

Report in Brief

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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Audit

In 2012, Oregon was one of the first States to adopt a type of Medicaid accountable care organization when it established coordinated care organizations (CCOs). A CCO is a network of different types of participating providers that have agreed to work together in their local communities to provide coordinated care to Medicaid beneficiaries. Two goals of the CCO model are to improve access to care and the quality of care.

Our objective was to determine whether Oregon's oversight ensured that four CCOs complied with selected Federal and State Medicaid requirements related to access to care and quality of care.

How OIG Did This Audit

We judgmentally selected four CCOs in Oregon and visited them to obtain a general understanding of their policies and procedures related to selected access-to-care and quality-of-care requirements. We selected one CCO that served an urban area, one CCO that served a rural area, and two CCOs that served a mix of urban and rural areas. We had no expectation that the four CCOs would be representative of all CCOs.

We reviewed the following areas at each CCO: the provider credentialing process, beneficiary grievance and appeals processes, compliance with time and distance standards and timely access standards, and assignment of primary care providers (PCPs). Our audit period was calendar years 2016 and 2017.

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

What OIG Found

The CCOs generally complied with Federal and State requirements related to time and distance standards and timely access standards, as well as requirements related to assignment of PCPs. However, the CCOs did not comply with requirements related to provider credentialing and beneficiary grievances and appeals. Specifically, CCOs: (1) did not ensure that services were provided within the scope of license of a provider with a restricted license or report providers with licensing board actions against them, (2) did not credential all provider types (e.g., mental health providers), and (3) did not perform or document all minimum required credentialing checks. In addition, CCOs did not resolve or review beneficiary grievances appropriately and did not adjudicate appeals in compliance with their contracts with Oregon. Also, CCOs submitted inaccurate or incomplete data on grievances and appeals, which Oregon used for oversight.

These issues occurred because: (1) Oregon provided insufficient oversight of, and guidance to, the CCOs and (2) the CCOs provided insufficient oversight of, and guidance to, their subcontractors. Because not all providers were appropriately credentialed, there was an increased risk of poor quality of care. In addition, the mishandling of grievances and appeals may have reduced beneficiaries' access to care and the quality of care.

What OIG Recommends and Oregon Comments

We recommend that Oregon provide additional guidance to CCOs on: (1) the processes for provider credentialing and for beneficiary grievances and appeals and (2) monitoring subcontractors. We also recommend that Oregon take actions to: (1) ensure that CCOs do not subcontract the adjudication of final appeals and (2) ensure that the data that CCOs submit on grievances and appeals are accurate and complete.

In written comments on our draft report, Oregon stated that it acknowledged our findings, supported our recommendations, and was committed to making improvements for the areas in which our findings indicated areas of concern. In addition, Oregon provided information on actions that it had taken or planned to take to address our recommendations. For example, Oregon stated that it would determine the feasibility of universal application and credentialing procedures at the State level.