9%	99.8%	>99.9%
YCCO	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Source: 2023 Delivery System Network Evaluation										

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

Description	Score
Full Compliance	≥ 95%
Not Meeting Compliance	< 95.0%

Why this matters to members

The geographic distribution of providers indicates whether the network of providers is distributed appropriately relative to the location of the member population. Measuring the time and distance from the member's residence to provider location helps ensure providers are geographically available within each service area. CCOs should monitor time and distance changes regularly to ensure members have continued access to needed providers within appropriate time and distance. CCOs must actively monitor their member population closely (e.g., prevalence of diseases/diagnoses, utilization and demographics) to determine how to improve their provider network.

What this tells us about performance

In 2023, CCOs were expected to provide access to 95 percent of members within 30 miles or 30 minutes of a provider in urban settings, and 95 percent of members within 60 miles or 60 minutes of a provider in rural settings. The tables above show the percentages of CCO members with access to core service categories by urban and rural geographic classifications, respectively.

Not all CCOs have urban settings within their service areas (i.e., AH, CHA, PCS-CG, and UHA). All CCOs with urban settings met the urban time and distance access standards for the listed provider types with the exception of CPCCO, which did not meet the access standard for substance use disorder (SUD) providers, obstetrician/gynecologist (OB/GYN), outpatient physical therapy (OPT), and skilled nursing facility (SNF) specialty providers. However, these provider types were

nearly compliant with the access standard, ranging from 92.3 percent compliant to 92.7 percent compliant and impacting between 147 members (i.e., OB/GYN) and approximately 370 members (i.e., SNF). Additionally, the CCO's urban setting within its otherwise rural service area is a small, remote community that had been classified under OHA's methodology as urban due to the community's proximity to a sufficiently populous town located just across the Washington border. CPCCO's results for rural time and distance access indicate 100 percent access for members to all but SNF facilities for the listed aggregate provider types. As such, these results should not necessarily be interpreted to mean that CPCCO members were without access to key services.

All CCO service areas include at least some rural settings. The CCOs met the rural time and distance access standards for the listed provider types with the exceptions of AH (i.e., durable medical equipment, pharmacy and SNF), AC (i.e., durable medical equipment and SNF), CPCCO (i.e., SNF), and EOCCO (i.e., durable medical equipment and SNF). These results are representative of the often-constrained pool of facilities available for contracting in rural areas. However, each CCO with noncompliant access rates had one or more facilities that were far enough below standards to merit further review or follow-up. The CCOs showed a high level of compliance with state-established time and distance access standards for primary care provider (PCP) services with noncompliance related to specific specialty providers, as measured against the 2023 time and distance standard.

Despite the CCOs' efforts to address network deficiencies, the results identify opportunities to improve the quality of the CCOs' provider data, their monitoring of members' needs, population assessment and management, monitoring of their DSN, and the implementation of network adequacy interventions.

About the data

The DSN Annual Evaluation report is prepared on an annual basis by HSAG. The report evaluates the CCOs' delivery system networks to assess network adequacy and compliance with Oregon's standards for access to care. The DSN Annual Evaluation Report is posted publicly on the Quality Assurance page.

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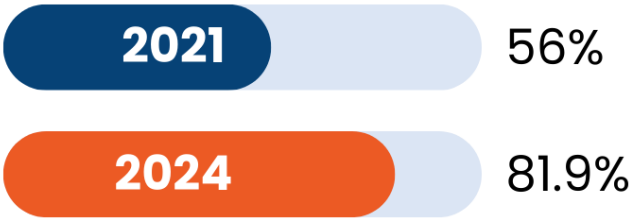
MANAGED CARE COMPLIANCE

Measuring compliance with federal managed care regulations, Oregon Administrative Rules (OARs), and contract requirements allows OHA and CCOs to better understand strengths, opportunities for improvement, recommendations, and the necessary actions that will bring the CCOs into compliance with federal managed care regulations and state requirements with the standard areas reviewed.

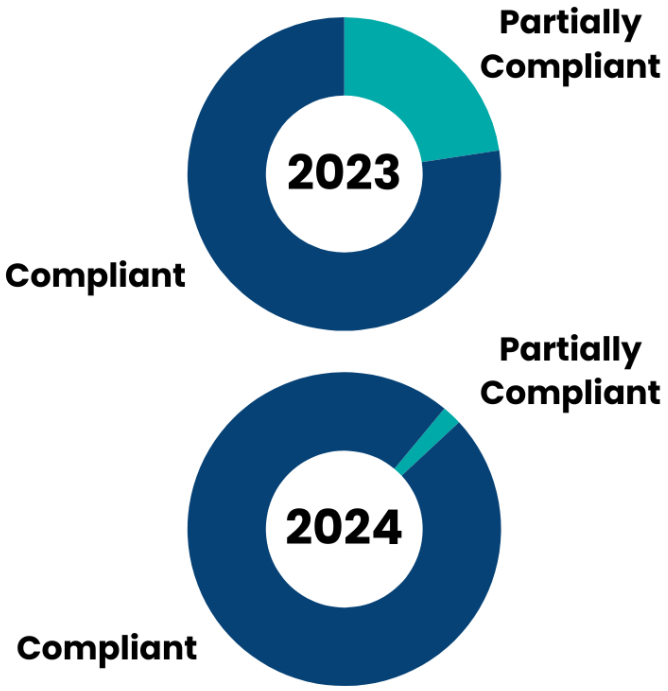
Assurance of Adequate Capacity and Availability of Services



Most frequent opportunities for CCO improvement

Develop and implement a methodology for monitoring and maintaining its provider network for the federal and State-required components.
Demonstrate corrective action when providers fail to meet appointment standards.
Revise provider and member communications to include the appropriate access to care and service requirements.
Strengthen documentation, monitoring, and implementation processes to fully meet federal and state requirements and support timely access to care and services.

Non-Quantitative Treatment Limitations (NQTL) Compliance with Mental Health Parity Standards



Improvements were made in NQTL compliance across all 3 management categories year over year with all but 1 CCO compliant in 2024.

Adequate capacity and availability of services

Table 4: Compliance with Assurance of Adequate Capacity and Availability of Services requirements

Compliance Monitoring Review, Standard I and II, 2021

Compliance Monitoring Review, Standard I, 2024

CCO	Standard I, 2021	Standard II, 2021	Standard I, 2024	Number of Resolved Findings/ Total Number of Improvement Plan Findings (2021)	Number of Compliant Elements (2024)	Total Number of Elements (2024)
AH	50%	75%	86.80%	Stand. I: 0/1 & Stand. II: 0/1	14	19
AC	62%	63%	71.10%	Stand. I: 0/3	8	19
CHA	50%	63%	71.10%	Stand. I: 0/2	9	19
CPCCO	31%	63%	76.30%	Stand. I: 1/2 & Stand. II: 0/1	12	19
EOCCO	81%	88%	89.50%	N/A	15	19
HSO	46%	50%	55.30%	Stand. I: 0/9 & Stand. II: 0/2	3	19
IHN	38%	75%	89.50%	N/A	15	19
JCC	31%	63%	76.30%	Stand. I: 1/2 & Stand. II: 0/1	12	19
PCS-CO	65%	63%	89.50%	Stand. I: 0/1	15	19
PCS-CG	65%	63%	89.50%	Stand. I: 0/1	15	19
PCS-LN	65%	63%	89.50%	Stand. I: 0/1	15	19
PCS-MP	65%	63%	89.50%	Stand. I: 0/1	15	19
TCHP-N	75%	90%	86.80%	Stand. I: 0/1 & Stand. II: 1/1	14	19
TCHP-S	46%	75%	86.80%	Stand. I: 0/1 & Stand. II: 1/1	14	19
UHA	85%	88%	78.90%	Stand. I: 0/1	12	19
YCCO	65%	75%	84.20%	Stand. I: 0/1	13	19
Statewide CCO Compliance Score	56%	56%	81.90%			

Source: External Quality Review Technical Reports, 2021 and 2024

Note: The state compliance standard is 100 percent. Standards I and II were combined in 2024 into one standard (Standard I). The combined 2024 standard included all requirements previously found in Standards I and II.

Rating	Description
High Confidence (≥ 95%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated substantial compliance with state, federal, and contract requirements. CCO's performance exhibited mostly Met ratings and high overall compliance scores.
Moderate confidence (≥ 85 – <95%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated moderate compliance with state, federal, and contract requirements. CCO's performance exhibited a mix of Met, Partially Met, and Not Met ratings resulting in moderate compliance scores, indicating opportunities for improvement.
Low Confidence (≥75 – <85%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated low compliance with state, federal, and contract requirements. CCO's performance exhibited a mix of Met, Partially Met, and Not Met ratings resulting in low to moderate compliance scores indicating opportunities for improvement.
No Confidence (<75%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated general noncompliance with state, federal, and contract requirements. CCO's performance exhibited a large proportion of Partially Met and Not Met ratings resulting in low compliance scores, indicating substantial opportunities for improvement across most standards.

Why this matters to members

Assurance of Adequate Capacity and Availability of Services requirements assessed the CCO's ability to maintain and monitor a network of appropriate providers to ensure members have adequate access to covered services. Key responsibilities included:

- Maintaining a provider network with written agreements to ensure timely and medically appropriate access to services.
- Ensuring access to out-of-network services when necessary and coordinating payment so members are not burdened by extra costs.
- Allowing members to obtain a second opinion from a network provider or externally at no cost.
- Providing physical access, reasonable accommodations, and accessible equipment for members with disabilities.

- Promoting culturally, linguistically appropriate, and trauma-informed service delivery for all members, including those with limited English proficiency, diverse backgrounds, disabilities, and varying gender identities or orientations.
- Anticipate members' needs by forecasting enrollment and expected service utilization to guide network capacity, while gathering data on wait times, provider panel availability, and grievances and appeals to continuously improve timely access to care.

What this tells us about performance

The Assurance of Adequate Capacity and Availability of Services standard focused on the CCO's network capacity monitoring and quality improvement efforts to address deficiencies.

2024 findings: The statewide compliance score rose from 56 percent in 2021 to 81.9 percent in 2024, reflecting a substantial overall improvement. While none of the CCOs met the state compliance standard of 100 percent, almost all CCOs made improvements in comparison to their 2021 scores. Six CCOs (EOCCO, IHN, PCS-CO, PCS-CG, PCS-LN, and PCS-MP) received a compliance score of 89.5 percent, which was the highest score. HSO received the lowest compliance score of 55.3 percent. IHN showed the most dramatic increase, jumping from 38 percent in 2021 to 89.5 percent in 2024, a gain of over 50 percentage points. UHA's score decreased from 85 percent in 2021 to 78.9 percent in 2024, making it the only CCO that did not improve over time. CCOs received findings due to insufficient documentation supporting operations, 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.

Opportunities for improvement include:

- Strengthen documentation, monitoring, and implementation processes to fully meet federal and state requirements and support timely access to care and services.
- Develop and implement a methodology for monitoring and maintaining its provider network for the federal and state-required components.
- Demonstrate corrective action when providers fail to meet appointment standards.
- Revise provider and member communications to include the appropriate access to care and service requirements.

All CCOs were required to develop an improvement plan based on the 2021 and 2024 compliance reviews.

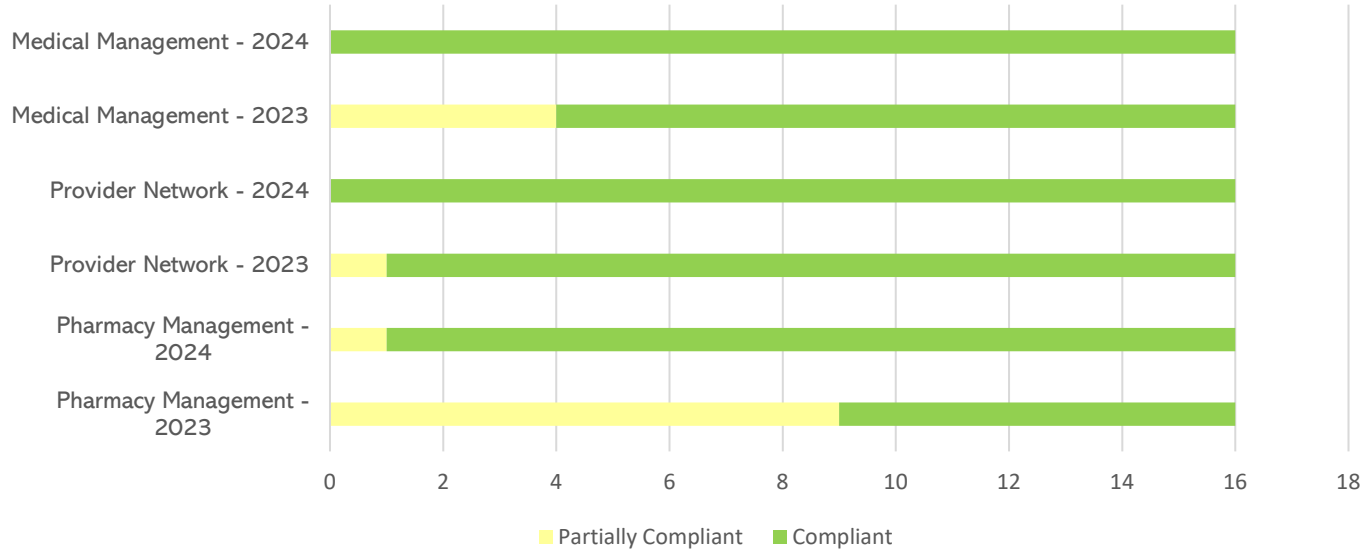
About the data

Federal Medicaid Managed Care Regulations requires that an EQRO conduct a review to determine CCO compliance with the standards set forth in 42 CFR §438 — Managed Care Subpart D. HSAG, Oregon's EQRO, conducts CMRs of each of its contracted CCOs, across 16 standards. Individual CCO CMRs and overall Statewide Annual Technical Reports are posted publicly.

Mental health parity

CCOs are evaluated across a variety of key areas including a review of the CCOs' treatment limitations on mental health/substance use disorder benefits to ensure they are comparable to and applied no more stringently than limitations applied to the medical/surgical benefits. Non-quantitative treatment limitations (NQTLs) are a mechanism used by CCOs to manage and ensure members' health care is necessary and appropriate. The most prevalent NQTLs were utilization management processes (i.e., prior authorization, concurrent review, and retrospective review); medical necessity criteria; provider credentialing requirements; and drug utilization review mechanisms (e.g., formulary design).

Figure 1: NQTL Domain Compliance with Mental Health Parity Standards



Why this matters to members

Federal mental health parity regulations are intended to ensure that coverage and access to services for the treatment of mental health (MH) and SUD conditions are provided in parity with treatments provided for medical and surgical (M/S) conditions. Access to behavioral health services should not be more restrictive than physical health services.

What this tells us about performance

Except for one CCO, all other CCOs resolved 2023 partially compliant and not compliant findings and provided the appropriate documentation to demonstrate compliance with mental health parity requirements and standards. HSO was unable to fully resolve the 2023 pharmacy management findings because sufficient documentation was not provided demonstrating adequate oversight of subcontractors' compliance with parity standards for formulary design, resulting in a Partially Compliant rating.

About the data

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 House Bill 3046 (2021). The reports are available publicly on the Mental Health Parity page.

OREGON HEALTH AUTHORITY

NETWORK ADEQUACY

CCO provider network capacity is assessed across service disciplines, catagorized into four distinct provider types: Primary Care Providers, Primary Care Dentists, Mental Health Providers, and Substance Use Disorder Treatment Providers.

To better understand if a CCO's network has enough providers to meet member needs, compliance is reviewed by measuring the following for each of the provider types:

- How many providers are available compared to the number of members?
- How many active providers are serving OHP members?
- How many providers are located within the CCO's service area?
- How many providers are accepting new members?

Statewide Network Adequacy

Primary Care Providers

-Serving all ages: 69%
-Located in service area: 76.6%
-Serving OHP patients: 97.5%
-Accepting new patients: 72.2%

Primary Care Dentists

-Serving all ages: 77%
-Located in service area: 59.2%
-Serving OHP patients: 97.4%
-Accepting new patients: 84.1%

Mental Health Providers

-Serving all ages: 88%
-Located in service area: 49%
-Serving OHP patients: 88.9%
-Accepting new patients: 70.5%

Substance Use Disorder Treatment Providers

-Serving all ages: 76%
-Located in service area: 46.3%
-Serving OHP patients: 84.3%
-Accepting new patients: 74.1%

How is network adequacy performance measured?

No single measure of access is sufficient to fully reflect access for CCO members. Measures must be evaluated comprehensively. For example, provider-to-member ratios may show a picture of strong access to care. However, examination against the percentage of those providers actively rendering care to CCO enrollees, the percentage of providers located within the service area, or compliance with OHA's time and distance standard, may identify access improvements or concerns not previously observed when considering one specific measure.

The information below represents CCO performance against those measures. In general, the quantitative and qualitative results from this evaluation demonstrate that CCOs have continued to improve their oversight and management of the provider networks within their service areas and address deficiencies. The CCOs have established network monitoring programs that focus on aligning the adequacy of its networks to members' needs, though some CCO programs remain limited in scope. However, CCOs face challenges maintaining an adequate quantity, type and mix of providers within the service area.

About the data

- Statewide and/or service area challenges (e.g., workforce shortages, payer mix, geography) may impact the ability of a CCO to completely address access to care gaps within their community. Please refer to Appendix D for Medicaid enrollment by County in 2024. The measures included in this report do not consider the uniqueness or challenges of individual service areas that may lead to differences in performance.
- OHA calculates provider-to-member ratios and percentages based on CCO provider network information, OHA claims and encounter data, and member enrollment data.
- A provider is considered "active" if their National Provider Identifier (NPI) is present in the claims and encounter data for that CCO within 18 months preceding the beginning of the DSN Provider Capacity Report reporting period.
- It can be challenging for CCOs to maintain accurate information related to the "accepting new members" data element. Therefore, it is important to interpret this data element with caution as a standalone measure.
- Information from the DSN Provider Capacity Report and OHA's analysis thereof is made available publicly via the DSN Annual Evaluation report, prepared by HSAG. CCOs receive

evaluations of their submitted DSN Provider Capacity Reports through the CCO deliverables portal. The DSN Annual Evaluation report is posted publicly on the Quality Assurance webpage.

