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Date: August 12, 2020

To: Lori A. Ahlstrand
Regional Inspector General for Audit Services
Office of Inspector General
Department of Health and Human Services

From: Dave Inbody
CCO Operations Manager
Health Systems Division
Oregon Health Authority

Subject: Response to OIG Audit Report

In response to the draft report from the U.S. Department of Health and Human Services, Office of Inspector General (OIG) entitled *Oregon's Oversight Did Not Ensure That Four Coordinated-Care Organizations Complied with Selected Medicaid Requirements Related to Access to Care and Quality of Care,* the Oregon Health Authority (OHA) acknowledges the findings and supports the five recommendations identified.

On January 1, 2020, new five-year contracts became effective with 12 entities to operate as coordinated care organizations (CCOs) in 15 service areas. This new contract period, referred to as CCO 2.0, includes a significant expansion of CCO requirements and a renewed focus by OHA on compliance and accountability to federal and state Medicaid requirements. The findings provided by OIG as part of this report will provide critical insight in OHA's continued commitment to member access to care and quality of care.

OHA is pleased that OIG found CCOs were generally compliant with federal and state requirements related to time and distance standards, timely access standards, and requirements related to assignment of primary care physicians. Despite these positive findings, OHA will continue to evaluate these areas to ensure adequate access to all services covered under CCO contract and state rules. This will be achieved through a variety of compliance and reporting requirements, most notably the Delivery System Network (DSN) reporting and Compliance Monitoring Reviews conducted by an external quality review organization (EQRO), in collaboration with OHA's Quality Assurance and Contract Oversight unit. Since the OIG audit of CCOs occurred, OHA has contracted with a new EQRO, Health Services Advisory Group (HSAG), to conduct this work. OHA is confident this work will be more thorough and extensive than has been provided in the past.

For the areas in which OIG's findings indicated areas of concern, OHA is committed to making improvements. Based on the findings identified in this report, OIG provided five recommendations:

Recommendation #1: Provide additional guidance to CCOs on the processes for provider credentialing and for beneficiary grievances and appeals

OHA Response:

The CCO contract, Exhibit B, Part 4, Section 6a. states the requirement for CCOs to have credentialing policies and procedures as follows:

> *Contractor shall have written policies and procedures for collecting evidence of credentials, screening the credentials, reporting credential information and recredentialing of Participating Providers including Acute, primary, dental, behavioral, Substance Use Disorder Providers, and facilities used to deliver Covered Services, consistent with PPACA Section 6402, 42 CFR 438.214, 42 CFR 455.400-455.470 (excluding 455.460), OAR 410-141-3510 and Exhibit G of this Contract, except as provided in Para. B, of this Sec. 6, Ex. B, Part 4.*

The CCO contract also requires the maintenance of records (Exhibit B, Part 4, Section 6f.) that documents academic credentials, training received, licenses and certifications, and reports from the National Practitioner Data Bank. All CCO providers are included in the DSN Report that CCOs submit to OHA on a quarterly basis. The contract includes information about credentialing of providers designated by CMS as "moderate or high risk." OHA convenes a monthly forum with CCOs to discuss operational matters. OHA has used this forum to solicit questions from CCOs related to provider credentialing and will remind CCOs about the opportunity to submit questions to the monthly forum and directly to OHA.

CCOs are required to monitor providers with respect to nine different criteria (Exhibit G, Section 2b.). Also included in the DSN Report is the description of five different CCO processes including the "Processes used to develop, maintain and Monitor an appropriate Provider Network that is sufficient to provide adequate access to all services covered under this Contract." (Exhibit G, Section 2c.(2)). Through the quarterly DSN Provider Capacity report submissions, CCOs are expected to report the credentialing date of providers, which will allow OHA to determine if CCOs are credentialing, and recredentialing, providers within the expected timeframes.

In the next 12 months, OHA will determine the feasibility of providing universal application and credentialing procedures at the state level. Currently, OHA is responsible for credentialing for providers serving open card members (fee for service) – those individuals who qualify for Medicaid but are not enrolled with a CCO. Acknowledging the additional staffing requirements and technological changes necessary to implement this initiative, it will likely require additional budgetary support.

Additional support for OHA, as well as CCOs, in provider credentialing may be the implementation of a provider directory. The Oregon Health Information Technology (OHIT) unit is implementing a provider directory, which will serve as a central repository for provider data drawn from state data, provider data, and third-party data. Working directly with CCOs, OHIT is seeking to provide needed support to CCOs in capturing and maintaining accurate provider data. Through engagement with the Quality Assurance & Contract Oversight unit, opportunities to bolster the data collection associated with the quarterly DSN report are being explored. Although this effort is still in an early stage of implementation, it offers a promising approach to the management and oversight of provider credentialing.

In early 2020, to address the findings related to appeals and grievances, OHA reviewed and approved CCO appeal and grievance policies and procedures and the CCO member notice templates for Notice of Adverse Benefit Determination (NOABD) and Notice of Appeal Resolution (NOAR). These reviews identified non-compliant elements with OHA requiring the CCOs to make corrections. In addition, OHA has issued guidance to reiterate CCO contract and state rule requirements regarding verbal requests for appeal, grievance, and hearing processes. Further, ongoing OHA review of CCO Appeals and Grievance Log and Summary Report (Exhibit I) will ensure required elements are retained in NOABDs.

Owner: Dave Inbody, CCO Operations Manager

Contributors: OHA Management Team, Health Systems Division Management Team, Licensing and Certification unit, Business Information Systems unit, Oregon Health Information Technology (OHIT) unit

Implementation/Completion Dates: Initial work is underway and will continue through the length of the CCO contract (December 31, 2024).

Recommendation #2: Provide additional guidance to CCOs on monitoring subcontractors

OHA Response:

OHA agrees with this recommendation. This is a challenging consideration for OHA, as well as the CCOs. While the new CCO contract seeks to address this issue through additional CCO deliverables and reporting requirements, it is critical for OHA to remain diligent to ensure these requirements are met. Many of the new deliverables require greater documentation of the work conducted by subcontractors and CCO oversight of this work. Some examples include the requirement that each CCO develop a health equity plan, perform quarterly language access and interpreter reporting, and perform quarterly non-emergent medical transportation (NEMT) reporting. The CCO deliverables specific to subcontractor monitoring are annual reporting to identify all subcontracted and delegated work, annual reporting on subcontractor performance, and submission of subcontractor corrective action plans and updates to OHA. OHA has provided guidance documents and submission templates for many of these deliverables, as well as direct assistance to support CCOs in successfully submitting these deliverables.

This effort has been centralized with the reconstituted Quality Assurance and Contract Oversight unit. The primary responsibility of this team is to ensure that CCO contractual requirements are achieved. In analyzing the challenges to CCOs in meeting requirements during the first CCO contract period (2012-2019), the processes for submitting CCO deliverables and reporting requirements were decentralized, inconsistent, and not always clearly communicated. Through the efforts of this team, in association with the CCO Compliance Project, a multi-unit OHA workgroup, the processes associated with submitting deliverables are being examined and standardized processes are being developed. Through centralized monitoring of deliverables, tracking of timeliness of submission, completeness of documentation, and quality of performance, OHA will be better able to identify potential issues and support CCOs to improve their oversight of subcontractors.

Recognizing the significance of this undertaking, OHA has submitted a budgetary request for the 2021-2023 biennium to fund four additional members of the Quality Assurance and Contract Oversight unit, as well as improvements in data collection, tracking, and reporting. Although a decision on this request will not be determined until the next legislative session in 2021, it is a strong indication of the priority and significance OHA has placed on this effort.

Based on the volume of grievances, added emphasis by OHA has been placed on addressing NEMT concerns. OHA analysis indicates there is a large number of grievances in reference to NEMT. OIG's audit report indicates that NEMT represents 69% of access to care grievances, which is the most common grievance type. Besides the addition of quarterly NEMT reporting, OHA undertook a corrective action plan specific to the NEMT issues associated with one CCO. This effort resulted in frequent tracking of on-time performance and provider no-shows. OHA has also conducted bi-weekly meetings with the CCO to review NEMT operations and ensure access to care and quality of member care. This work continues and has provided valuable insight to the challenges faced in the delivery of NEMT services.

The Health Systems Division of OHA is also undertaking an initiative to make improvements to the process of handling member and provider complaints. This work seeks to standardize and automate processes for submitting complaints, tracking progress, resolving issues promptly, and analyzing data to better understand the root causes for areas of concern.

Owner: Dave Inbody, CCO Operations Manager

Contributors: Quality Assurance & Contract Oversight Unit, Transformation Center, Provider Services unit, CCOs

Implementation/Completion Dates: Work is underway and will continue through the length of the CCO contract (December 31, 2024).