Network adequacy: Primary care providers, 2024

Table 5: 2024 CCO Provider Network Measures – Primary Care Providers (PCP)

	Provider-to-Member Ratio	% Serving All Ages	% Serving Adults only	% Serving Children only	% Located in Service Area	% Serving OHP Patients	% Accepting New Patients
AH	1:378	68%	21%	12%	100.0%	96.2%	100.0%
AC	1:188	63%	29%	8%	98.6%	95.3%	38.3%
CHA	1:320	92%	0%	8%	100.0%	98.9%	70.5%
CPCCO	1:24	84%	2%	14%	8.1%	98.4%	58.3%
EOCCO	1:99	1%	56%	43%	29.5%	94.7%	94.3%
HSO	1:233	74%	17%	15%	82.4%	98.3%	68.6%
IHN	1:279	40%	47%	13%	76.8%	98.8%	98.1%
JCC	1:40	84%	2%	14%	10.6%	98.0%	59.3%
PCS-CG	1:211	72%	18%	10%	97.8%	98.9%	85.6%
PCS-CO	1:334	71%	13%	15%	99.2%	99.2%	75.0%
PCS-LN	1:273	77%	11%	12%	99.4%	99.2%	53.4%
PCS-MP	1:485	79%	10%	11%	99.4%	99.4%	27.6%
TCHP-S	1:59	82%	9%	9%	59.7%	94.7%	98.6%
TCHP-N	1:95	75%	12%	13%	90.4%	92.0%	93.3%
UHA	1:284	80%	11%	9%	60.7%	98.6%	48.3%
YCCO	1:30	60%	21%	19%	98.2%	98.9%	75.7%
CCO Average	1:277	66%	28%	18%	87.4%	96.3%	80.7%

Source: Q1 2024 Delivery System Network Provider Capacity Report Data

Network adequacy: Oral health, 2024

Table 6: 2024 CCO Provider Network Measures – Primary Care Dentists (PCDs)							
	Provider-to-Member Ratio	% Serving All Ages	% Serving Adults only	% Serving Children only	% Located in Service Area	% Serving OHP Patients	% Accepting New Patients
AH	1:1,339	86%	0%	14%	72.7%	100.0%	100.0%
AC	1:1,239	75%	2%	24%	100.0%	96.4%	96.4%
CHA	1:1,083	65%	0%	35%	53.9%	100.0%	84.6%
CPCCO	1:187	84%	0%	16%	14.2%	99.5%	97.6%
EOCCO	1:573	75%	6%	19%	76.8%	96.5%	78.9%
HSO	1:966	78%	10%	12%	95.6%	96.2%	76.6%
IHN	1:689	85%	0%	15%	76.7%	85.3%	93.0%
JCC	1:763	80%	0%	20%	63.3%	97.8%	81.1%
PCS-CO	1:285	78%	2%	20%	23.5%	98.9%	74.4%
PCS-CG	1:68	78%	2%	20%	6.8%	98.9%	74.4%
PCS-LN	1:342	78%	2%	20%	26.0%	98.9%	74.4%
PCS-MP	1:570	78%	2%	20%	39.2%	98.9%	74.4%
TCHP-N	1:194	85%	0%	15%	97.7%	94.8%	68.4%
TCHP-S	1:353	80%	0%	20%	64.8%	97.2%	85.2%
UHA	1:1,644	88%	0%	12%	96.0%	100.0%	100.0%
YCCO	1:712	76%	0%	24%	40.0%	98.2%	94.6%
CCO Average	1:1,493	84%	7%	13%	97.5%	94.7%	83.3%
Source: Q1 2024 Delivery System Network Provider Capacity Report Data							

Network adequacy: Mental health providers, 2024

Table 7: 2024 CCO Provider Network Measures – Mental Health Providers (MHPs)							
	Provider-to-Member Ratio	% Serving All Ages	% Serving Adults only	% Serving Children only	% Located in Service Area	% Serving OHP Patients	% Accepting New Patients
AH	1:109	98%	<1%	1%	62.4%	93.7%	100.0%
AC	1:125	63%	37%	<1%	96.0%	91.0%	83.5%
CHA	1:206	>99%	<1%	0%	86.1%	94.2%	100.0%
CPCCO	1:14	99%	<1%	1%	6.4%	88.5%	0.2%*
EOCCO	1:55	1%	98%	1%	28.7%	78.6%	0.1%*
HSO	1:133	99%	1%	1%	80.9%	89.5%	9.4%*
IHN	1:55	>99%	<1%	<1%	31.9%	85.7%	98.1%
JCC	1:22	99%	<1%	1%	19.5%	88.1%	0.2%*
PCS-CO	1:18	>99%	<1%	0%	18.8%	93.3%	86.6%
PCS-CG	1:5	>99%	<1%	0%	2.6%	93.3%	86.6%
PCS-LN	1:22	>99%	<1%	0%	31.7%	93.3%	86.6%
PCS-MP	1:36	>99%	<1%	0%	16.3%	93.3%	86.6%
TCHP-N	1:24	98%	<1%	1%	94.8%	84.8%	99.2%
TCHP-S	1:18	>99%	0%	<1%	69.3%	79.7%	100.0%
UHA	1:163	61%	22%	17%	61.7%	92.9%	93.7%
YCCO	1:16	98%	1%	2%	76.3%	82.6%	97.6%
CCO Average	1:64	88%	10%	2%	49.0%	88.9%	70.5%

Source: Q1 2024 Delivery System Network Provider Capacity Report Data

*Note: Differences in the methodology used to calculate the accepting new patients value have been noted by the CCO which may have an impact on the displayed value.

Network adequacy: Substance use providers, 2024

Table 8: 2024 CCO Provider Network Measures – Substance Use Disorder Providers							
	Provider-to-Member Ratio	% Serving All Ages	% Serving Adults only	% Serving Children only	% Located in Service Area	% Serving OHP Patients	% Accepting New Patients
AH	1:398	95%	5%	0%	48.7%	91.9%	100.0%
AC	1:533	53%	46%	<1%	87.5%	93.0%	92.2%
CHA	1:575	100%	0%	0%	67.4%	93.9%	100.0%
CPCCO	1:78	>99%	<1%	<1%	6.5%	90.2%	0.6%*
EOCCO	1:197	2%	97%	<1%	30.4%	73.4%	0.0%*
HSO	1:828	>99%	<1%	<1%	65.4%	90.7%	3.6%*
IHN	1:192	>99%	<1%	0%	38.2%	78.2%	99.4%
JCC	1:128	>99%	<1%	<1%	17.7%	91.4%	0.6%*
PCS-CO	1:139	100%	0%	0%	17.8%	88.3%	96.9%
PCS-CG	1:33	100%	0%	0%	1.2%	88.3%	96.9%
PCS-LN	1:166	100%	0%	0%	33.7%	88.3%	96.9%
PCS-MP	1:277	100%	0%	0%	25.9%	88.3%	96.9%
TCHP-N	1:187	>99%	<1%	0%	92.8%	74.5%	100.0%
TCHP-S	1:84	>99%	<1%	0%	50.9%	71.3%	100.0%
UHA	1:274	13%	84%	3%	32.7%	74.0%	100.0%
YCCO	1:111	99%	1%	0%	86.7%	79.9%	99.4%
CCO Average	1:263	76%	24%	<1%	46.3%	84.3%	74.1%

Source: Q1 2024 Delivery System Network Provider Capacity Report Data

*Note: Differences in the methodology used to calculate the accepting new patients value have been noted by the CCO which may have an impact on the displayed value.

What this tells us about performance and why it matters to members

Provider-to-member ratios

OHA has not defined network adequacy standards for provider-to-member ratios. However, these ratios, combined with other network measures, offer valuable insights into the adequacy of a CCO's provider network. A robust provider network that provides services across the

continuum of care improves a CCO's ability to meet regulatory obligations for access to primary care, oral health, mental health and substance use disorder benefits.

More providers in a CCO network, as demonstrated by lower provider-to-member ratios, can mean that CCO members have more access to providers (e.g., primary care providers, primary care dentists, mental health providers, substance use disorder providers). CCOs with lower ratios of providers serving only adults and/or providers serving only pediatric members may be able to better accommodate member choice and the needs of members requiring specialized care. This is especially critical for pediatric care.

Evaluating provider-to-member ratios alongside other metrics provides a fuller picture of access. Comparing CCO ratios (across all age groups) to the statewide CCO average helps identify potential gaps. CCOs with ratios higher than the statewide average suggest insufficient access to care. The statewide CCO average serves as a comparison point (not a standard) and it is important to note that a high statewide ratio indicates there are potential access issues across all CCOs requiring immediate attention.

The provider data noted below demonstrates potential access concerns for a subset of CCOs. To mitigate potential access concerns, CCOs noted below are encouraged to evaluate their provider networks in the context of member demographics and needs. The assessment should be used to identify the appropriate number, type and mix of providers needed in the network to meet member needs. CCOs should use the information to inform their provider contracting strategy and increase the number of contracted providers.

It is important to have an adequate supply of primary care providers and primary care dentists because they serve as a hub for health care service delivery and coordination of care. Based on the data analyzed, CCOs with significantly higher PCP provider-to-member ratios than the CCO average — such as AH, CHA, PCS-CG, PCS-MP — raise concerns about overall access to sufficient primary care providers. Similarly, UHA had primary care dentist provider-to-member ratios that were higher than the CCO average which indicates more limited access to primary care dentists within the network of providers.

Based on the data analyzed, CCOs with higher mental health and substance use disorder provider-to-member ratios include AH, AC, CHA, HSO, and UHA and AH, AC, CHA, HSO, PCS-MP, and UHA, respectively. Gaps in access to behavioral health services are detrimental to a member's health and

may exacerbate other health problems. CCOs should evaluate members' behavioral health needs and utilization of behavioral health services to determine if adjustments need to be made.

Across all provider types, age group-specific data highlights potential access concerns, especially for children. CCOs should evaluate member specific needs by age groups to determine if the network required further adjustments to meet specialized care needs and preferences.

Located in service area

A higher percentage of providers within a CCO's service area reflects its ability to ensure care is geographically accessible to members. Traveling to access medical, dental, or behavioral health care can present a challenge to CCO enrollees, especially members with limited transportation access, and can manifest as a barrier to accessing care. Providers should be within the service area and available near members.

For CCOs reporting provider networks at a "global" level due to shared provider participation across multiple contracts, it is crucial to evaluate provider-to-member ratios in relation to the percentage of providers located within the specific service area. CCOs reporting at a global level should monitor their network to ensure they have a sufficient supply of providers within the service area and within time and distance standards, as established by OHA.

To mitigate potential access concerns, CCOs noted below are encouraged to map providers available within the service area to determine if the network has a sufficient mix, type and quantity of providers available to members within close geographic proximity. The assessment should be used to identify the gaps in the network and appropriate strategies should be deployed to increase the number of providers available in the service area.

Geographic proximity to primary care providers and primary care dentists is critical to provide preventative care, early disease detection, and manage chronic diseases. Based on the data analyzed, CPCCO and JCC have a limited number of primary care providers within their service areas. EOCCO and TCHP-N rates are also concerning and may require attention to evaluate if the number of available providers in the service area is enough. For primary care dentists, PCS-CG, PCS-CO, and CPCCO have limited access within their service areas. PCS-LN, PCS-MP, and YCCO rates are also concerning and require evaluation and action.

Based on the data analyzed, most CCOs face challenges ensuring behavioral health providers are available within the service area. CPCCO, JCC, PCS-CO, PCS-CG, and PCS-MP have

significantly lower percentages of mental health providers in the service area. CPCCO, JCC, PCS-CO, and PCS-CG face the same challenge with SUD providers in the service area.

Active providers serving OHP members

An active provider is one who is listed in the provider directory and renders care to OHP members on a regular basis. Availability of providers is a function of the number of providers, their willingness to participate in OHP, and their ability to offer timely appointments.

A CCO with a robust and active provider network is more likely able to meet its regulatory obligations to ensure access to benefits covered under the Oregon Health Plan. A higher percentage of providers considered active in the network indicates greater access for CCO enrollees to that provider type. Lower percentages of active providers indicate a lower level of access and the potential presence of a "ghost network" (i.e., providers reported to be participating in the network in the CCO provider directory who are not actually available to render care).

To mitigate concerns, CCOs may implement ongoing monitoring (e.g., claims analysis) of providers to assess if there are inactive providers in the network. Implementation of appropriate strategies (e.g., rate increases, directed payments, value based payments) to improve the rate of active providers will help address concerns for behavioral health services.

Based on the data analyzed, most CCOs report high percentages of active primary care providers and primary care dentists. IHN is the only CCO that has a lower percentage of active primary care dentists, compared to other CCOs.

For behavioral health providers, gaps between reported and active mental health providers raise significant concerns about the ability of members to receive mental health treatment services within those service areas. CPCCO, EOCCO, IHN, JCC, TCHP-N, TCHP-S, and YCCO had rates of active providers lower than the CCO average. Given the demand for SUD treatment services and statewide access constraints, any gap between reported participation and actual care delivery raises concerns. EOCCO, TCHP-N, TCHP-S, and UHA have lower rates of active providers and IHN and YCCO have moderate rates, underscoring concerns about network performance.

Accepting new members

A higher percentage of providers accepting new patients suggests better access for new members seeking to establish care with the CCO. Greater availability of providers accepting new

members provides more choice for new CCO members and existing members looking to switch providers. CCOs with more providers open to new patients are better positioned to accommodate new members and offer network flexibility.

To mitigate concerns, CCOs may implement ongoing monitoring (e.g., secret shopper surveys, reporting) of providers to assess if providers are accepting new members and if appointments are provided in a timely manner.

Based on the data analyzed, AC, CHA, CPCCO, HSO, JCC, PCS-LN, PCS-MP, UHA, PCS-CG and YCCO have lower rates of primary care providers accepting new patients. PCS-CO, PCS-CG, PCS-LN, PCS-MP, TCHP-N, EOCCO and HSO have lower rates of primary care dentists accepting new patients. Low rates of acceptance indicate potential challenges for members establishing or changing care. Although PCS-CO, PCS-CG, PCS-LN, PCS-MP and TCHP-N have high-performing provider-to-member ratios the low and moderate rates of providers accepting new members has the effect of limiting access for members.

CPCCO, EOCCO, HSO, and JCC have lower rates of mental health providers and substance use disorder providers accepting new patients, which is further compounded by the low rates of providers in the service area.

OREGON HEALTH AUTHORITY

SERVICE DELIVERY

About this operational area

This operational area is focused on monitoring quality, identifying areas for improvement, tracking patient outcomes, and making informed decisions about resource allocation and system efficiency within each CCO.

What does service delivery look like?

Coverage of Services

This measure ensures members get the care they need by preventing misuse of healthcare resources. It also requires CCOs to provide emergency and post-stabilization services without prior authorization and to have a system for reviewing authorization requests based on medical necessity.

Grievance & Appeal System

CCOs must provide a way for members to file and process grievances and appeals, ensuring their issues are heard and resolved.

Quality Improvement

CCOs are required to assess the quality and appropriateness of care to members, identify any gaps, and guide improvements to the delivery of care.

OREGON HEALTH AUTHORITY

COVERAGE OF SERVICES

Health service coverage refers to how well a service reaches and benefits the members it is meant to serve. It involves the entire process, from allocating resources to achieving the intended outcomes.

Coverage of Services

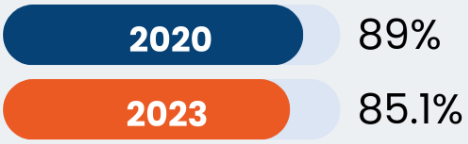
CCOs must implement a comprehensive and transparent system to review, approve, or deny authorization requests, ensuring members receive timely access to medically necessary services. The decline in performance means CCOs need to ensure coverage and authorization processes fully align with state requirements.

Compliance Monitoring Review Standard IV, Statewide

Coordination and Continuity of Care

To assess needs, the CCO must conduct screenings and assessments to identify members with special healthcare needs and prioritize them for care. CCOs are required to provide immediate support to address the member's specific needs through a targeted care plan.

Compliance Monitoring Review Standard III, Statewide



Emergency & Post-stabilization Services

The CCO is responsible for regularly monitoring its processes, so members consistently receive the services they need. The CCO is responsible for ensuring processes prevent inappropriate denials and continuous alignment with federal guidelines.

Compliance Monitoring Review Standard XVI, Statewide

Coverage of services

Table 9: Compliance with Coverage and Authorization of Services requirements

Compliance Monitoring Review, Standard IV, 2020 and 2023

CCO	2020	2023	Number of Resolved Findings/ Total Number of Improvement Plan Findings (2023)	Total Number of Elements (2023)
AH	97%	63.9%	1/10	18
AC	100%	75.0%	7/9	18
CHA	94%	86.1%	5/5	18
CPCCO	82%	69.4%	6/11	18
EOCCO	91%	77.8%	8/8	18
HSO	85%	44.4%	2/15	18
IHN	94%	61.1%	10/14	18
JCC	82%	69.4%	6/11	18
PCS-CO	97%	75.0%	7/8	18
PCS-CG	97%	77.8%	6/7	18
PCS-LN	97%	72.2%	8/9	18
PCS-MP	97%	75.0%	7/8	18
TCHP-N	N/A	61.1%	8/11	18
TCHP-S	94%	61.1%	8/11	18
UHA	100%	86.1%	5/5	18
YCCO	91%	66.7%	4/12	18
Statewide CCO Compliance Score	94%	70.1%		

Sources: External Quality Review Technical Reports & Compliance Monitoring Reviews, 2020 and 2023

Note: The state compliance standard is 100 percent. TCHP-N did not have data available in 2020 because the CCO was not available in that service area until Sept. 1, 2020.

Rating	Description
High Confidence (≥ 95%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated substantial compliance with state, federal, and contract requirements. CCO's performance exhibited mostly Met ratings and high overall compliance scores.
Moderate confidence (≥ 85 – <95%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated moderate compliance with state, federal, and contract requirements. CCO's performance exhibited a mix of Met, Partially Met, and Not Met ratings resulting in moderate compliance scores, indicating opportunities for improvement.
Low Confidence (≥75 – <85%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated low compliance with state, federal, and contract requirements. CCO's performance exhibited a mix of Met, Partially Met, and Not Met ratings resulting in low to moderate compliance scores indicating opportunities for improvement.
No Confidence (<75%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated general noncompliance with state, federal, and contract requirements. CCO's performance exhibited a large proportion of Partially Met and Not Met ratings resulting in low compliance scores, indicating substantial opportunities for improvement across most standards.

Why this matters to members

Members should receive services that are sufficient in amount, duration, or scope to reasonably be expected to achieve member needs and the purpose of the requested service. CCOs should not arbitrarily deny or reduce requested services because of other extenuating circumstances surrounding the request. The member's health condition or health issue must be at the core of decision making.

What this tells us about performance

CCOs must implement a comprehensive and transparent system to review, approve, or deny authorization requests, ensuring members receive timely access to medically necessary services. Decision makers should have the appropriate clinical expertise to apply medical necessity criteria consistently and fairly, preventing unnecessary delays in care. Additionally, members must be notified promptly of any decisions, whether it's an approval or denial, with clear explanations of the rationale behind those decisions and guidance on their rights to appeal or seek further review if needed.

While CHA and UHA both achieved the highest 2023 compliance score of 86.1 percent, CHA experienced the smallest decline from its 2020 score, falling only 7.9 percentage points. CHA's performance indicates a relatively stronger retention of performance compared to other CCOs. HSO recorded the lowest compliance score in 2023 at 44.4 percent. While all CCOs declined in performance between 2020 and 2023, CHA had the least amount of decline while HSO recorded the largest decline of over 40 percentage points. Although some CCOs demonstrate higher compliance scores than others, no CCO currently meets the 100 percent state standard. The consistent decline in performance across nearly all plans emphasizes that improvements are needed to ensure coverage and authorization processes fully align with state requirements.

Opportunities for improvement:

- Develop standardized protocols that create clear, written procedures for reviewing, approving, or denying authorization requests.
- Ensure appropriate expertise by assigning decision making authority to staff with the relevant clinical and operational knowledge.
- Formalize a process that requires decision makers to reach out to requesting providers for additional clinical details before issuing a denial.
- When additional information is needed, implement (or reinforce) authorized extension periods and maintain detailed records of any conversations and supplemental information obtained, ensuring comprehensive documentation to support final coverage decisions.
- Create comprehensive oversight protocols that develop robust monitoring standards that go beyond simply reviewing subcontractor policies and attestations.
- Clearly define the scope and level of delegation to subcontractors and any subsequent downstream entities, ensuring accountability at every level.
- Establish routine reporting mechanisms and performance metrics for subcontractors to demonstrate they meet both federal and state requirements.

All CCOs were required to develop an improvement plan based on the Contract Years 2020 and 2023 compliance reviews.

About the report

Federal Medicaid Managed Care Regulations requires an EQRO conduct a review to determine CCO compliance with the standards set forth in 42 CFR §438 — Managed Care Subpart D. OHA contracts with HSAG as its EQRO to conduct CMRs of each of its contracted CCOs, across 16 standards. Individual CCO CMRs and overall Statewide Annual Technical Reports are posted publicly.

Coordination and continuity of care

Table 10: Compliance with Coordination and Continuity of Care requirements

Compliance Monitoring Review, Standard III, 2020 and 2023

CCO	2020	2023	Number of Resolved Findings/ Total Number of Improvement Plan Findings (2023)	Total Number of Elements (2023)
AH	97%	72.20%	4/4	9
AC	90%	88.90%	2/2	9
CHA	80%	72.20%	3/4	9
CPCCO	87%	88.90%	2/2	9
EOCCO	83%	83.30%	2/3	9
HSO	90%	44.40%	2/9	9
IHN	73%	88.90%	2/2	9
JCC	87%	88.90%	2/2	9
PCS-CO	100%	94.40%	1/1	9
PCS-CG	100%	88.90%	2/2	9
PCS-LN	100%	88.90%	2/2	9
PCS-MP	100%	88.90%	2/2	9
TCHP-N	N/A	94.40%	1/1	9
TCHP-S	77%	94.40%	1/1	9
UHA	93%	94.40%	1/1	9
YCCO	70%	88.90%	0/2	9
Statewide CCO Compliance Score	89%	85.10%		

Sources: External Quality Review Technical Reports & Compliance Monitoring Reviews, 2020 and 2023

Note: The state compliance standard is 100 percent. TCHP-N did not have data available in 2020 because the CCO was not available in that service area until Sept. 1, 2020.