Recommendation #3: Take actions to ensure that CCOs do not subcontract the adjudication of final appeals

OHA Response:

OHA agrees with this recommendation and has taken steps to address it. Currently, the CCO contract addresses this requirement in Exhibit I, Section 1e.(11) as follows:

> *Contractor* [CCO] *shall not Delegate to a Subcontractor or Participating Provider the Adjudication of an Appeal, in accordance with OAR 410-141-3875(14).*

OHA is working with CCOs to ensure this requirement is being met. This has included identification and verification of the process followed for resolution of a member appeal in response to a NOABD, most notably if there is an indication that subcontractors were operating on behalf of the CCO. This included OHA review of CCO policies and procedures related to appeals and grievances, review of NOAR templates, and review by OHA of CCOs' subcontracted and delegated work reports. The Quality Assurance and Contract Oversight unit is also working closely with the OHA's Hearings unit to identify cases in which the appeals process conducted by the CCO is not compliant with the CCO contract and state or federal regulations. Ongoing discussions with CCOs

have sought to better define the circumstances in which it is acceptable for subcontractors to act and those circumstances when CCOs are required to act. This work reiterated the requirement for all CCO deliverable requirements to be submitted by CCOs.

Owner: Dave Inbody, CCO Operations Manager

Contributors: Quality Assurance & Contract Oversight Unit, Health Systems Division, CCOs

Implementation/Completion Dates: Work is underway and will continue through the length of the CCO contract (December 31, 2024).

Recommendation #4: Take actions to make the language in the CCO contract related to the appeal resolution period consistent with the OARs

OHA Response:

This discrepancy was resolved in the 2018 CCO contract and remains in alignment with the OAR, which was renumbered as OAR 410-141-3890 effective January 1, 2020. The current contract language, which appears in Exhibit I, Section 4b.(2)(a) is as follows:

> *Contractor [CCO] shall resolve standard Appeals as expeditiously as a Member's health condition requires and no later than sixteen (16) days from the day Contractor received the Appeal. Contractor may extend this timeframe by up to fourteen (14) days if:*
>
> *i. The Member requests the extension; or*
>
> *ii. Contractor shows (to the satisfaction of OHA, upon its request) that there is need for additional information and how the delay is in the affected Member's interest.*

This is consistent with the language in OAR 410-141-3890(4) which is as follows:

> *For standard resolution of an appeal and notice to the affected parties, the MCE shall establish a timeframe that is no longer than 16 days from the day the MCE receives the appeal.*

The extension language in the CCO contract is consistent with OAR 410-141-3890(4)(b):

> *The MCE may extend the timeframes from section (3) of this rule by up to 14 days if:*
>
> *(A) The member requests the extension; or*
>
> *(B) The MCE shows to the satisfaction of the Authority upon its request that there is need for additional information and how the delay is in the member's interest.*

OHA will work to ensure these timelines are met through the review and approval of CCO appeal and grievance policies and procedures and the CCO member notice templates for NOABDs and NOARs.

Owner: Dave Inbody, CCO Operations Manager

Contributors: Quality Assurance & Contract Outsight unit

Implementation/Completion Dates: This issue was resolved with the new CCO contract effective January 1, 2020.

Recommendation #5: Take actions to ensure that the data that CCOs submit on grievances and appeals in the grievance workbooks are accurate and complete

OHA Response:

OHA recognizes the value of ensuring data submitted by CCOs regarding grievances and appeals are accurate and complete. CCOs are required to submit their Grievance and Appeals System Log on a quarterly basis, as well as their Grievance System Report.

OHA selects a sample from the NOABDs listed in the Log within the ten days after the submission and provides it to the CCO. The CCO then has 14 days to submit all associated NOABDs and Prior Authorization (PA) documentation for the sample cases. OHA evaluates the NOABDs and PA documentation based on criteria in 21 areas of compliance. Upon completion of the evaluation, OHA provides each CCO with the results identifying any areas requiring corrective action.

For each NOABD sample, the CCO must include the NOABD letter, Hearing Request Form, the Notice of Hearing Rights, and the language translation and nondiscrimination statement. This is consistent with CCO contract language appearing in Exhibit I, Section 10b.

Due to the COVID pandemic, OHA extended deadlines for 27 CCO deliverables and waived seven deliverables. Neither the deadline for the Grievance and Appeals Log nor the Grievance System Report were altered.

Owner: Veronica Guerra, Quality Assurance and Contract Oversight Manager

Contributors: Quality Assurance and Contract Oversight Unit, CCOs, CCO Compliance Project Workgroup

Implementation/Completion Dates: Work is underway and will continue quarterly through the length of the CCO contract (December 31, 2024).

/David G. Inbody/

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