Rating	Description
High Confidence (≥ 95%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated substantial compliance with state, federal, and contract requirements. CCO's performance exhibited mostly Met ratings and high overall compliance scores.
Moderate confidence (≥ 85 – <95%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated moderate compliance with state, federal, and contract requirements. CCO's performance exhibited a mix of Met, Partially Met, and Not Met ratings resulting in moderate compliance scores, indicating opportunities for improvement.
Low Confidence (≥75 – <85%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated low compliance with state, federal, and contract requirements. CCO's performance exhibited a mix of Met, Partially Met, and Not Met ratings resulting in low to moderate compliance scores indicating opportunities for improvement.
No Confidence (<75%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated general noncompliance with state, federal, and contract requirements. CCO's performance exhibited a large proportion of Partially Met and Not Met ratings resulting in low compliance scores, indicating substantial opportunities for improvement across most standards.

Why this matters to members

Care coordination helps support members by organizing care across providers, services, and needs. It can assist a member in finding physical, dental, and behavioral health care, as well as other resources in the community to aid with non-medical needs. Care coordination is instrumental in improving the overall quality and efficiency of the health care services the member receives.

What this tells us about performance

CCOs must ensure they have continuous, coordinated care across different providers, services, and needs. This helps manage member health needs more effectively and ensures privacy is maintained while providing necessary support. To assess needs, the CCO must conduct screenings and assessments to identify members with special health care needs and prioritize them for personalized care. Beginning in 2024, CCOs are required to assess the level of each member's risk and provide immediate support to address the member's needs through a personalized care plan, referred to as risk stratification. The CCO must ensure that care coordination and member information are handled in a way that respects privacy laws and protects members' personal health data.

The 2023 statewide average was 85.10 percent, down slightly from 89 percent in 2020, indicating significant room for improvement. This overall decline highlights the need for continued monitoring, targeted interventions, and a commitment to ongoing improvement. PCS-CO, TCHP-N, TCHP-S, and UHA showed the highest compliance score at 94.4 percent. YCCO shows the most improvement, rising from 70 percent to 88.90 percent. In contrast, HSO experienced the largest drop, declining from 90 percent to 44.40 percent.

Opportunities for improvement:

- Develop and implement clear procedures for member screening, assessments, reassessments, and care planning.
- Ensure each member is notified of, and has clear access to, the person primarily responsible for coordinating their services.
- Conduct regular internal audits to verify compliance with federal and state standards.
- Require subcontractors to demonstrate concrete systems and documentation for managing care coordination responsibilities.
- Implement clear performance metrics and reporting requirements to track subcontractor adherence to federal and state requirements.

All CCOs were required to develop an improvement plan based on the CY 2020 and 2023 compliance reviews.

About the report

Federal Medicaid Managed Care Regulations requires an EQRO conduct a review to determine CCO compliance with the standards set forth in 42 CFR §438 — Managed Care Subpart D. OHA contracts with HSAG as its EQRO to conduct CMRs of each of its contracted CCOs, across 16 standards. Individual CCO CMRs and overall Statewide Annual Technical Reports are posted publicly.

Emergency and post-stabilization services

Table 11: Compliance with Emergency and Post-stabilization Services requirements

Compliance Monitoring Review, Standard XVI, 2023

CCO	2023	Number of Resolved Findings/ Total Number of Improvement Plan Findings (2023)	Total Number of Elements (2023)
AH	70.80%	7/7	12
AC	87.50%	3/3	12
CHA	83.30%	4/4	12
CPCCO	83.30%	3/3	12
EOCCO	83.30%	4/4	12
HSO	62.50%	4/9	12
IHN	66.70%	1/6	12
JCC	83.30%	3/3	12
PCS-CO	87.50%	3/3	12
PCS-CG	87.50%	3/3	12
PCS-LN	87.50%	3/3	12
PCS-MP	87.50%	3/3	12
TCHP-N	100%	N/A	12
TCHP-S	100%	N/A	12
UHA	100%	N/A	12
YCCO	95.80%	0/1	12
Statewide CCO Compliance Score	85.40%		

Sources: External Quality Review Technical Reports and Compliance Monitoring Reviews, 2023

Note: The state compliance standard is 100 percent.

Rating	Description
High Confidence (≥ 95%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated substantial compliance with state, federal, and contract requirements. CCO's performance exhibited mostly Met ratings and high overall compliance scores.
Moderate confidence (≥ 85 – <95%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated moderate compliance with state, federal, and contract requirements. CCO's performance exhibited a mix of Met, Partially Met, and Not Met ratings resulting in moderate compliance scores, indicating opportunities for improvement.
Low Confidence (≥75 – <85%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated low compliance with state, federal, and contract requirements. CCO's performance exhibited a mix of Met, Partially Met, and Not Met ratings resulting in low to moderate compliance scores indicating opportunities for improvement.
No Confidence (<75%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated general noncompliance with state, federal, and contract requirements. CCO's performance exhibited a large proportion of Partially Met and Not Met ratings resulting in low compliance scores, indicating substantial opportunities for improvement across most standards.

Why this matters to members

In an emergency, members should be able to access emergency services and post-stabilization care without any restrictions or necessary authorizations to ensure each member's right to prompt care. Members are not expected to pay for emergency services, even if the provider is not under contract with the CCO.

What this tells us about performance

This standard requires the CCO to ensure access to emergency and post-stabilization services without prior authorization. The CCO's policies and procedures must address coverage and payment for emergency and post-stabilization services. The CCO is also responsible for regularly monitoring its processes so members consistently receive the services they need.

In 2023, TCHP-N, TCHP-S, and UHA met the state standard with a 100 percent compliance score. At the other end of the spectrum, HSO registered the lowest compliance score at 62.5 percent. Overall, the statewide compliance score stood at 85.4 percent, indicating that while a few CCOs fully met the state standard, most CCOs still need additional efforts to reach 100 percent compliance.

Opportunities for improvement:

- Create clear, standardized protocols so emergency and post-stabilization services are promptly approved without requiring prior authorization. Ensure processes address retrospective reviews and prevent inappropriate denials.
- Establish regular audits and oversight mechanisms to detect, review, and correct any inappropriate denials of emergency or post-stabilization services, ensuring continuous alignment with federal guidelines.
- Educate staff and network providers on federal requirements and the proper use of prior authorizations, emphasizing that emergency care must not be denied due to a lack of preapproval.

All CCOs were required to develop an improvement plan based on the CY 2023 compliance reviews.

About the data

Federal Medicaid Managed Care Regulations requires an EQRO conduct a review to determine CCO compliance with the standards set forth in 42 CFR §438 — Managed Care Subpart D. OHA contracts with HSAG as its EQRO to conduct CMRs of each of its contracted CCOs, across 16 standards. Individual CCO CMRs and overall Statewide Annual Technical Reports are posted publicly.

OREGON HEALTH AUTHORITY

GRIEVANCE & APPEAL SYSTEM

It is important that CCOs have a clear and accessible system for grievances and appeals. This ensures that members can voice concerns or challenge decisions related to their care.

Key aspects to ensure a member's rights are protected and concerns are addressed in a timely manner:

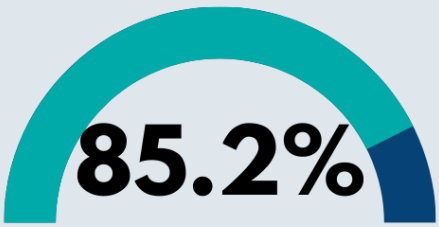
- Provide a structured way for members to file and process grievances and appeals.
- Ensure members receive prompt acknowledgement notices and information about adverse benefit determinations.
- A process to expedite appeals to address urgent issues.

Most frequent opportunities for statewide improvement:

- Compliance with federal and State grievance and appeal requirements
  - Adherence to requirements for appropriate decision-makers.
  - Compliance with time frames for acknowledging and responding to grievances and/or appeals.
  - Readability level of notices.
- Implementation of the most current state-issued templates for:
  - Compliance with Notices of Adverse Benefit Determination (NOABD).
  - Compliance with Notices of Appeal Resolution (NOAR).

Statewide
Compliance with federal Grievance and Appeal System requirements, CMR Standard X

2020



2023

Grievance and Appeal System

Table 12: Compliance with Grievance and Appeal Systems requirements

Compliance Monitoring Review, Standard X, 2020 and 2023

CCO	2020	2023	Number of Resolved Findings/ Total Number of Improvement Plan Findings (2023)	Total Number of Elements (2023)
AH	84%	79.6%	11/11	27
AC	95%	85.2%	5/8	27
CHA	89%	81.5%	9/10	27
CPCCO	91%	87.0%	5/7	27
EOCCO	82%	85.2%	8/8	27
HSO	86%	77.8%	3/12	27
IHN	84%	85.2%	8/8	27
JCC	91%	87.0%	5/7	27
PCS-CO	84%	88.9%	6/6	27
PCS-CG	84%	88.9%	6/6	27
PCS-LN	84%	87.0%	7/7	27
PCS-MP	84%	88.9%	6/6	27
TCHP-N	N/A	85.2%	8/8	27
TCHP-S	84%	83.3%	9/9	27
UHA	89%	92.6%	4/4	27
YCCO	89%	79.6%	8/11	27
Statewide CCO Compliance Score	87%	85.2%		

Sources: External Quality Review Technical Reports & Compliance Monitoring Reviews, 2020 and 2023

Note: The state compliance standard is 100 percent. TCHP-N did not have data available in 2020 because the CCO was not available in that service area until Sept. 1, 2020.

Rating	Description
High Confidence (≥ 95%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated substantial compliance with state, federal, and contract requirements. CCO's performance exhibited mostly Met ratings and high overall compliance scores.
Moderate confidence (≥ 85 – <95%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated moderate compliance with state, federal, and contract requirements. CCO's performance exhibited a mix of Met, Partially Met, and Not Met ratings resulting in moderate compliance scores, indicating opportunities for improvement.
Low Confidence (≥75 – <85%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated low compliance with state, federal, and contract requirements. CCO's performance exhibited a mix of Met, Partially Met, and Not Met ratings resulting in low to moderate compliance scores indicating opportunities for improvement.
No Confidence (<75%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated general noncompliance with state, federal, and contract requirements. CCO's performance exhibited a large proportion of Partially Met and Not Met ratings resulting in low compliance scores, indicating substantial opportunities for improvement across most standards.

Why this matters to members

A clear, standardized, and accessible system for grievances and appeals ensures that members can voice concerns or challenge decisions related to their care, ensuring their rights are protected and their concerns addressed in a timely manner. Member protections include: the receipt of prompt acknowledgment notices and information about adverse benefit determinations, helping them stay informed about their cases; availability of expedited processes to address urgent issues, ensuring members' needs are handled quickly and effectively; and the ability to challenge the denial of coverage for services or payment for services.

What this tells us about performance

This standard requires CCOs to maintain a system for grievances and appeals that includes required member information and communications. The CCO's policies and procedures should address how grievances are filed and processed, the appeals process related to adverse benefit determinations, assistance with the grievance and appeal process, time frames for issuing acknowledgement notices and notices of adverse benefit determination (NOABDs), as well as an expedited appeal process.

In 2023, overall, the statewide compliance score decreased slightly, from 87 percent in 2020 to 85.2 percent in 2023, indicating that while some CCOs made improvements, continued effort is needed for all CCOs to work toward the 100 percent compliance standard. UHA achieved the highest compliance score at 92.6 percent, whereas HSO recorded the lowest at 77.8 percent.

Opportunities for improvement:

- Assign decision-makers with the appropriate expertise for each step in the grievance and appeal process.
- Develop and monitor internal timelines for acknowledging and responding to grievances and appeals while regularly reviewing member notices for clarity and accessibility, incorporating member feedback and plain language to ensure compliance with regulatory standards.
- Use the latest NOABD and Notice of Appeal Resolution (NOAR) forms provided by the state to reduce errors and ensure all required information is conveyed.
- Adopt the latest NOABD and NOAR forms provided by the state, integrate these into internal policies and procedures for consistent use across all member communications, and conduct periodic audits to confirm adherence to template requirements, promptly addressing any identified gaps.

About the data

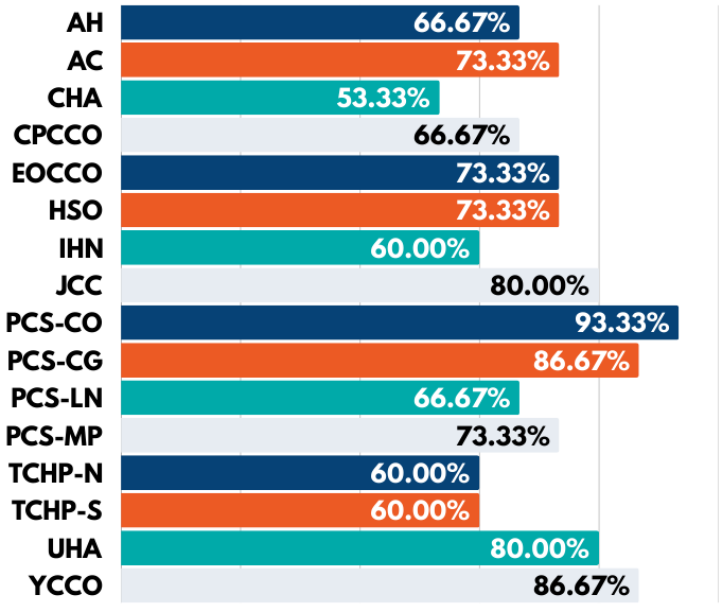
Federal Medicaid Managed Care Regulations require an EQRO conduct a review to determine CCO compliance with the standards set forth in 42 CFR §438 — Managed Care Subpart D. OHA contracts with HSAG as its EQRO to conduct CMRs of each of its contracted CCOs, across 16 standards. Individual CCO CMRs and overall Statewide Annual Technical Reports are posted publicly.

OREGON HEALTH AUTHORITY

QUALITY IMPROVEMENT

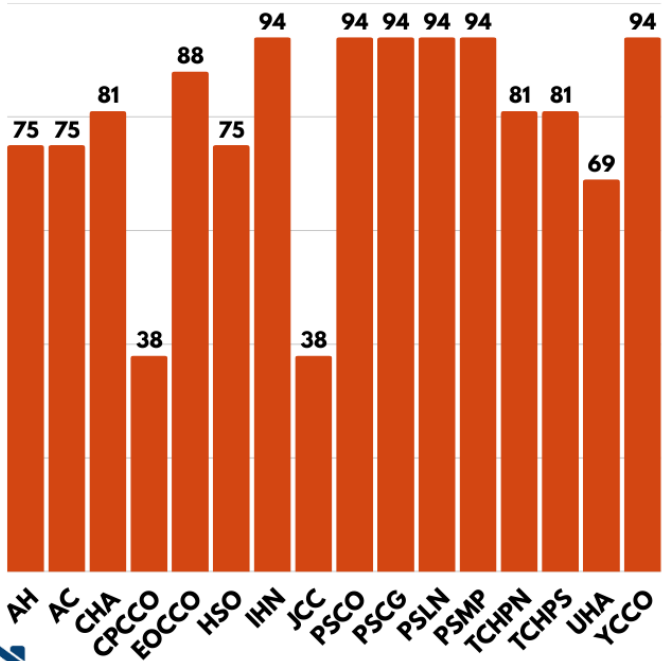
CCOs must establish a robust quality assessment and performance improvement (QAPI) program that can detect both under and over-utilization. This program should regularly assess how well services meet members' needs, identify any gaps, and guide improvements so members receive safe, effective, and timely care. OHA uses incentives to reward exceptional performance by CCOs.

CCO Incentive Metrics Met



Nine CCOs were above the statewide average of 72.08% for incentive metrics met, while four CCOs were at least 10% below the average.

CCO Compliance Scores



While some CCOs approached near perfect compliance, the statewide average of 79% indicates that as a whole, CCOs still fell short of the 100% standard and have room for continued improvement.

Quality Improvement

Table 13: Compliance with Quality Assessment and Performance Improvement (QAPI) requirements

Compliance Monitoring Review, Standard XII, 2022

CCO	2022	Number of Resolved Findings/ Total Number of Improvement Plan Findings (2022)	Total Number of Elements (2022)
AH	75%	1/1	8
AC	75%	2/2	8
CHA	81%	2/2	8
CPCCO	38%	1/4	8
EOCCO	88%	1/2	8
HSO	75%	2/3	8
IHN	94%	1/1	8
JCC	38%	1/4	8
PCS-CO	94%	N/A	8
PCS-CG	94%	N/A	8
PCS-LN	94%	N/A	8
PCS-MP	94%	N/A	8
TCHP-N	81%	1/1	8
TCHP-S	81%	1/1	8
UHA	69%	1/1	8
YCCO	94%	1/1	8
Statewide CCO Compliance Score	79%		

Sources: External Quality Review Technical Reports and Compliance Monitoring Reviews, 2022

Note: The state compliance standard is 100 percent.

Rating	Description
High Confidence (≥ 95%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated substantial compliance with state, federal, and contract requirements. CCO's performance exhibited mostly Met ratings and high overall compliance scores.
Moderate confidence (≥ 85 – <95%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated moderate compliance with state, federal, and contract requirements. CCO's performance exhibited a mix of Met, Partially Met, and Not Met ratings resulting in moderate compliance scores, indicating opportunities for improvement.
Low Confidence (≥75 – <85%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated low compliance with state, federal, and contract requirements. CCO's performance exhibited a mix of Met, Partially Met, and Not Met ratings resulting in low to moderate compliance scores indicating opportunities for improvement.
No Confidence (<75%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated general noncompliance with state, federal, and contract requirements. CCO's performance exhibited a large proportion of Partially Met and Not Met ratings resulting in low compliance scores, indicating substantial opportunities for improvement across most standards.

Why this matters to members

Every Medicaid member, especially those with special health care needs (SHCN) and those receiving long-term services and supports (LTSS), deserves high quality, effective and appropriate care that meets member needs.

This standard requires the CCO to establish a quality assessment and performance improvement (QAPI) program with mechanisms for detecting under- and overutilization and assess the quality and appropriateness of care furnished to members with SHCN and members receiving LTSS.

What this tells us about performance

The QAPI program established by the CCO should regularly assess how well services meet members' needs, identify any gaps, and guide improvements so members receive safe, effective, and timely care.

In 2022, IHN, PCS-CO, PCS-CG, PCS-LN, PCS-MP, and YCCO achieved the highest compliance score, each at 94 percent. On the other end of the spectrum, CPCCO and JCC recorded the lowest compliance scores of 38 percent. While some organizations approached near perfect compliance, the statewide average of 79 percent indicates that as a whole, CCOs still fell short of the 100 percent standard and have room for continued improvement.

Opportunities for improvement:

- Clearly define responsibilities for program leadership and staff, ensuring the CCO can effectively monitor and evaluate the quality of services in line with member needs and priorities.
- Develop robust processes for gathering, reviewing, and reporting data on service quality and appropriateness, enabling timely interventions and continuous improvement.
- Realign and strengthen QAPI program policies, procedures, and oversight structures to ensure full compliance and create a robust framework for enhancing member care.

All CCOs were required to develop an improvement plan based on the CY 2022 compliance reviews.

About the data

Federal Medicaid Managed Care Regulations requires an EQRO conduct a review to determine CCO compliance with the standards set forth in 42 CFR §438 — Managed Care Subpart D. OHA contracts with HSAG as its EQRO to conduct CMRs of each of its contracted CCOs, across 16 standards. Individual CCO CMRs and overall Statewide Annual Technical Reports are posted publicly.

2023 Incentive Measure Performance Overview

The Oregon Health Authority (OHA) established a Quality Incentive Program to provide financial incentives to reward exceptional CCO performance and continuous quality improvement on a set of access, quality, and outcome metrics selected annually by the Metrics & Scoring Committee. Through this program, CCOs achieve financial rewards if they meet specific performance benchmarks or improvement targets. Each CCO is eligible for maximum funding totaling up to 4.25% of the amounts paid to the CCO during 2023. Allocations for CCOs are based upon the CCO achieving the fifteen incentive measures and targets identified for 2023. To receive 100% of funds, a CCO must meet or exceed the benchmark or the improvement target on at least 12 of the 15 measures. All funds not allocated are redistributed based on CCO performance toward challenge pool measures.

Table 14: Quality Incentive Program Measure Performance, 2023

CCO	Measures Met (out of 15 measures)	Percent of Funding Received	Challenge Pool Measures Met (out of 4 measures)	Total Payment
AH	10	80%	4	$7,131,897
AC	11	90%	3	$15,614,618
CHA	8	60%	3	$4,505,011
CPCCO	10	80%	3	$9,437,034
EOCCO	11	90%	3	$20,117,813
HSO	11	90%	4	$111,146,987
IHN	9	70%	3	$18,317,964
JCC	12	100%	3	$17,571,982
PCS-CO	14	100%	4	$24,077,891
PCS-CG	13	100%	4	$5,032,318
PCS-LN	10	80%	2	$21,176,323
PCS-MP	11	90%	3	$36,189,605
TCHP-N	9	70%	2	$7,774,505
TCHP-S	9	70%	2	$6,921,008

UHA	12	100%	4	$11,616,235
YCCO	13	100%	4	$10,409,550
Total	173	-	51	**$327,040,743**
Statewide Average	10.8	86%	3.2	**$20,440,046**
Sources: Oregon CCO Quality Incentive Program: CCO Metrics 2023 Final Report				

Why this matters to members

The CCO Quality Incentive Program is required for ensuring high-quality, equitable care for over one million Oregon Health Plan (Medicaid) members. Performance results directly impact member health outcomes and access to services. The program is an important part of the coordinated care model. Independent evaluation showed that the program successfully drove improvements overall from 2012 to 2017. OHA is committed to using the CCO quality incentive program as a tool to improve health equity.

What this tells us about performance

The 2023 Incentive Measure Performance Overview table highlights the performance of CCOs across various quality of care measures. Since 2022, CCOs have improved year over year, yet there are several opportunities for improvement. The full report is published and available online.

Upstream measures continue to build CCOs' capacity. In 2023, the CCO Quality Incentive Program launched the new SDOH Social Needs Screening and Referral measure, which aims to have CCO members' social needs acknowledged and addressed. This was also the first year the program had improvement targets for the Health Equity Measure: Meaningful Language Access. This measure assesses the percentage of visits for which a qualified and certified interpreter was provided to a sample of members who needed interpreter services. From 2022 to 2023, CCO statewide performance on this measure increased from 5.6% to 10.7%. Ongoing work is needed to improve access to interpreter services and related data collection.

For children preparing for kindergarten, dental and oral health services rose above pre-pandemic rates. Dental and oral health services were some of the measures most negatively affected

by the pandemic. After falling by 27% in 2020, CCO statewide performance on Preventive Dental or Oral Health Services for children ages 1-5 has gradually improved each year. For this age group, 2023 was the first year when CCO statewide performance rose above pre-pandemic levels.

CCOs mostly improved on behavioral health care measures. CCOs improved most on age-appropriate screening for alcohol and other substance use (Screening, Brief Intervention and Referral to Treatment [SBIRT] Rate 1), as well as Depression Screening and Follow-up. However, Initiation and Engagement of Substance Use Disorder Treatment did not improve as much. Substance use disorder treatment is an area to watch, as OHA is supporting additional quality improvement on these measures.

Disruptions in care during the pandemic likely continued to affected immunization measures. Immunizations for children and adolescents largely held steady in 2023 and have not yet recovered to pre-pandemic levels. Immunization measures have a look back period, meaning they capture services over multiple years. There is also some evidence1 that vaccine hesitancy grew during the pandemic, which may have contributed to lower immunization rates.

About the data

The CCO Performance Metrics Dashboard expands on the data summarized here and pulled from the 2023 Final Report. It describes in more detail the progress of Oregon's CCOs on quality measures. Viewers can quickly find their metric of interest and see individual CCO trends over time.

This information comes from the CCO Metrics 2023 Final Report which is published and available online: Oregon Health Authority. Oregon CCO Quality Incentive Program: CCO Metrics 2023 Final Report. Portland, Oregon. August 2024.

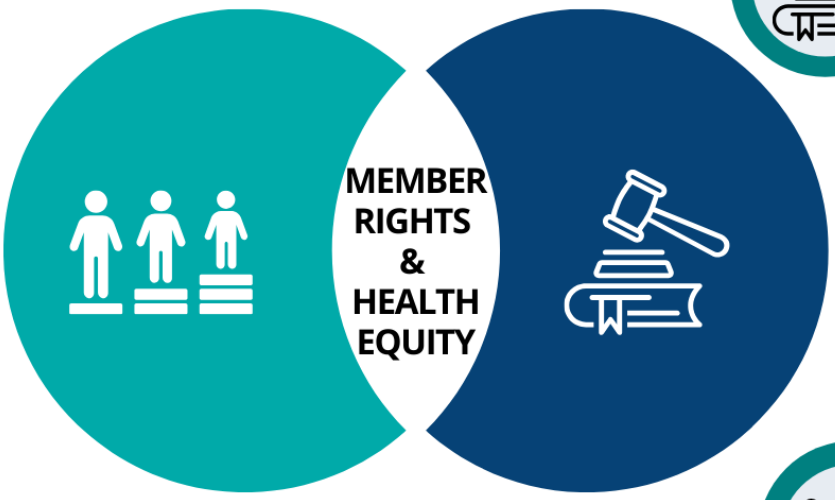
https://www.oregon.gov/oha/HPA/ANALYTICS/CCOMetrics/2023-CCO-Metrics-Annual-Report.pdf.

OREGON HEALTH AUTHORITY

MEMBER RIGHTS & HEALTH EQUITY

About this operational area

Each CCO sets its own goals within each focus area and their annual progress updates. CCOs outline their objectives for developing infrastructure and capacity for health equity and the timeline for measuring their progress. This area is focused on identifying and addressing gaps in healthcare access, enhancing cultural competence, strengthening ties with communities, and utilizing data to identify disparities and maintain accountability in addressing health equity.



Member Rights & Information

The CCO must ensure that member rights are respected and allowed to be exercised freely without affecting the treatment of members. The CCO's policies, procedures, and member information must include state and federal requirements.

Health Equity

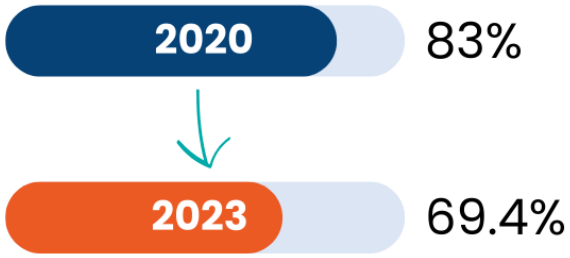
This measures CCO efforts in promoting health equity to reduce health inequities and disparities, provide healthcare access, and improve member health outcomes.

OREGON HEALTH AUTHORITY

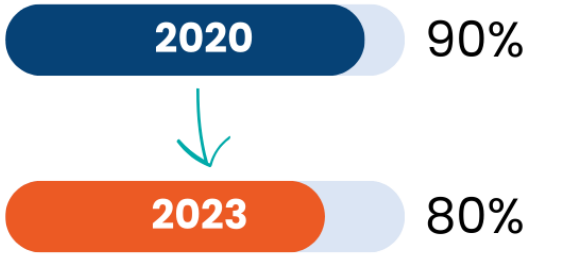
MEMBER RIGHTS & INFORMATION

CCOs are required to provide information to members in a way that is easy to access and understand, including the provision of materials in alternative formats and languages. The CCO must have a mechanism to communicate significant changes in a timely manner. The CCO's policies and procedures must address how the CCO ensures compliance with furnishing each member with required information within the state-established time frames.

Compliance Monitoring Review Standard VII, 2020 and 2023



Compliance Monitoring Review Standard XIV, 2020 and 2023



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

- Failure to maintain and implement policies and procedures that aligned with federal and State requirements for member rights and protections, including specific requirements for advance directives.
- Failure to inform its members, subcontractors, and/or network providers of members' rights.
- Deficits or lack of operational structure and failure to demonstrate implementation of an established process to ensure timely and proper member communication.
- Revisions to policies and procedures, and member facing materials to align with state and federal requirements.

Members have the right to receive information about any decisions made by the CCO to deny coverage of a requested service. The Notice of Adverse Benefit Determination contains information explaining the reason for denial and describing the process to request an appeal of the decision. In mid-2021, OHA clarified the requirements for Notices of Adverse Benefit Determinations (NOABD) and developed model notice templates aligned with state and federal regulations. The below figures denote the percentage of compliance with those requirements.

Compliance with Notice of Adverse Benefit (NOABD) requirements

Statewide CCO Average by Year

Member rights and information

Table 15: Compliance with Member Rights and Protections requirements
Compliance Monitoring Review Standard VII, 2020 and 2023

CCO	2020	2023	Number of Resolved Findings/ Total Number of Improvement Plan Findings (2023)	Total Number of Elements (2023)
AH	89%	90%	1/1	5
AC	78%	60%	3/4	5
CHA	89%	70%	3/3	5
CPCCO	61%	50%	2/5	5
EOCCO	83%	70%	3/3	5
HSO	78%	60%	2/4	5
IHN	89%	70%	3/3	5
JCC	61%	50%	2/5	5
PCS-CO	89%	70%	3/3	5
PCS-CG	89%	70%	3/3	5
PCS-LN	89%	70%	3/3	5
PCS-MP	89%	70%	3/3	5
TCHP-N	N/A	70%	3/3	5
TCHP-S	83%	70%	3/3	5
UHA	94%	90%	1/1	5
YCCO	94%	80%	2/2	5
Statewide CCO Compliance Score	83%	69.4%		

Sources: External Quality Review Technical Reports & Compliance Monitoring Reviews, 2020 and 2023

Note: TCHP-N did not have data available in 2020 because the CCO was not available in that service area until Sept. 1, 2020.

Rating	Description
High Confidence (≥ 95%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated substantial compliance with state, federal, and contract requirements. CCO's performance exhibited mostly Met ratings and high overall compliance scores.
Moderate confidence (≥ 85 – <95%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated moderate compliance with state, federal, and contract requirements. CCO's performance exhibited a mix of Met, Partially Met, and Not Met ratings resulting in moderate compliance scores, indicating opportunities for improvement.
Low Confidence (≥75 – <85%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated low compliance with state, federal, and contract requirements. CCO's performance exhibited a mix of Met, Partially Met, and Not Met ratings resulting in low to moderate compliance scores indicating opportunities for improvement.
No Confidence (<75%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated general noncompliance with state, federal, and contract requirements. CCO's performance exhibited a large proportion of Partially Met and Not Met ratings resulting in low compliance scores, indicating substantial opportunities for improvement across most standards.

Why this matters to members

Medicaid members have specific rights and protections, outlined in federal and state regulations, that ensure they receive a standard set of protections and experience their care in the same way across CCOs and providers.

The standard evaluates the CCOs ability to inform its members, subcontractors, and network providers of members' rights. The CCO must ensure that member rights are respected and allowed to be exercised freely without affecting the treatment of members. The CCO's policies, procedures, and member information must include the State and federal requirements for advance directives.

What this tells us about performance

This data tells us that all CCOs except AH demonstrated a decline in performance. Except for UHA, all other CCOs showed a decline of more than 10 percentage points from 2020 to 2023. Overall, the statewide compliance score decreased significantly, from 83 percent in 2020 to 69.4 percent in 2023, indicating that considerable continued effort is needed for all CCOs to attain the 100 percent compliance standard. CCO performance declined because most CCOs did not have policies and operational processes that aligned with federal and State protections.

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

- Failure to inform its members, subcontractors, and/or network providers of members' rights.
- Failure to maintain and implement policies and procedures that aligned with federal and State requirements for member rights and protections, including specific requirements for advance directives.

All CCOs were required to develop an improvement plan based on the CY 2023 compliance review.

About the report

Federal Medicaid Managed Care Regulations requires an EQRO conduct a review to determine CCO compliance with the standards set forth in 42 CFR §438 — Managed Care Subpart D. OHA contracts with HSAG as its EQRO to conduct CMRs of each of its contracted CCOs, across 16 standards. Individual CCO CMRs and overall Statewide Annual Technical Reports are posted publicly.

Member information

Table 16: Compliance with Member Information requirements
Compliance Monitoring Review Standard XIV, 2020 and 2023

CCO	2020	2023	Number of Resolved Findings/ Total Number of Improvement Plan Findings (2023)	Total Number of Elements (2023)
AH	95%	84.1%	6/7	22
AC	100%	70.5%	9/11	22
CHA	85%	65.9%	7/11	22
CPCCO	80%	68.2%	6/12	22
EOCCO	80%	79.5%	4/8	22
HSO	85%	68.2%	0/11	22
IHN	85%	86.4%	5/6	22
JCC	80%	68.2%	6/12	22
PCS-CO	95%	90.9%	3/4	22
PCS-CG	95%	90.9%	3/4	22
PCS-LN	95%	90.9%	3/4	22
PCS-MP	95%	90.9%	3/4	22
TCHP-N	N/A	77.3%	9/10	22
TCHP-S	90%	77.3%	9/10	22
UHA	100%	93.2%	3/3	22
YCCO	90%	77.3%	4/9	22
Statewide CCO Compliance Score	90%	80.0%		

Sources: External Quality Review Technical Reports & Compliance Monitoring Reviews, 2020 and 2023

Note: TCHP-N did not have data available in 2020 because the CCO was not available in that service area until Sept. 1, 2020.

Rating	Description
High Confidence (≥ 95%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated substantial compliance with state, federal, and contract requirements. CCO's performance exhibited mostly Met ratings and high overall compliance scores.
Moderate confidence (≥ 85 – <95%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated moderate compliance with state, federal, and contract requirements. CCO's performance exhibited a mix of Met, Partially Met, and Not Met ratings resulting in moderate compliance scores, indicating opportunities for improvement.
Low Confidence (≥75 – <85%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated low compliance with state, federal, and contract requirements. CCO's performance exhibited a mix of Met, Partially Met, and Not Met ratings resulting in low to moderate compliance scores indicating opportunities for improvement.
No Confidence (<75%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated general noncompliance with state, federal, and contract requirements. CCO's performance exhibited a large proportion of Partially Met and Not Met ratings resulting in low compliance scores, indicating substantial opportunities for improvement across most standards.

Why this matters to members

Members have the right to receive information about their plan and benefits in a way that is easy to access and understand, including the provision of materials in alternative formats and languages.

The standard evaluates the CCO's ability to provide information to its members in a way that is easy to access and understand, including the provision of materials in alternative formats and languages. The CCO must have a mechanism to communicate significant changes in a timely manner. The CCO's policies and procedures should address how the CCO ensures compliance with furnishing each member with required information within the state-established time frames.

What this tells us about performance

This data tells us that all CCOs except IHN demonstrated a decline in performance. When comparing 2020 to 2023, most CCOs had a decline between five to ten percentage points. AC experienced the greatest decline, dropping 29.5 percentage points. Overall, the statewide compliance score decreased, from 90 percent in 2020 to 80 percent in 2023, indicating continued effort is needed for all CCOs to attain the 100 percent compliance standard. Most CCOs

were unable to demonstrate member facing materials, provided by the CCO or subcontractor, aligned with federal and state requirements.

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

- Deficits or lack of operational structure and failure to demonstrate implementation of an established process to ensure timely and proper member communication.
- Revisions to policies and procedures, and member facing materials to align with State and federal requirements,

All CCOs were required to develop an improvement plan based on the CY 2020 and 2023 compliance review.

About the report

Federal Medicaid Managed Care Regulations requires an EQRO conduct a review to determine CCO compliance with the standards set forth in 42 CFR §438 — Managed Care Subpart D. OHA contracts with HSAG as its EQRO to conduct CMRs of each of its contracted CCOs, across 16 standards. Individual CCO CMRs and overall Statewide Annual Technical Reports are posted publicly.

Denial notices

Table 17: Compliance with Notice of Adverse Benefit (NOABD) requirements					
CCO	Q1 2022	Q1 2023	Q32023	Q1 2024	Q2 2024
AH	74%	72%	90%	90%	88%
AC	93%	81%	90%	75%	78%
CHA	65%	60%	68%	73%	88%
CPCCO	80%	94%	76%	83%	90%
EOCCO	74%	78%	79%	66%	71%
HSO	66%	73%	84%	84%	75%
IHN	65%	76%	79%	63%	85%
JCC	76%	83%	83%	69%	90%
PCS-CG	77%	59%	67%	60%	88%
PCS-CO	79%	50%	74%	85%	82%
PCS-LN	65%	71%	50%	88%	85%
PCS-MP	69%	68%	65%	78%	85%
TCHP-N	59%	69%	63%	71%	83%
TCHP-S	59%	74%	78%	71%	69%
UHA	56%	88%	90%	85%	92%
YCCO	63%	86%	88%	74%	86%
CCO Average	70%	74%	76%	76%	84%

Source: Exhibit I Grievance and Appeal Log Sample of NOABDs and Corresponding Prior Authorization Information, 2022-2024

Description of Performance (100% compliance standard)	All Quarters
High Performance	≥ 95%
Moderate Performance	75-94%
Low Performance	< 75%

Why this matters to members

Members have the right to receive information about any decisions made by the CCO to deny coverage of a requested service. The Notice of Adverse Benefit Determination (NOABD) contains information explaining the reason for denial and describing the process to request an appeal to the CCO's decision. It also describes the state fair hearing process protection. All member rights and protections should be communicated to members through the notice.

It is important for members to understand coverage decisions and the reasons for the denial. If the decision was not based on medical necessity or appropriateness, members, providers, or their representatives are able to seek a reconsideration that considers their medical needs and history.

What this tells us about performance

In mid-2021, OHA clarified the requirements for NOABDs and developed model notice templates aligned with state and federal regulations. Despite extensive technical assistance and education, CCOs have been slow to adopt these templates and continue to face challenges adhering to the requirements for NOABDs. Lengthy timeframes to update grievance and appeal systems are the most common reason cited by CCOs preventing them from achieving compliance. In addition, CCOs face numerous challenges overseeing subcontractors to ensure they adopt the most recent NOABD template that includes updated NOABD requirements.

Performance overview by quarter based on the data analyzed:

- Q1 2022: AC (93%) and CPCCO (80%) outperformed all other CCOs. Nine CCOs performed below other CCOs and UHA performed the poorest.
- Q1 2023: CPCCO (94%) and UHA (88%) outperformed all other CCOs. PCS-CO scored lowest at 50 percent, 50 percentage points below the compliance standard.
- Q3 2023: AH, AC, and UHA performed above all other CCOs at 90 percent. PCS-LN performed lowest at 50 percent, 50 percentage points below the compliance standard.
- Q1 2024: AH outperformed all other CCOs at 90 percent. PCS-CG was lowest at 60 percent, 40 percentage points below the compliance standard.

- Q2 2024: UHA (92%) and CPCCO/JCC (90%) performed above all others. TCHP-S scored lowest at 69 percent, 31 percentage points below the compliance standard. Several CCOs have made considerable improvements since Q1 2022.

To mitigate these performance issues, CCOs should improve internal processes to update NOABD requirements, work with their appeal and grievance system vendors to reduce the amount of time it takes to make system changes. Subcontracted entities may require additional support and oversight to ensure the updated NOABD template is adopted and implemented. Periodic subcontractor reporting and auditing will help improve adherence to NOABD requirements.

About the data

The data is from the quarterly sample of NOABDs issued to members. OHA provides CCOs NOABD member notice templates, posts the evaluation criteria used to review the NOABD sample, and provides CCO evaluations through the CCO deliverables portal.

OREGON HEALTH AUTHORITY

HEALTH EQUITY

Health inequities are unfair differences in the health of people or groups. These differences are based on social, economic and other factors such as racism and other forms of bias, discrimination and oppression. CCOs are tasked with analyzing their existing infrastructure to advance equity for all of their members. The goal is to drive organizational change by enhancing the CCO's capacity to promote health equity through direct actions, resource allocation, organizational commitment, community partnerships, and ongoing accountability.

Visits using an interpreter statewide

- **Interpreters are an essential member right, helping to ensure members and providers can understand each other, and that members have the information they need to get and stay healthy.**
- **Language Access and Interpreter Services reports help OHA understand what members are actually experiencing when they see a provider.**
- **These reports help identify where there are gaps in service, inequities in the system, and opportunities for improvement.**

Integration and Utilization of Traditional Health Workers (THWs)

- **THWs are trusted community members who often share socioeconomic backgrounds and lived experiences with CCO members, making them uniquely positioned to provided person- and community-centered care. They help bridge the gap between communities and healthcare systems.**
- **THW Integration and Utilization Data reports measures the progress of expanding the number of contracted THWs within the CCO's networks.**
- **These reports help identify where there is a need to increase the available supply of THWs to support members and expand access to care.**

Language access and interpreter services

Table 18: Provider visits where members utilized language interpreters

All provider types

CCO	Number of visits utilizing an interpreter			
	2022-2023	2023-2024	# of members with language other than English	Interpreter visits per member with language other than English
AH	1,572	1,631	688	2.37
AC	3,158	6,044	2,493	2.42
CHA	2,357	3,681	1,552	2.37
CPCCO	16,186	6,385	3,059	2.09
EOCCO	37,381	62,551	13,999	4.47
HSO	396,327	440,250	99,067	4.44
IHN	23,871	23,018	7,528	3.06
JCC	10,311	16,127	7,733	2.09
PCS-CO	1,9856	33,257	6,866	4.84
PCS-CG	12,126	17,732	5,104	3.47
PCS-LN	17,490	28,039	6,982	4.03
PCS-MP	105,722	158,650	37,962	4.18
TCHP-N	21,135	67,294	16,573	4.06
TCHP-S	3,180	8,767	1,906	4.60
UHA	654	2,238	729	3.07
YCCO	20,053	45,496	6,787	6.70
Statewide average	691,379	921,160	219,008	4.21

Why this matters to members

Interpreters are an essential member right, helping to ensure members and providers can understand each other, and that members have the information they need to get and stay healthy. Language Access and Interpreter Services reports help OHA understand what members are actually experiencing when they see a provider. These reports help identify where there are gaps in service, inequities in the system, and opportunities for improvement.

OHA's Health Care Interpreter Program includes two levels of credentialing: qualification and certification. Certified interpreters meet all of the qualification requirements, plus have a passing certification from a recognized national or state organization. They assist people in Oregon and in their communities by providing high-quality health care interpretation.

What this tells us about performance

Due to data limitations, CCO performance was not assessed using a performance scale. The interpreter reports include member-level data for each encounter, but they do not include data for each member who has reported a language preference. Home language preferences were identified through the Medicaid Demographic REALD Report but may not reflect members' spoken language and English proficiency. CCOs should determine language access needs among members and identify gaps in meeting language access needs by evaluating the languages spoken by the provider network and utilization of interpreter services.

Based on the data analyzed, most CCOs saw a significant increase in interpreter utilization at provider visits from the 2023 to the 2024 reporting period. Statewide, there was an average of 24.81percent more visits where a member used an interpreter.

The rate of interpreter visits per members with language other than English suggests access challenges exist for interpreter services. All CCOs, especially those with lower rates, should carry out an analysis to assess if interpreter services are accessible and meet the needs of members.

About the data

The Language Access and Interpreter Services Report is a required contract deliverable submitted by CCOs on a quarterly basis. Each report includes rolling data from the prior 12 months. The reports contain protected health information and are not posted publicly. OHA provides a report

template for CCO data compilation. Data requested includes individual member information, care type and visiting setting, language and method of interpretation, and if the member refused interpreter services.

Health Equity Plan

Progress towards health equity plan focus areas

Table 19: Health Equity (HE) Plan Focus Areas Progress								
CCO	Designated HE Administrator	CCO Training Plan Includes HE Fundamentals	Progress Implementing REALD Standards	Progress Implementing SOGI Standards	Progress Implementing CLAS Standards	Service Area Investments Language Access Services	Member & Community Inclusion in CCO Activities	Allocation of Staff & Resources to Advance HE in the CCO & Community
AH	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
AC	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
CHA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
CPCCO	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
EOCCO	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
HSO	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
IHN	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
JCC	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
PCS (all areas)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
TCHP (all areas)	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
UHA	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
YCCO	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Source: Health Equity Plan, 2024								

Why this matters to members

In the Health Equity Plans, CCOs are tasked with thoroughly analyzing their existing infrastructure to advance equity. At a minimum, they must assess their structure, governance, staff, program and service mix, collaborations, and available resources. The goal is to drive organizational change by enhancing the CCO's capacity to promote health equity through direct actions, resource allocation, organizational commitment, community partnerships, and ongoing accountability. An effective and meaningful CCO Health Equity Plan focuses on the following significant areas:

- Identifying and addressing gaps in health care access, quality, and outcomes among different populations.
- Enhancing the cultural competence of health care providers and systems to better meet the needs of diverse populations.
- Strengthening ties with communities to develop plans and strategies that align with local needs, which includes incorporating community feedback into service design and policy adjustments. This process involves actively seeking input from community members, analyzing their feedback, and making necessary changes to ensure that services and policies align with community needs and preferences.
- It also includes adopting Culturally and Linguistically Appropriate Services (CLAS) standards and implementing an organizational framework that equips CCOs to better address equity challenges.
- Using data to identify disparities, monitor progress, and maintain accountability in addressing health equity.

The requirement for CCOs to conduct a thorough analysis of their infrastructure to advance health equity holds significant implications for members and improves the overall quality of care and service delivery to meet the diverse needs of members (e.g., cultural, linguistic, health needs).

- Members can expect more culturally responsive care, with access to resources like quality health care interpreters, member involvement in the creation of materials, and culturally appropriate health programs becoming more prevalent.

- As CCOs assess and strengthen their governance, members may witness greater involvement of community voices, including member representation, in the decision-making process.
- CCOs may adopt transparent practices that keep members informed about how equity goals are being met and how resources are allocated to address disparities.
- By forming partnerships with local organizations and community groups, CCOs develop programs that are better suited to the specific needs of members, either introducing new services or enhancing access to existing ones.
- Ensuring structural changes and resource allocation means that health equity efforts are not short-term but integrated into the CCOs' operations. This indicates that members can anticipate consistent improvements over time.

What this tells us about performance

Since 2020, OHA has requested that CCOs share a plan aimed at developing and enhancing their health equity infrastructure. Each CCO sets its own goals within each focus area and their annual progress updates. CCOs outline their objectives for developing infrastructure and capacity for health equity, the methods they plan to use to reach those goals, and the timeline for measuring their progress.

The Health Equity Plan allows OHA to monitor CCO efforts in promoting health equity and provides opportunities for OHA to offer direction and technical assistance when necessary and requested.

Before 2020, while CCOs undertook numerous activities related to health equity, there was no unified approach across all 16 CCOs in specific focus areas. This inconsistency highlighted the need for CCOs to share best practices and examples, enabling them to identify common areas of attention or focus.

The Health Equity Plan evaluation shows continued progress towards meeting the elements included in OHA's guidance document. A subset of CCOs – HSO, IHN, PCS-CG, PCS-CO, PCS-LN, PCS-MP, TCHP-N, and TCHP-S – did not show evidence of investments in the service area to improve language access services.

About the data

The Health Equity Plan is an annual deliverable submitted by CCOs. The deliverable and OHA defined focus areas aim to reduce health inequities and disparities, provide health care access, and improve member health outcomes. The deliverable is evaluated by OHA and shared with CCOs through the CCO deliverables portal.

Traditional Health Workers

Table 20: Traditional Health Worker Integration and Utilization											
CCO		Community Health Workers		Doulas		Peer Support Specialists		Peer Wellness Specialists		Navigators	
	Year	Provider to member ratios	# of CHWs	Provider to member ratios	# of Doulas	Provider to member ratios	# of PSS	Provider to Member Ratios	# of PWS	Provider to Member Ratios	# of Navigators
AH	2023	1:1178	25	1:29456	1	1:526	56	1:1281	23	1:29456	1
	2024	1:955	30	1:28656	1	1:562	51	1:1246	23	1:9552	3
AC	2023	1:943	72	1:7548	9	1:531	128	1:67930	1	_	0
	2024	1:984	67	1:7329	9	1:489	135	1:21987	3	_	0
CHA	2023	1:4045	7	1:14157	2	1:506	56	1:28313	1	_	0
	2024	1:5512	5	1:9187	3	1:405	68	_	0	_	0
CPCCO	2023	1:1406	28	1:5622	7	1:856	46	1:9839	4	1:39357	1
	2024	1:1141	34	1:3234	12	1:532	73	1:12936	3	1:38808	1
EOCCO	2023	1:716	111	1:11346	7	1:722	110	1:26475	3	_	0
	2024	1:625	128	1:4706	17	1:526	152	1:16000	5	1:40000	2
HSO	2023	1:1673	253	1:2629	161	1:1809	234	1:8299	51	1:12093	35
	2024	1:1266	356	1:1383	326	1:1400	322	1:8347	54	1:6439	70
IHN	2023	1:1041	85	1:3051	29	1:1106	80	1:14746	6	_	0
	2024	1:892	96	1:2255	38	1:883	97	1:4761	18	_	0
JCC	2023	1:705	93	1:5959	11	1:643	102	_	0	_	0
	2024	1:1141	34	1:3234	12	1:532	73	1:12936	3	1:38808	1
PCS-CO	2023	1:3613	21	1:10838	7	1:766	99	1:12644	6	1:7587	10
	2024	1:2388	31	1:6731	11	1:698	106	1:12340	6	1:2742	27
PCS-CG	2023	1:818	21	1:1908	9	1:716	24	1:17176	1	1:2454	7
	2024	1:343	47	1:1789	9	1:596	27	1:8053	2	1:1150	14
PCS-LN	2023	1:5464	17	1:2815	33	1:929	100	1:46443	2	1:13269	7
	2024	1:2573	35	1:1732	52	1:500	180	1:12866	7	1:5003	18

Table 20: Traditional Health Worker Integration and Utilization											
CCO		Community Health Workers		Doulas		Peer Support Specialists		Peer Wellness Specialists		Navigators	
	Year	Provider to member ratios	# of CHWs	Provider to member ratios	# of Doulas	Provider to member ratios	# of PSS	Provider to Member Ratios	# of PWS	Provider to Member Ratios	# of Navigators
PCS-MP	2023	1:9460	15	1:4730	30	1:1173	121	1:8869	16	1:17738	8
	2024	1:3235	46	1:3382	44	1:744	200	1:8754	17	1:8754	17
TCHP-N	2023	1:3207	17	1:1211	45	1:343	159	1:2596	21	1:54517	1
	2024	1:1038	60	1:788	79	1:439	142	1:15572	4	1:4152	15
TCHP-S	2023	1:1595	25	1:2345	17	1:699	57	1:39871	1	1:39871	1
	2024	1:770	46	1:1864	19	1:217	163	1:8854	4	1:5903	6
UHA	2023	1:1989	21	1:5966	7	1:1193	35	_	0	_	0
	2024	1:2677	15	1:20078	2	1:1434	28	_	0	_	0
YCCO	2023	1:2062	19	1:4897	8	1:344	114	1:3014	13	_	0
	2024	1:1683	22	1:544	68	1:394	94	1:2468	15	1:37015	1

Source: THW Integration and Utilization Data Report, 2023 and 2024

Note: (-) indicates the provider to member ratio cannot be calculated because there is no access to the THW type.

Figure 2: Count of THW Integration Across all CCOs

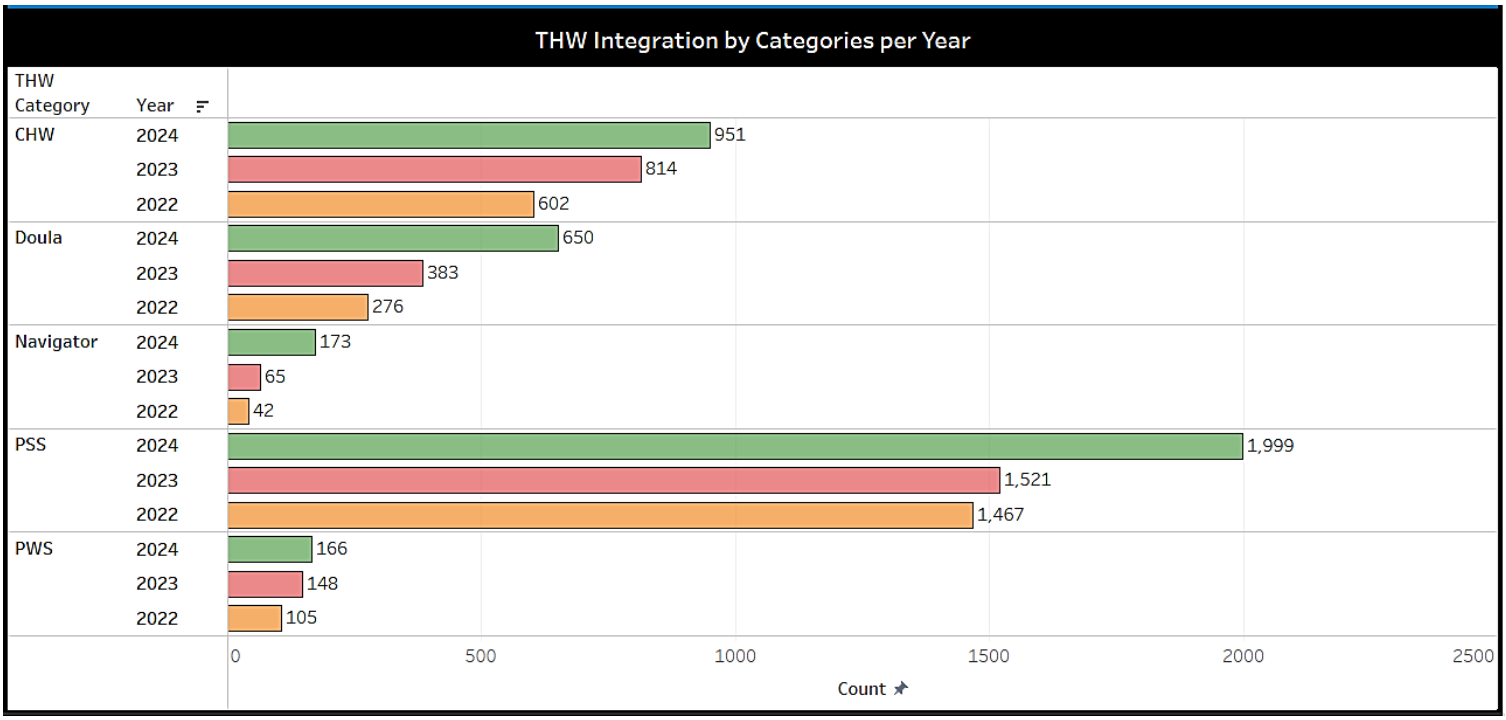
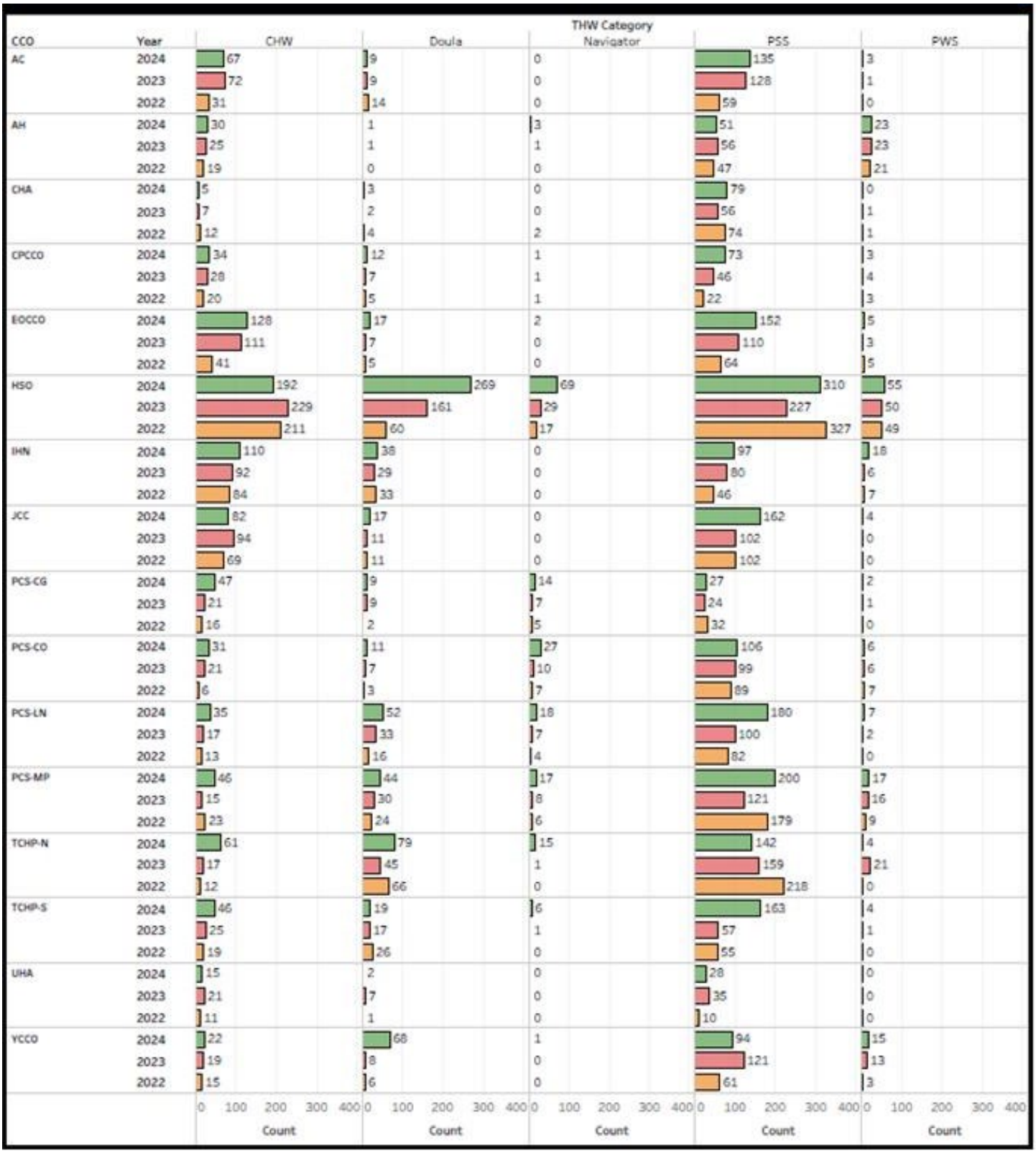


Figure 3: Count of THW Integration by CCO



Why this matters to members

Traditional Health Workers (THWs) are trusted community members who often share socioeconomic backgrounds and lived experiences with CCO members, making them uniquely positioned to provide person- and community-centered care. They bridge the gap between communities and healthcare systems. THWs enhance access to appropriate care by connecting individuals with health services, advocating for members, supporting treatment adherence, and empowering members to take charge of their health. The Oregon Health Authority (OHA) promotes the adoption and expanded use of THWs to support members in navigating healthcare, obtaining resources, receiving health education, and improving overall well-being while addressing their cultural and linguistic needs.

Beyond direct member support, THWs are instrumental in assisting and collaborating with healthcare and social service providers to deliver comprehensive services, enhance care coordination, and improve health outcomes. Additionally, Traditional Health Workers play a critical role in addressing workforce shortages by filling gaps in care, particularly, in underserved and rural communities. Their contributions help expand access to essential services ensuring members have the support needed to address the social determinants of health.

What this tells us about performance

The 2024 THW Integration and Utilization data showcases progress in expanding the number of contracted THWs within the CCO's networks (compared to 2022 and 2023). Across all CCOs, considerable strides have been made in increasing the number of contracted Community Health Workers, Doulas and Peer Support Specialists. However, some CCOs have experienced limited gains in expanding contracts for these THW roles: Community Health Workers, Doulas, and Peer Support Specialists.

Except for a few CCOs, the majority of CCOs made limited progress increasing the number of contracted Navigators (AH, CPCCO, EOCCO, YCCO) and Peer Wellness Specialists (AC, CPCCO, EOCCO, HSO, IHN, JCC, PCS-CO, PCS-CG, PCS-LN, PCS-MP, TCHP-S, TCHP-N, YCCO). Of note, no access to Navigators (AC, CHA, IHN, JCC, UHA) and Peer Wellness Specialists (CHA, UHA) exists for members enrolled with a subset of CCOs. CCOs face challenges increasing the number of Navigators due to the absence of billing methodologies that will support the broader use of this

workforce. An opportunity for CCOs to address the billing and payment issues is to consider the development of alternative payment methodologies to support the increase of Navigators. OHA, CCOs, and the Traditional Health Worker Commission will continue to work together to identify solutions to address the payment/billing issues.

Although OHA has not established standards for THWs, CCOs should use member needs, demographics, and utilization trends to determine if there is a need to increase the available supply of THWs to support members and expand access to care. CCOs with limited to no access to THWs should develop plans to increase access to the services provided by THWs.

About the data

The THW Integration and Utilization Data Report is submitted on an annual basis. The report collects data to measure integration and utilization of THWs including: an assessment of member satisfaction; provider to member ratios; number of THWs in the network; employment with CCO or under contract/agreement; self-referrals and care team referrals to THW services; demographics of THWs; number of THWs in clinical versus community-based settings and encounters for each setting; and payment models used for THWs.

OREGON HEALTH AUTHORITY

PROGRAM INTEGRITY

About this operational area

As the administrators of the Medicaid program in our state, the Oregon Health Authority and its CCO partners serve as stewards, protecting public funds and the public's trust in government service. In that stewardship role, the values and practice of transparency, accountability, and conscientiousness are critical to the success of the Oregon Health Plan and most importantly, to the health and well-being of more than 1.4 million Oregonians.

What does program integrity look like?

Preventing Fraud, Waste and Abuse

Maintaining robust programs to identify probable misuse of Medicaid funding and services, as well as establishing thoughtful prevention measures to avoid future fraud, waste, and abuse.

Subcontracting & Delegation

Ensuring accountability by having a strong focus on CCO subcontractor performance. Tracking CCO strategies and timelines for issue resolution. Then taking demonstrative action if resolution is not reached.

Resolution of Audit Findings

Working with an objective organization to review compliance, for state and CCO operations. Each year, the EQR organization performs audits and documents unresolved CCO findings.

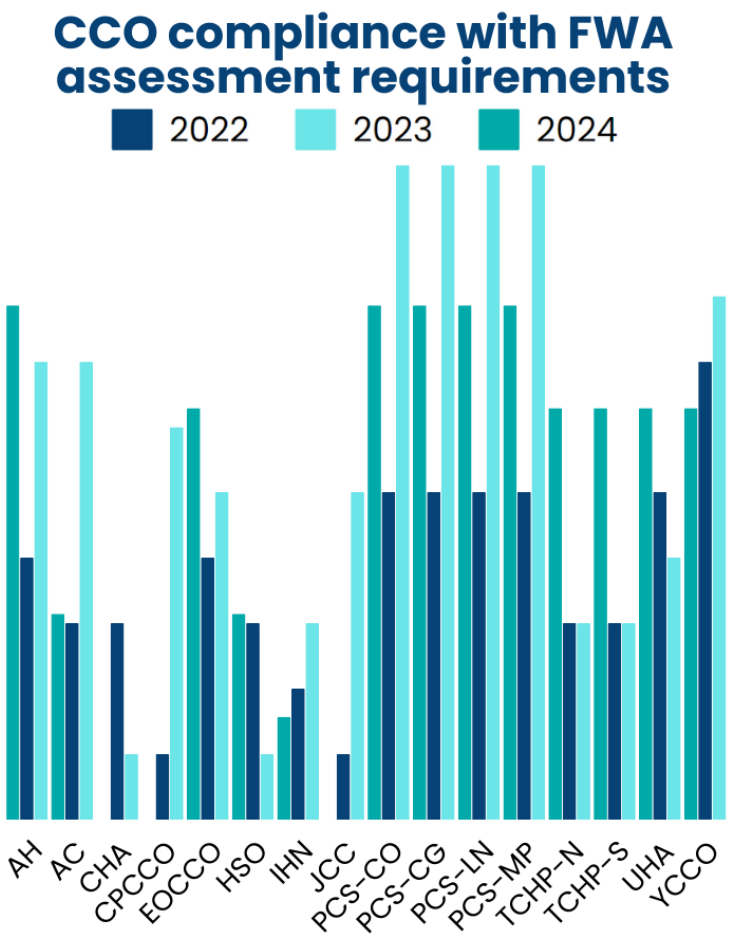
OREGON HEALTH AUTHORITY

PREVENTING FRAUD, WASTE & ABUSE

CCOs are required to maintain robust programs to identify probable misuse of Medicaid funding and services, as well as establishing thoughtful compliance measures to prevent future fraud, waste, and abuse (FWA).

From 2022 to 2024, fourteen CCOs made significant improvements and achieved compliance with specific Fraud, Waste, and Abuse requirements. These CCOs were able to demonstrate they have:

- Policies and procedures available for staff that clearly outline their operational process to meet all Fraud, Waste, and Abuse state and federal requirements.
- Appropriate operational infrastructure to detect, monitor, and audit potential Fraud, Waste, and Abuse among employees, providers, and subcontractors.
- Mechanisms to evaluate and identify performance gaps, which will determine the CCO's approach and focus for the upcoming year. One of the performance gaps is compliance with the FWA Assessment. In 2022 and 2023, all CCOs had low performance scores, which is less than 75% compliance. In 2024, twelve CCOs had low performance scores and four CCOs had moderate performance scores, which is 75% to 94.9%.



Fraud, Waste and Abuse Prevention Handbook

Table 21: Compliance with Fraud, Waste and Abuse (FWA) Prevention Handbook requirements			
CCO	2022	2023	2024
AH	92.9%	82.1%	100.0%
AC	96.4%	78.6%	100.0%
CHA	44.8%	28.6%	75.0%
CPCCO	75.0%	71.4%	100.0%
EOCCO	92.9%	78.6%	100.0%
HSO	60.7%	28.6%	78.6%
IHN	82.1%	71.4%	100.0%
JCC	75.0%	71.4%	100.0%
PCS-CO	96.4%	85.7%	100.0%
PCS-CG	96.4%	85.7%	100.0%
PCS-LN	96.4%	85.7%	100.0%
PCS-MP	96.4%	85.7%	100.0%
TCHP-N	82.1%	71.4%	100.0%
TCHP-S	82.1%	71.4%	100.0%
UHA	82.1%	67.9%	100.0%
YCCO	82.1%	67.9%	100.0%
Statewide Average	83.38%	70.8%	97.1%

Source: FWA Prevention Handbook Evaluations, 2022-2024

Note: In 2023, there was a change in the scoring approach to score all elements individually. Prior to 2023, elements were grouped and were not scored individually.

Description of Performance	2022	2023	2024
High Performance	≥ 95.0%	≥ 95.0%	≥ 95.0%
Moderate Performance	75.0-94.9%	75.0-94.9%	75.0-94.9%
Low Performance	< 75.0%	< 75.0%	< 75.0%

Why this matters to members

State and federal Fraud, Waste and Abuse (FWA) laws help protect members from unsafe practices, and make sure government funds are spent responsibly on high quality care that truly benefits members.

A strong FWA program detects and stop any activities from employees, providers, or others that could harm members financially or negatively affect the quality of their care.

What this tells us about performance

This data tells us that 14 CCOs made significant improvements and achieved full compliance and approval of their FWA Prevention Handbook, which is a compilation of the CCOs' FWA policies and procedures. These CCOs were able to demonstrate they have policies and procedures available for staff that clearly outlines their operational process to meet state and federal FWA requirements.

Prior to 2024, none of the CCOs received OHA approval of their FWA Prevention Handbook due to continued noncompliance. CHA and HSO performed below all other CCOs scoring 75 percent and 78.6 percent, respectively, and falling below the compliance target by 25 and 21.4 percentage points, respectively. The compliance target is 100 percent.

About the data

The FWA Prevention Handbook is a required contract deliverable submitted by CCOs on an annual basis and evaluation results are returned through the CCO deliverables portal. The FWA Prevention Handbook is the CCO's infrastructure or roadmap for meeting all state and federal regulatory requirements and includes a compilation of policies and procedures. OHA provides a report and evaluation tool and guidance document. Additional FWA contract deliverables, such as the Fraud, Waste, and Abuse Annual and Quarterly Audit, Referral and Investigation Reports, were not included in this document and may provide additional context about CCO performance.

Fraud, Waste and Abuse Prevention Plans

Table 22: Compliance with Fraud, Waste and Abuse (FWA) Prevention Plan requirements			
CCO	2022	2023	2024
AH	72.7%	50.0%	100.0%
AC	72.7%	25.0%	100.0%
CHA	0%	12.5%	50.0%
CPCCO	54.6%	25.0%	100.0%
EOCCO	72.7%	50.0%	100.0%
HSO	18.2%	12.5%	25.0%
IHN	81.8%	25.0%	100.0%
JCC	54.6%	37.5%	100.0%
PCS-CO	90.9%	50.0%	100.0%
PCS-CG	90.9%	50.0%	100.0%
PCS-LN	90.9%	50.0%	100.0%
PCS-MP	90.9%	50.0%	100.0%
TCHP-N	72.7%	37.5%	100.0%
TCHP-S	72.7%	37.5%	100.0%
UHA	81.8%	25.0%	100.0%
YCCO	90.9%	37.5%	100.0%
Statewide Average	69.31%	35.9%	92.2%
Source: FWA Prevention Plan Evaluations, 2022-2024			

Description of Performance	2022	2023	2024
High Performance	≥95.0%	≥95.0%	≥95.0%
Moderate Performance	75.0% - 94.9%	75.0% - 94.9%	75.0% - 94.9%
Low Performance	<75%	<75%	<75%

Why this matters to members

A prospective plan to detect fraud, waste, and abuse will stop and prevent any activities from employees, providers, or others that could harm members financially or negatively affect the quality of their care.

What this tells us about performance

The FWA Prevention Plan should describe the steps that the organization will take to achieve compliance with its standards by using reasonably designed monitoring and auditing systems. The FWA Prevention Plan must include the data sources, measures, criteria, and method(s) the CCO is planning to use to implement, analyze, and report on the effectiveness of the policies and procedures set forth in the FWA Prevention Handbook.

This data tells us that 14 CCOs made significant improvements and achieved full compliance with the Prevention Plan requirements in 2024. CHA and HSO performed below all other CCOs, scoring 50 percent and 25 percent, respectively, and falling below the compliance target by 50 and 75 percentage points, respectively. The compliance target is 100 percent. These two CCOs do not have an approved FWA Prevention Plan indicating there are potential operational challenges to implementing state and federal requirements. These CCOs might be less equipped to adequately monitor, detect, and audit employees, providers and subcontractors.

Prior to 2024, none of the CCOs achieved full compliance with the Prevention Plan requirements.

About the data

The FWA Prevention Plan is a required contract deliverable submitted by CCOs on an annual basis and evaluation results are returned through the CCO deliverables portal. The FWA Prevention Plan describes the steps the CCO will take to achieve compliance with its standards through monitoring and auditing mechanisms. OHA provides a report and evaluation tool and guidance document. Additional FWA contract deliverables, such as the Fraud, Waste, and Abuse Annual and Quarterly Audit, Referral and Investigation Reports, were not included in this document and may provide additional context about CCO performance.

Fraud, Waste and Abuse Assessments

Table 23: Compliance with Fraud, Waste and Abuse (FWA) Assessment requirements			
CCO	2022	2023	2024
AH	71.4%	36.4%	63.6%
AC	28.6%	27.3%	63.6%
CHA	0%	27.3%	9.1%
CPCCO	0%	9.1%	54.5%
EOCCO	57.1%	36.4%	45.5%
HSO	28.6%	27.3%	9.1%
IHN	14.3%	18.2%	27.3%
JCC	0%	9.1%	45.5%
PCS-CO	71.4%	45.5%	90.9%
PCS-CG	71.4%	45.5%	90.9%
PCS-LN	71.4%	45.5%	90.9%
PCS-MP	71.4%	45.5%	90.9%
TCHP-N	57.1%	27.3%	27.3%
TCHP-S	57.1%	27.3%	27.3%
UHA	57.1%	45.5%	36.4%
YCCO	57.1%	63.6%	72.7%
Statewide Average	44.64%	33.5%	52.8%
Source: FWA Assessment Evaluations, 2022-2024			

Description of Performance	2022	2023	2024
High Performance	≥ 95.0%	≥ 95.0%	≥ 95.0%
Moderate Performance	75.0-94.9%	75.0-94.9%	75.0-94.9%
Low Performance	< 75.0%	< 75.0%	< 75.0%

Why this matters to members

Robust and regular monitoring of providers, subcontractors and other entities providing services and care to members helps detect and prevent activities that could harm members financially or negatively affect the quality of care.

What this tells us about performance

FWA Annual Assessment shows the results and evaluation of the activities outlined in the Prevention Handbook and Prevention Plan. The annual assessment must explain how it deviated from the FWA Prevention Handbook and Prevention Plan, and why, as well as any changes implemented based on the assessment outcomes. The assessment allows the CCO to evaluate its Prevention Plan activities, determine the approach and focus for the upcoming year, and ensure the policies and procedures are implemented as intended. Ongoing evaluation and improvement of detection and prevention strategies is critical to prevent fraud, waste, and abuse.

PCS-CO, PCS-CG, PCS-LN, and PCS-MP made significant improvements and are performing above all other CCOs. CHA and HSO performed below all other CCOs both scoring 9.1 percent and falling below the compliance target by 90.9 percentage points. The compliance target is 100 percent. All CCOs with scores below the compliance target should work on developing an internal quality improvement process to evaluate previous audits and approaches to monitor fraud, waste, and abuse, and improve upon those activities in subsequent years. CCOs may also benefit from additional technical assistance to support them in developing an annual assessment process and ensuring implementation of the policies and procedures outlined in the FWA Prevention Handbook.

About the data

The FWA Assessment is a required contract deliverable submitted by CCOs on an annual basis and evaluation results are returned through the CCO deliverables portal. OHA provides a report and evaluation tool and guidance document. Additional FWA contract deliverables, such as the Fraud, Waste, and Abuse Annual and Quarterly Audit, Referral and Investigation Reports, were not included in this document and may provide additional context about CCO performance.

OREGON HEALTH AUTHORITY

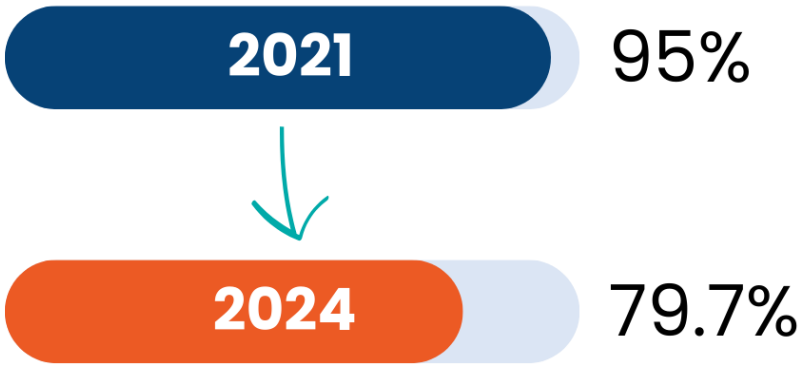
SUBCONTRACTING & DELEGATION

CCOs are required to demonstrate accountability and responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State.

From 2021 to 2024, fourteen CCOs demonstrated a decline in performance in federal compliance of Subcontracting and Delegation requirements. Eleven CCOs showed a decline of 10 percentage points or more over that time period. In 2024, the CCOs were evaluated against a more rigorous standard to assess their capacity to provide adequate oversight and monitoring of subcontractors.

CCOs with lower scores have more limited ability to perform adequate oversight of subcontracted functions to ensure the subcontractor is following all state and federal requirements. All sixteen CCOs were required to develop an improvement plan based on the 2024 review.

CCO compliance with Subcontractual and Delegation requirements



Most frequent opportunities for CCO improvement

- Lack of federally required language in written agreements with subcontractors.
- Lack of appropriate oversight and monitoring of its subcontractors.
- Failure to follow up and take corrective action when a subcontractor was not compliant with its contractual obligations.

Table 24: Compliance with Subcontractual and Delegation requirements Compliance Monitoring Review, Standard VI, 2021 and 2024				
CCO	2021	2024	Number of Findings (2024)	Total Number of Elements (2024)
AH	86%	87.50%	1	4
AC	100%	62.50%	3	4
CHA	100%	62.50%	3	4
CPCCO	93%	87.50%	1	4
EOCCO	100%	87.50%	1	4
HSO	93%	75.00%	2	4
IHN	100%	75.00%	2	4
JCC	93%	87.50%	1	4
PCS-CO	100%	75.00%	2	4
PCS-CG	100%	75.00%	2	4
PCS-LN	100%	75.00%	2	4
PCS-MP	100%	75.00%	2	4
TCHP-N	100%	87.50%	1	4
TCHP-S	100%	87.50%	1	4
UHA	93%	87.50%	1	4
YCCO	64%	87.50%	1	4
Statewide CCO Compliance Score	95%	79.70%		
Sources: External Quality Review Technical Reports and Compliance Monitoring Review, 2021 and 2024				

Rating	Description
High Confidence (≥ 95%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated substantial compliance with state, federal, and contract requirements. CCO's performance exhibited mostly Met ratings and high overall compliance scores.

Rating	Description
Moderate confidence (≥ 85 – <95%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated moderate compliance with state, federal, and contract requirements. CCO's performance exhibited a mix of Met, Partially Met, and Not Met ratings resulting in moderate compliance scores, indicating opportunities for improvement.
Low Confidence (≥75 – <85%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated low compliance with state, federal, and contract requirements. CCO's performance exhibited a mix of Met, Partially Met, and Not Met ratings resulting in low to moderate compliance scores indicating opportunities for improvement.
No Confidence (<75%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated general noncompliance with state, federal, and contract requirements. CCO's performance exhibited a large proportion of Partially Met and Not Met ratings resulting in low compliance scores, indicating substantial opportunities for improvement across most standards.

Why this matters to members

Members receiving services from subcontracted entities must receive the same level of high-quality services and adequate access to care, as defined in the CCO contract. Members should experience the benefits and services in the same manner as if they received them directly from the CCO.

What this tells us about performance

CCOs should maintain ultimate responsibility for adhering to and complying with all terms and conditions of the CCO's contract with the state even if a subcontractor is providing services to members. The CCO must maintain contracts with subcontractors that meet federal requirements. The CCO must also ensure oversight and monitoring of subcontractors and corrective action for any identified areas of noncompliance to ensure members receive services in accordance with state and federal requirements.

This data tells us that 14 CCOs demonstrated a decline in performance in Standard VI with 11 CCOs showing a decline of 10 percentage points or more from CY 2021 to CY 2024. AC and CHA performed below all other CCOs scoring 62.50 percent and falling below the compliance target of 100 percent by 37.50 percentage points. In 2024, the CCOs were evaluated against a more rigorous standard to assess their capacity to provide adequate oversight and monitoring of subcontractors. CCOs with lower scores have more limited ability to perform adequate

oversight of subcontracted functions to ensure the subcontractor is following all state and federal requirements.

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

- Written agreements with subcontractors lacked federally required language;
- Lack of appropriate oversight and monitoring of its subcontractors; and
- Failure to follow up and take corrective action when a subcontractor was noncompliant with its contractual obligations.

All CCOs were required to develop an improvement plan based on the CY 2024 compliance review.

About the data

Federal Medicaid Managed Care Regulations requires an EQRO conduct a review to determine CCO compliance with the standards set forth in 42 CFR §438 — Managed Care Subpart D. OHA contracts with HSAG as its EQRO to conduct CMRs of each of its contracted CCOs, across 16 standards. Individual CCO CMRs and overall Statewide Annual Technical Reports are posted publicly.

OREGON HEALTH AUTHORITY

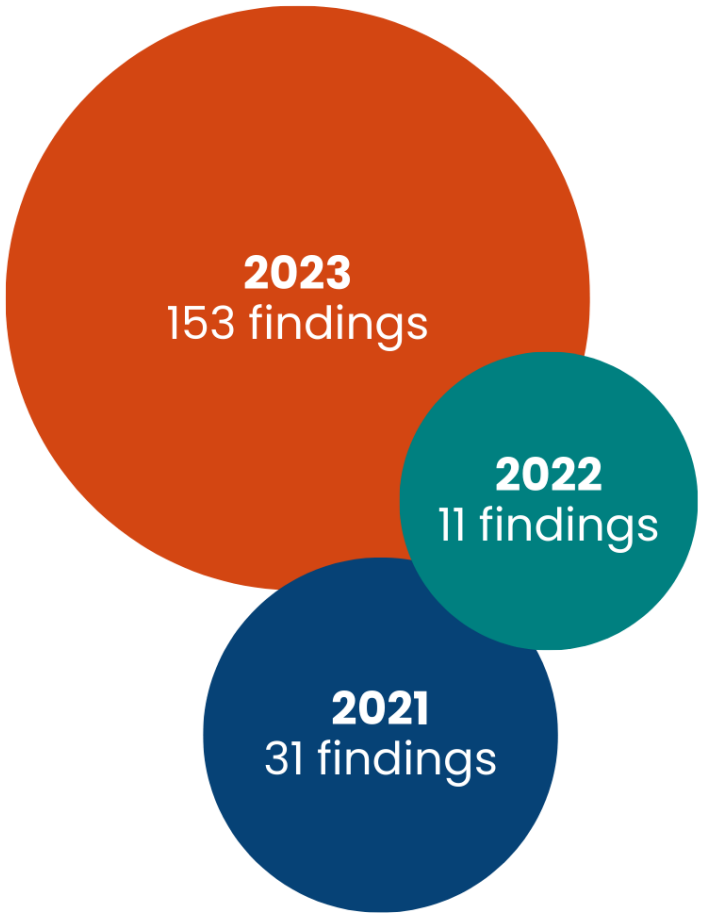
RESOLUTION OF AUDIT FINDINGS

OHA works with an objective organization to review compliance for state and CCO operations. Each year, the External Quality Review organization performs audits and documents CCO findings in Compliance Monitoring Reviews.

Compliance Monitoring Reviews are carried out on an annual basis and the compliance target for reviewed standards is 100 percent.

- If a CCO does not receive a 100 percent score, it must develop an improvement plan to outline the actions it will take to resolve the findings identified during the review.
- Findings should be resolved immediately, and evidence of resolution must be presented at the following year's annual review.
- Outstanding findings from previous reviews indicate a potential operational gap exists within the CCO and may indicate a need for improved quality assurance and quality improvement efforts.

Statewide total of unresolved findings from Compliance Monitoring Reviews



Compliance Monitoring Reviews (2020-2023): Unresolved findings

Table 25: Compliance Monitoring Review Unresolved Findings					
CCO	2021	2022	2023	Total Unresolved	Total Resolved
AH	2	0	10	12	32
AC	3	0	8	11	31
CHA	3	0	6	9	35
CPCCO	2	3	16	21	27
EOCCO	0	1	5	6	31
HSO	11	1	47	59	17
IHN	0	0	10	10	31
JCC	2	3	16	21	27
PCS-CG	1	0	2	3	23
PCS-CO	1	0	2	3	23
PCS-LN	1	0	2	3	26
PCS-MP	1	0	2	3	24
TCHP-N	1	1	4	6	31
TCHP-S	1	1	4	6	32
UHA	1	0	0	1	15
YCCO	1	1	19	21	20
Statewide total	31	11	153		
Sources: External Quality Review Technical Reports and Compliance Monitoring Reviews, 2021-2023					

Why this matters to members

State and federal requirements protect members and ensure they receive access to a minimum set of benefits and services. The inability to meet federal and state requirements for a prolonged period results in an adverse impact on access to services, timeliness of care, and quality of care.

What this tells us about performance

Compliance Monitoring Reviews (CMRs) are carried out on an annual basis and the compliance target for reviewed standards is 100 percent. CCOs achieving a 100 percent compliance score are fully compliant with federal and state requirements. If a CCO does not receive a 100 percent score for reviewed standards, the CCO must develop an improvement plan to outline the actions it will take to resolve the findings identified during the review. Findings should be resolved immediately, and evidence of resolution must be presented at the following year's annual CMR. Outstanding findings from previous reviews indicate a potential operational gap exists within the CCO and may indicate a need for improved quality assurance and quality improvement efforts.

As shown in the table above, all CCOs have outstanding findings from previous CMRs. HSO has the most unresolved findings followed by JCC, CPCCO, and YCCO. CCOs with numerous findings may need to perform a root cause analysis to identify operational gaps that need to be corrected to improve overall ability to respond to audits and ensure compliance with state and federal requirements.

About the data

OHA contracts with HSAG as its EQRO to conduct CMRs of each of its contracted CCOs, across 16 standards. Individual CCO CMRs and overall Statewide Annual Technical Reports are posted publicly.

OREGON HEALTH AUTHORITY

FINANCIAL PERFORMANCE

About this operational area

Financial Performance is a key indicator for each unique CCO business model. It demonstrates the ability to continue to maintain business operations, which includes coordination and delivery of medical services to OHP members. CCOs are stewards of the billions of dollars in state and federal funds required to run Oregon Health Plan and the Medicaid program. OHA monitors the financial performance of these entities quarterly and provides feedback and inquiries related to the financial results, this includes current financial performance as well as the overall risk of solvency for continuation of overall business structure.

Measuring CCO financial performance includes:

- Operating Margin
- Minimum Medical Loss Ratio
- Days Cash on Hand
- Restricted Reserves
- Rate of Growth
- Asset to Liability Ratio
- Subcapitation
- Risk-Based Capital

Information reported by the CCOs helps OHA monitor the overall financial performance and informs the building of capitation rates the CCOs are allocated to cover the provision of benefits. Safeguarding the financial solvency of the CCOs is an important regulatory role of OHA. Oregon Revised Statute (ORS) 415.011 (Oregon Health Authority regulation of financial solvency of CCOs) gives OHA the ability to regulate the financial solvency of the CCO entities to align with regulation of domestic insurers. OHA is also required by ORS 414.593(3) to make the reports submitted under the CCO Contract readily available to the public.

Since 2020, OHA has monitored and reported on CCO financial solvency and provided transparency that had not been available previously. All tables and graphs presented came from publicly available information reported by the CCOs.

- The Exhibit L – Financial reporting template
    - Report L3 – Restricted Reserves
    - Report L4 – Key Financial Indicators
    - Report L5 – Semi-Annual Balance Sheet of Corporate Activity
    - Report L6 – Semi-Annual Statement of Revenues, Expenses and Changes in Net Assets – OHP Line of Business.
    - Report L6 OHP SE – Annual Sub-capitated Statement of Revenue and Expenses.
- The National Association of Insurance Commissioners (NAIC) Statutory Statements
- Rate of Growth templates
- Minimum Medical Loss Ratio Reporting
- Medicaid Efficiency and Performance Program

CCOs have mandatory delivery of their financial reporting quarterly, and receive feedback from OHA regarding their financial trends, compliance with the CCO Contract, Exhibit L, and the statutory requirements for NAIC statutory statements, as well as the Risk-Based Capital (RBC) requirement the CCOs report on annually. CCOs have filed using the Exhibit L since the Affordable Care Act (ACA) expansion in 2013 and the NAIC Statutory Statements since June 2020. NAIC

financial reporting benchmarks have allowed OHA to evaluate the risks of solvency for the CCOs, and to note which CCOs are operating compared to the NAIC benchmarks, noting the industry standard for a fully solvent health care organization.

Net operating margin

Table 26: Exhibit L Net Operating Margin by CCO by Year					
CCO	2020	2021	2022	2023	2024
AH	1.1%	0.8%	0.2%	2.5%	1.3%
AC	3.0%	3.0%	7.7%	-0.6%	-0.2%
CHA	2.5%	3.5%	5.2%	1.9%	0.8%
CPCCO	0.7%	2.1%	3.8%	1.6%	-0.2%
EOCCO	3.8%	5.5%	3.1%	0.5%	-2.5%
HSO	-0.1%	0.1%	0.6%	0.9%	0.4%
IHN	0.6%	2.2%	3.8%	-0.9%	-0.1%
JCC	0.1%	0.8%	5.3%	3.1%	0.9%
PCS-CO	5.8%	3.3%	9.5%	6.4%	6.4%
PCS-CG	6.9%	3.4%	10.2%	2.0%	3.5%
PCS-LN	2.5%	5.2%	11.3%	5.7%	4.3%
PCS-MP	-0.8%	0.9%	7.2%	5.5%	1.1%
TCHP-N	0.0%	-2.9%	8.6%	8.5%	11.7%
TCHP-S	4.2%	7.8%	6.7%	-0.5%	-4.6%
UHA	5.2%	4.4%	7.0%	2.0%	3.6%
YCCO	3.7%	4.3%	7.3%	-2.7%	-0.6%
Consolidated Net Operating Income	1.5%	2.1%	4.6%	2.2%	1.3%
Source: CCOs on Exhibit L Financial Reporting, Report L6					

Why this matters to members

Information reported by the CCOs helps OHA monitor the overall financial performance as well as build the capitation rates paid to CCOs to cover OHP members.

What this tells us about performance

Net operating margin is presented with the Key Financial Indicators on Report L4, and easily calculated from the Report L6 - Statement of Revenue and Expenses. This is a Key Performance Indicator of OHP business operations, as it measures the percentage of revenue to operating income/(loss) by CCO.

Each entity that holds a CCO contract is entitled to choose their business model and may vary in their decision-making process for handling other types of revenue and expenses as an entity. Net operating margin is meant to report only on their OHP line of business. While this measurement does not fully capture all the business activity of a CCO, it strictly measures the percentage of profit after medical claims expense and CCO administrative expenses by contract.

More about the data

This financial analysis is based upon information reported by the CCOs on Exhibit L Financial Reporting, Report L6 – Semi-Annual Statement of Revenues, Expenses and Changes in Net Assets – OHP Line of Business.

CCO risk-accepting entities

Figure 4: Exhibit L SE - Subcapitated Premiums as a Percentage of CCO Premiums

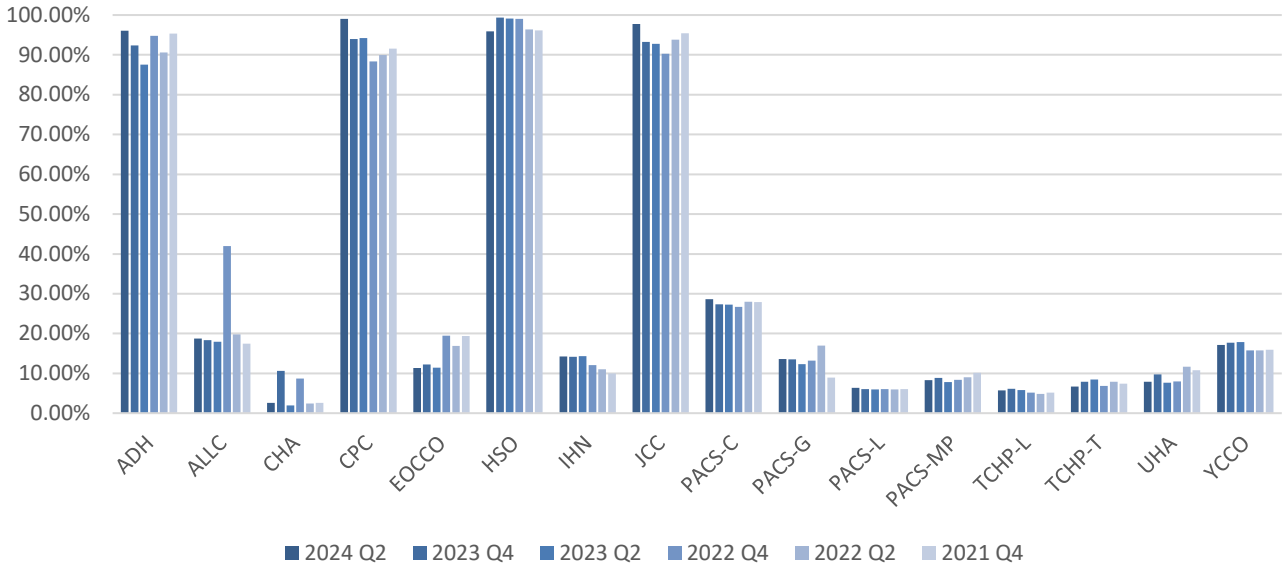


Table 27: Provider/Network Sub-capitation to Risk-Accepting Entities as a percentage of total CCO Capitation

	2024	2023	2022	2021
CCO	Q2	Q4	Q4	Q4
AH	96.09%	92.36%	94.75%	95.36%
AC	18.76%	18.37%	41.93%	17.44%
CHA	2.58%	10.62%	8.72%	2.62%
CPCCO	99.01%	93.96%	88.35%	91.54%
EOCCO	11.37%	12.20%	19.47%	19.42%
HSO	95.88%	99.36%	99.02%	96.13%
IHN	14.26%	14.19%	12.04%	9.96%
JCC	97.75%	93.28%	90.27%	95.45%

Table 27: Provider/Network Sub-capitation to Risk-Accepting Entities as a percentage of total CCO Capitation				
	2024	2023	2022	2021
CCO	Q2	Q4	Q4	Q4
PCS-CO	28.59%	27.33%	26.68%	27.94%
PCS-CG	13.56%	13.52%	13.23%	8.92%
PCS-LN	6.34%	6.06%	6.07%	6.04%
PCS-MP	8.31%	8.87%	8.37%	10.13%
TCHP-S	5.70%	6.14%	5.16%	5.18%
TCHP-N	6.66%	7.92%	6.86%	7.42%
UHA	7.92%	9.78%	7.99%	10.79%
YCCO	17.12%	17.72%	15.74%	15.90%
Source: Exhibit L SE, Report L6 OHP SE				

Why this matters to members

In addition to tracking the overall financial health of the CCO, we also have included the percentage of sub-capitation revenue reported for the Group 1 and Group 2 risk-accepting entities as a percentage of the CCO's reported net premium revenues.

What this tells us about performance

The Risk-Accepting Entity Financial Reports provide visibility of the financial performance of CCO subcontractors. OHA does not receive copies of the contracts written between CCOs and their risk-accepting entities, but we do monitor the financial performance. Each CCO and their level of delegation of risk varies. OHA takes this allowance for delegation into consideration in our overall review process, as a higher level of delegation means that the solvency risk could pass to these underlying delegated entities. OHA does require that CCOs provide the financial transparency of Exhibit L income and loss for all risk-accepting entities that meet the Group 1 and Group 2 criteria definition.

- Group 1: A sub-capitated entity receives a total of 5 percent or more of the CCO's Net Premiums (Line 2 of the Exhibit L6 OHP Report).
- Group 2: A sub-capitated entity receives a total of less than 5 percent or more than 0.5 percent of the CCO's Net Premiums (Line 2 of the Exhibit L6 OHP Report) AND the sub-capitated entity is either a mental health provider/organization or a dental care provider/organization.

More about the data

This financial analysis is based upon information reported by the CCOs on Exhibit L SE Reporting Report L6 OHP SE – Annual Sub-capitated Statement of Revenue and Expenses.

Restricted Reserves

Table 28: Restricted Reserve Deficit Tracking, Contract Years 2020 - 2024

	2020				2021				2022				2023				2024		
CCO	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Total
AH						1													1
AC									1	1	1				1		1		5
CHA				1	1	1			1	1									5
CPCCO				1	1		1	1	1	1									6
EOCCO										1									1
HSO				1	1														2
IHN				1	1	1	1	1			1					1	1		8
JCC	1	1	1	1	1			1	1	1	1								9
PCS-CO					1	1	1	1	1										5
PCS-CG				1	1		1	1	1						1				6
PCS-LN					1	1	1	1	1		1								6
PCS-MP				1	1			1	1		1				1		1		7

Table 28: Restricted Reserve Deficit Tracking, Contract Years 2020 - 2024																		
TCHP-S																		0
TCHP-N														1				1
UHA					1		1	1										3
YCCO																		0
Total 1s by Quarter	1	1	1	7	10	5	6	8	8	5	5	0	0	0	4	1	3	0	
Source: Exhibit L Report L3																		

Why this matters to members

Information reported by the CCOs helps OHA monitor the overall financial performance as well as safeguard providers and members to cover medical costs for a short period of time if financial insolvency occurs.

What this tells us about performance

Restricted Reserves are meant to safeguard approximately two weeks of CCO medical spending in case of a rapid CCO insolvency. CCOs are required by the contract to enter into a Model Depository Agreement with OHA, specifically for a principal amount of a bank account to be held until OHA has agreed to withdrawals.

CCOs are monitored quarterly to determine whether they are meeting requirements. Over the last four quarters of available data (Q3 2023 to Q2 2024), there were eight incidents of non-compliance among five CCOs. No CCO failed to meet requirements for more than two quarters during this period.

During the COVID-19 Public Health Emergency (PHE) and the related expansion of OHP/Medicaid membership, OHA continued to monitor the needs of the Restricted Reserve accounts and noted that for the first time in the CCO 2.0 Contract period, many CCOs were not meeting the requirement. The table indicates that Q1 2021 had 10 of the 16 CCO Contracts out of

compliance with their Restricted Reserve, and that only two CCOs never had a Restricted Reserve deficit to date.

More about the data

This financial analysis is based upon information reported by the CCOs on Exhibit L Report L3 – Restricted Reserves. CCOs use this report to calculate their Restricted Reserve needs based upon previously reported medical expenses and provide balances of their Restricted Reserves account on the last day of the reporting period.

Risk-Adjusted Rate of Growth (RAROG)

Table 29: Risk-Adjusted Rate of Growth (RAROG)			
CCO	Unadjusted Rate of Growth 2022-2023	Risk-Adjusted Rate of Growth 2022-2023	Annualized RAROG 2020-2023
AH	-2.5%	-3.8%	3.0%
AC	16.8%	14.4%	6.4%
CHA	9.0%	12.4%	0.6%
CPCCO	19.8%	18.1%	6.3%
EOCCO	6.4%	6.8%	6.6%
HSO	7.5%	7.4%	6.0%
IHN	7.5%	6.5%	3.9%
JCC	15.1%	14.6%	6.5%
PCS-CO	9.7%	8.3%	4.2%
PCS-CG	4.7%	5.5%	6.9%
PCS-LN	10.0%	9.1%	4.6%
PCS-MP	8.4%	6.6%	4.0%
TCHP-S	18.9%	16.7%	4.7%
TCHP-N	14.2%	12.3%	10.5%*
UHA	15.9%	14.3%	6.7%
YCCO	10.9%	9.4%	7.2%
Statewide Weighted Average	9.5%	8.7%	5.4%
Source: Risk-Adjusted Rate of Growth report			

Why this matters to members

The RAROG is presented annually to the Senate Health Care Committee as a part of the overall goal of transparency and accountability of statewide spending. It assists in the determination of future rates that will be paid per member for Medicaid coverage.

What this tells us about performance

OHA annually publishes the RAROG measurement for each CCO. Rate of growth measurements look at changes in CCO spending. CCO spending is considered in setting capitation rates in future years, so a restrained rate of growth helps meet statewide goals on medical spending. Risk adjustment means changing the rate of growth measurement to account for changes in the health risk of CCOs' membership. Health risk is measured by diagnosis and prescription drug data that indicate the presence of medical conditions. Risk adjustment can be helpful because CCO membership changes each year and adjusting for the changes in membership allows RAROG to focus on underlying cost growth.

Many factors can influence individual CCO rates of growth. Even after risk adjustment, individual CCO RAROGs can be unusually high or low in a single year and may reflect factors such as changes to local hospital pricing or large individual claims. The final column in the table above shows an average RAROG over the past three years.

More about the data

Annually the CCOs complete a Rate of Growth template, from which the calculation is derived.

Minimum Medical Loss Ratio (MMLR)

Table 30: Three-year Minimum Loss Ratio	
CCO	2021 - 2023
AH	90.67%
AC	89.08%
CHA	85.90%
CPCCO	85.71%
EOCCO	88.80%
HSO	88.39%
IHN	92.51%
JCC	85.17%
PCS-CO	86.92%
PCS-CG	86.42%
PCS-LN	87.46%
PCS-MP	87.93%
TCHP-N	76.11%*
TCHP-S	83.18%*
UHA	85.14%
YCCO	88.13%
Source: 2023 MLR Reporting	

*CCO is under 85 percent threshold and will be required to rebate back to the state and federal government.

Why it matters to members

The oversight on the minimum medical spending of CCOs safeguards members and encourages the CCOs to meet the requirements of spending 85 percent of their capitated payments on member's medical services.

What this tells us about performance

Oregon regulation meets the Centers for Medicare & Medicaid Services (CMS) minimum requirement that at least 85 percent of all Medicaid program spending goes towards medical spending instead of administrative services or towards organizational profits. CCOs submitted their 2023 MMLR filings on Sept. 3, 2024, marking the conclusion of the three-year MLR period. Two CCOs had a total of $49.2 million rebates. The final total could change as OHA's Office of Actuarial and Financial Analytics (OAFA) reviews the CCOs' MLR filings to verify all the financial information and ensure compliance.

More about the data

Each year, OAFA collects the CCOs' Minimum Medical Loss Ratio data, reviews the data for accuracy against their financial reporting, then submits the information to CMS. From 2021 to 2023, Oregon allowed CCOs to operate under a rolling three-year MLR period. No rebates were collected for 2021 or 2022, instead allowing CCOs to reach the 85 percent minimum over the three-year period.

CCO ratio of current assets to current liabilities

Table 31: CCO Current Ratio					
	2020	2021	2022	2023	2024
CCO	Q4	Q4	Q4	Q4	Q2
AH	1.93	1.14	0.91	1.21	1.29
AC	1.49	1.51	1.74	1.53	1.31
CHA	1.27	1.25	1.34	1.28	0.32
CPCCO	1.28	1.29	1.27	1.27	1.29
EOCCO	0.87	0.89	0.71	0.47	0.62
HSO	1.56	1.19	1.09	1.18	1.07
IHN	1.11	1.10	1.13	1.08	0.99
JCC	1.34	1.39	1.41	1.46	1.43
PCS	0.80	0.64	0.84	0.53	0.60
TCHP	0.93	0.79	0.41	0.49	0.53
UHA	1.98	1.32	1.42	1.18	1.19
YCCO	1.95	1.92	1.92	1.60	1.58
Statewide	1.17	1.01	1.01	0.88	0.86
Source: Exhibit L, Report L4					

Why this matters to members

OHA is tasked with safeguarding members in the event that a CCO can no longer operate. The short-term obligations of a CCO will be the first payments due in the case of a CCO insolvency. To meet those obligations, CCO would most easily use their liquid assets. It is important for OHA to periodically review this Key Indicator.

What this tells us about performance

Current ratio is presented with the Key Financial Indicators on Report L4 of the Exhibit L and 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. A healthy current ratio is at least 1, indicating the company has funds that at least meet their current debt needs with liquid assets.

More about the data

This financial analysis is completed as a part of Exhibit L, Report L4 – Key Financial Indicators. This data is collected biannually June 30 and December 31 of each year.

Days Cash on Hand

Table 32: Days Cash on Hand				
	2020	2021	2022	2023
CCO	Q4	Q4	Q4	Q4
AH	14.0	6.6	1.5	7.5
AC	52.2	52.2	65.3	46.3
CHA	111.1	147.6	156.3	131.7
CPCCO	44.3	38.1	40.4	44.3
EOCCO	52.3	52.2	41.9	18.0
HSO	15.3	8.2	7.6	9.3
IHN	44.3	52.1	53.4	45.8
JCC	29.7	18.0	15.3	30.9
PCS	20.4	18.9	37.9	13.7
TCHP	23.2	65.7	31.9	45.5
UHA	101.7	138.8	158.0	117.4
YCCO	112.7	90.7	136.2	115.3
Source: Exhibit L, Report L4				

Why this matters to members

OHA is tasked with safeguarding members in event that a CCO can no longer operate. Days Cash On Hand allows OHA to know how long operations can be sustained without use of Restricted Reserves.

What this tells us about performance

Days Cash on Hand is presented with the Key Financial Indicators on Report L4 of the Exhibit L and is calculated by dividing the current period's Cash and Short-term Investments by Member Service Expenses per day. The financial metric indicates how many days a CCO can continue to cover their member's medical expenses without any additional income coming in.

More about the data

This financial analysis is completed as a part of Exhibit L, Report L4 – Key Financial Indicators. This data is collected biannually at June 30 and December 31 of each year.

All the financial information and performance measures presented in the Financial Performance section of this report are available via OHA's CCO Financial Performance website.

Risk-Based Capital Calculation

Table 33: Risk-Based Capital Heatmap by CCO by year				
CCO	2023	2022	2021	2020
AH				
AC				
CHA				
CPCCO				
EOCCO				
HSO				
IHN				
JCC				
PCS-CO				
PCS-CG				
PCS-LN				
PCS-MP				
TCHP-LN				
TCHP-TC				
UHA				
YCCO				

Description of Performance	
Exceeds Compliance Goal	≥300%
Compliant	200% - 299%
Non-Compliant	<200%

Why this matters to members

Risk-Based Capital (RBC) is a method of measuring the minimum amount of capital appropriate for a reporting entity to support its overall business operations in consideration of its size and risk profile. This means that a CCO has an additional fail-safe if they experience periods of losses due to higher costs.

What this tells us about performance

Risk-Based Capital (RBC) is a method of measuring the minimum amount of capital appropriate for a reporting entity to support its overall business operations in consideration of its size and risk profile. The NAIC RBC system has two main components:

(1) the RBC formula, which establishes a hypothetical minimum capital level which is compared to a company's actual capital level, and

(2) an RBC law that grants automatic authority to the state insurance regulator to take specific actions based on the level of impairment.

The level of capital and surplus that a CCO needs to remain solvent will depend on the degree to which assets can lose value or the liabilities can increase. Insurers determine their own capital levels based on internal perceptions of risk and by their own level of comfort with that risk.

OHA relies upon the Oregon Administrative Rules, adapted from the NAIC, to manage the authorization levels established for RBC and the regulation of the CCOs. While licensed insurers begin with levels of intervention at 300% RBC, the CCOs must maintain greater than 200% before any OHA intervention occurs.

- Company Action Level: OAR 410-141-5205: 200%
- Regulatory Action Level: OAR 410-141-5210: 150%
- Authorized Control Level: OAR 410-141-5215: 100%
- Mandatory Control Level: OAR 410-141-5220: 70%

More about the data

This report is provided by the CCOs directly to OHA annually. It is available only to regulators and will not be posted on OHA's CCO Financial Performance website.

Glossary

Coordinated care organizations (CCOs)

- AH: Advanced Health
- AC: AllCare CCO, Inc.
- CHA: Cascade Health Alliance, LLC
- CPCCO: Columbia Pacific CCO, LLC
- EOCCO: Eastern Oregon CCO, LLC
- HSO: Health Share of Oregon
- IHN: InterCommunity Health Network
- JCC: Jackson Care Connect
- PCS-CO: PacificSource Community Solutions – Central Oregon
- PCS-CG: PacificSource Community Solutions – Columbia Gorge
- PCS-LN: PacificSource Community Solutions – Lane
- PCS-MP: PacificSource Community Solutions – Marion Polk
- TCHP-N: Trillium Community Health Plan, Inc. – North
- TCHP-S: Trillium Community Health Plan, Inc. – South
- UHA: Umpqua Health Alliance, LLC
- YCCO: Yamhill Community Care Organization

Provider types

- PCP: Primary Care Provider
- PCD: Primary Care Dentist
- MHP: Mental Health Provider

- SUD: Substance Use Disorder Provider
- OB/GYN: Obstetrics/Gynecology
- OPT: Optometry
- DME: Durable medical equipment
- HOSP: Hospital
- Rx: Prescription
- SNF: Post-hospital skilled nursing facility

Appendix A. Methodology and measure rating descriptions

Measure Types

Measure Type	Evaluator(s)	Basis of Evaluation	Rating Methodology
Compliance Monitoring Review (CMR)	External Quality Review Organization (HSAG)	Federal Medicaid Rules (42 CFR 438)	Compliance Confidence Levels (High, Moderate, Low, No)
Compliance Evaluations	Oregon Health Authority, Quality Assurance Team	State Rules (OAR 410-141) &/or CCO Contract Requirements	Degree of Compliance (High, Moderate, Low)
Performance Reporting (non-compliance standards)	Oregon Health Authority, Quality Assurance Team	State Rules (OAR 410-141) &/or CCO Contract Requirements	Relative to CCO Average (Out-Perform, Comparable, Under-Perform)
Key Operational Areas (non-performance standards)	Oregon Health Authority, Quality Assurance Team or Subject Matter Experts	No specific compliance or performance requirements	No rating is provided; importance of operational area provided in narrative

Compliance Evaluations

The compliance evaluation measures were based on requirements outlined in Federal and State requirements. The compliance standard for compliance evaluations is 100%. Compliance evaluations use an OHA-developed performance scale that evaluates performance in comparison to the compliance standard (100%) and assigns a corresponding high, moderate, or low performance level.

Performance Reporting

The performance reporting measures were evaluated in relation to the CCO average because compliance standards do not exist. However, state requirements (e.g., OAR, CCO Contract) may identify performance requirements for the subject area. Based on the comparison to the CCO average, each CCO received a rating of out-performing, comparable or under-performing (compared to the average).

Key Operational Areas

The operational measures (non-performance standards) do not have specific compliance or performance requirements outlined in State rules and/or CCO Contract (e.g., network adequacy measures, financial measures, etc.) and were not rated.

Compliance Monitoring Review

The objective of the Compliance Monitoring Reviews (CMR) is to provide meaningful information to OHA and the CCOs regarding:

- The CCOs' compliance with federal managed care regulations, Oregon Administrative Rules (OARs), and contract requirements with the standard areas reviewed.
- Strengths, opportunities for improvement, recommendations, or required actions to bring the CCOs into compliance with federal managed care regulations and State requirements with the standard areas reviewed.
- The quality, timeliness, and accessibility of care and services furnished by the CCOs, as addressed within the specific areas reviewed.

- Recommendations to improve the quality of care and services offered by the CCOs related to the areas reviewed.

CMRs assess CCO compliance with the federal compliance review standards outlined in 42 CFR §438.358(b)(1)(iii) and related State contract requirements. Contract Year (CY) 2023 began the new three-year review cycle for 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. A total of sixteen standards are reviewed over the three-year cycle. The standards reviewed include:

- Standard I – Availability of Services
- Standard II – Assurances of Adequate Capacity and Services
- Standard III – Coordination and Continuity of Care
- Standard IV – Coverage and Authorization of Services
- Standard V – Provider Selection
- Standard VI – Subcontractual Relationships and Delegation
- Standard VII – Member Rights and Protections
- Standard VIII – Confidentiality
- Standard IX – Enrollment and Disenrollment
- Standard X – Grievance and Appeal Systems
- Standard XI – Practice Guidelines
- Standard XII – Quality Assessment and Performance Improvement
- Standard XIII – Health Information Systems, including Information System Capabilities Assessment
- Standard XIV – Member Information
- Standard XVI – Emergency and Poststabilization Services

To assess for the CCOs' compliance with regulations, HSAG conducted the five activities described in CMS' EQR February 2023 (EQR Protocol 3).

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

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

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

Met indicates full compliance, defined as:

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

Partially Met indicates partial compliance, defined as:

- There is compliance with all documentation requirements, but CCO staff are unable to consistently articulate evidence of compliance during interviews; or

- CCO staff can describe and verify the existence of compliant practices during the interview, but documentation is found to be incomplete or inconsistent with practice.

Not Met indicates noncompliance, defined as:

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

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

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

Using the following standardized methodology, HSAG assigned a confidence level based upon the total percentage-of-compliance score for each of the standards and an overall percentage-of-compliance score across all standards to indicate the degree to which the CCOs achieved compliance with the standards reviewed. Ratings of *High Confidence, Moderate Confidence,* and *Low Confidence* to indicate the level of confidence exhibited by the CCO's performance.

Rating	Description
High Confidence (≥ 95%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated substantial compliance with state, federal, and contract requirements. CCO's performance exhibited mostly Met ratings and high overall compliance scores.
Moderate confidence (≥ 85 – <95%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated moderate compliance with state, federal, and contract requirements. CCO's

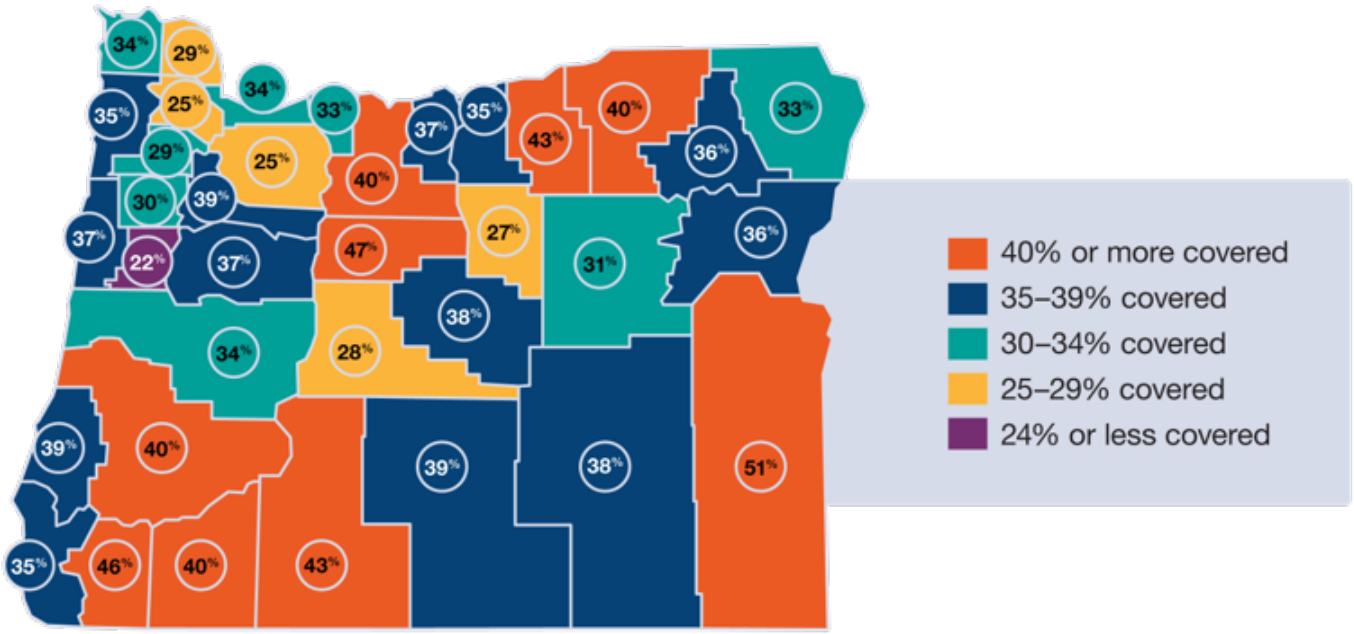
	performance exhibited a mix of Met, Partially Met, and Not Met ratings resulting in moderate compliance scores, indicating opportunities for improvement.
Low Confidence (≥75 – <85%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated low compliance with state, federal, and contract requirements. CCO's performance exhibited a mix of Met, Partially Met, and Not Met ratings resulting in low to moderate compliance scores indicating opportunities for improvement.
No Confidence (<75%)	The CCO's operational structure, policies and procedures, and implementation of its documented processes demonstrated general noncompliance with state, federal, and contract requirements. CCO's performance exhibited a large proportion of Partially Met and Not Met ratings resulting in low compliance scores, indicating substantial opportunities for improvement across most standards.

Appendix B. Tables

Appendix C. Figures

Appendix D: Medicaid Enrollment by County

The following map highlights the percentage of Medicaid enrollment across Fee-For-Service and Coordinated Care Organizations by county.



One factor that may impact provider availability for a CCO member is the health care coverage mix for residents between federal or state plans (Medicaid, Medicare) and commercial plans. This table reflects the percentage of residents living in a CCO's service area who are Medicaid and Medicare members. In areas served by more than one CCO, population was applied proportionately, based on the percentage of Medicaid-covered members served by each CCO.

Data provided by the Centers of Medicare and Medicaid (CMS) and OHA.

https://data.cms.gov/summary-statistics-on-beneficiary-enrollment/medicare-and-medicaid-reports/medicare-monthly-enrollment

https://www.oregon.gov/oha/hpa/analytics/pages/medicaid-enrollment.aspx#Dashboard

Member Mix by CCO Service Area			
CCO	Medicaid %	Medicare %	Medicaid & Medicare %
AH	38.2%	33.6%	71.8%
AC	43.3%	30.9%	74.2%
CHA	42.6%	26.0%	68.6%
CPCCO	32.3%	27.2%	59.5%
EOCCO	37.0%	21.0%	58.0%
HSO	30.1%	17.9%	48.0%
IHN	31.9%	24.4%	56.3%
JCC	40.2%	27.0%	67.2%
PCS-CO	30.8%	24.5%	55.3%
PCS-CG	35.7%	20.9%	56.6%
PCS-LN	33.9%	24.7%	58.6%
PCS-MP	37.8%	22.8%	60.6%
TCHP-LN	34.3%	25.2%	59.5%
TCHP-TC	30.3%	17.8%	48.1%
UHA	39.8%	31.5%	71.3%
YCCO	29.5%	21.1%	50.6%

Appendix E: 2023 Incentive Measures

- **Childhood Immunization Status** – Percentage of children who turned two years old in 2023 and had the Dtap, IPV, MMB, HIB, HepB, V2V, and PCV vaccines by their second birthday.
- **Immunization for Adolescents* –** Percentage of adolescents who turned 13 years old in 2023 and had the meningococcal, Tdap, and HPV vaccines by their 13th birthday.
- **Child and Adolescent Well Care Visits* –** Percentage of children three to six years old who had one or more well-child visits with a PCP during 2023.
- **Prenatal & Postpartum Care*** – Percentage of deliveries of live births between October 8, 2022 and October 7, 2023 who had a postpartum visit seven to 84 days after delivery.
- **Screening for Depression and Follow-up Plan** – Percentage of patients 12 years old and older screened for depression on the date of the encounter or up to 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool and, if positive, a follow-up plan is documented on the date of the eligible encounter.
- **Health Aspects of Kindergarten Readiness: CCO System-Level Social-Emotional Health –** CCOs must attest to all required components: Social-Emotional Health Reach Metric Data review and Assessment; Asset map of existing Social-Emotional Health Services and Resources; CCO-Led Cross-Sector Community Engagement; Action Plan to Improve Social-Emotional Health Service Capacity and Access.
- **Cigarette Smoking Prevalence** – Percentage of Medicaid members (13 years old and older) who currently smoke cigarettes.
- **Alcohol and Drug Misuse: Screening, Brief Intervention and Referral for Treatment (SBIRT)** – Percentage of patients 12 years old and older who received an age-appropriate screening and, of those with a positive full screen, percentage who received a brief intervention or referral to treatment.
- **Member Screening Preventive Dental or Oral Health Services, ages 1-5 and 6-14*** – Percentage of enrolled children one to five years old and six to 14 years old who received dental or oral health services during 2023.
- **Oral Evaluation for Adults with Diabetes** – Percentage of adults with diabetes who received at least one oral evaluation in 2023.
- **Mental and Physical Health and Oral Health Assessment within 60 days for Children in ODHS Custody** – Percentage of children ages 0-17 who received a physical health assessment, children ages 1-17 who received a dental health assessment, and children ages 4-17 who received a mental health assessment, within 60 days of the state notifying CCOs that the children were placed into custody with the Department of Human Services (foster care).
- **Comprehensive Diabetes Care** – Percentage of patients 18-75 years old with diabetes who had hemoglobin A1C > 9.0% during 2023.

- **Initiation and Engagement of Substance Use Disorder Treatment**
- **Health Equity Measure: Meaningful Language Access to Health Care Services for persons with limited English proficiency** – The proportion of visits with spoken and sign language interpreter needs that were provided with OHA qualified or certified interpreter services.
- **Social Determinants of Health: Social Needs Screening and Referral –** CCOs must attest to completion of all elements: prepare for equitable, trauma-informed, and culturally responsive screening and referrals; work with community-based organizations to build capacity for referrals and meeting social needs; support data sharing between CCOs, providers, and community-based organizations.

*- These are the four measures used to determine challenge pool fund distribution.