Audit Report

OHA Independent and Qualified Agent Contract Administration

Audit 23-005

Presented To:

Dave Baden, OHA Interim Director
Kristine Kautz, OHA Deputy Director
Dana Hittle, OHA Medicaid Director
Holly Heiberg, FFS Operations Director
Spencer Delbridge, FFS Operations and QA Manager
Margaret Cary, FFS Clinical Director
Tressa Perlichek, Provider and Member Services Manager
Donald Jardine, Medicaid Behavioral Health Policy Manager
Shawna McDermott, Interim HSD Director
Jon Collins, HSD Deputy Director
Mick Mitchell, HSD Business Operations Director

Joint ODHS/OHA Audit Committee

Presented By:

ODHS/OHA Internal Audit and Consulting
Hamza Sherwani, Principal Internal Auditor
Lauren Seda, Senior Internal Auditor
Sarah Landis, Chief Audit Executive

Date: October 19, 2023

Table of Contents

Executive Summary 3
Background 4
Scope and Objectives 4
Positive Results 5
Findings and Recommendations 6
Other Matters 18
Audit Methodology 19

Data Classification: Level 2 Limited per DAS Statewide Policy 107-004-050

Executive Summary

The Independent and Qualified Agent (IQA) contract is a required component of the Medicaid-funded 1915(i) Home and Community-Based Services (HCBS) State Plan Option. This program includes residential and in-home services provided through the behavioral health system and plays a crucial role in assessing needs, connecting individuals to care, and facilitating the allocation of services and resources to very vulnerable consumers. This audit, requested by Oregon Health Authority (OHA) Medicaid Section executive leadership, evaluated how the IQA contract was operationalized and administered to serve individuals experiencing mental illness.

The audit findings, primarily caused by weaknesses in control activities and monitoring, point to a fragmented, poorly monitored structure for one of the most critical components of the behavioral health treatment system: eligibility and level of care. System failures at this juncture have real consequences for consumer well-being and continuity of care, as well as on the behavioral health system capacity and OHA resources.

Audit highlights are as follows:

1. Internal OHA processes are not established for Secure Residential Treatment Facilities (SRTF) denial determinations by the IQA, causing individuals with a voluntary legal status to stay in restrictive settings without a medical or legal reason. This unnecessary stay may not be conducive to the individual's care, adds pressure on the overall behavioral health system capacity and delays other patients' access to care. Additionally, Medicaid funds are sometimes improperly used to pay for SRTF services that do not meet the criteria for Medicaid billing and the IQA assessments overridden by a default approval cause significant waste of the IQA staff's time and OHA funds spent on these assessments.
2. Appeal processes for providers are not transparent or well-established and are not clearly communicated, making it difficult for providers to contest adverse agency decisions such as addressing assessment results that do not capture the full needs of an individual or disputing a lower payment rate for services. The level of support for individuals is adversely impacted when providers are incorrectly paid less for their services. OHA potentially faces mistrust and strained provider relations without transparent appeal processes.
3. Due to a lack of adequate oversight, we noted several instances of insufficient or missing documentation for the IQA decision, supporting evidence and communication, making it difficult to confirm how the decision was made and whether it is accurate and consistent. For example, 5/12, 42% of Adult Foster Homes grievances we sampled had a change in the individual's Level of Service Inventory (LSI) rating without a documented change in individual needs. OHA cannot validate the IQA's decision and defend contested cases in hearings and appeals when documentation is missing.
4. Outreach efforts for programs, such as the State Plan Personal Care program providing services and supports to patients in their homes, are inadequate and not formally established to reduce pressure on behavioral health residential capacity and target underserved communities that struggle to access mental health services.

We make 15 recommendations to OHA to address these issues and strengthen internal controls to ensure individuals are well-served and resources are effectively and efficiently used. Management response is included at the end of this report.

Background

Comagine Health – a contracted vendor serving as OHA's Independent and Qualified Agent (IQA) provides several administrative services to support the Behavioral Health program and its provision of residential, in-home and outpatient services and supports to people diagnosed with chronic mental illness. Many of these services, primarily care planning, coordination, and eligibility determinations, are offered under the 1915(i) Home and Community Based Services (HCBS) State Plan Option approved by the Centers for Medicaid and Medicare Services. The State Plan Option establishes the requirement for an IQA, aligned with 42 CFR 441.715 and 720 and outlines targeted population and eligibility criteria. Comagine Health plays a crucial role in supporting the behavioral health system and currently holds a $70 million contract with OHA for IQA services for the duration of about 4 years, ending December 2024. They are projected to serve approximately 2,500 unduplicated individuals in calendar year 2023.

The services offered by Comagine Health require significant coordination from various behavioral health parties such as Community Mental Health Programs (county mental health departments and contracted non-profit organizations), mental health residential and non-residential treatment providers, individuals with chronic mental illness, OHA, Oregon State Hospital, Oregon Department of Human Services programs, etc. Referrals for residential, in-home and outpatient services and supports can come from many different sources, but the process for most eligibility determinations includes approval/consultation from a CMHP. Comagine Health maintains an electronic health record system called Jiva that contains all pertinent information supporting their assessments and eligibility determinations. IQA staff also access the state's Medicaid Management Information System (MMIS) to develop a Plan of Care and add their assessments, correspondence, and clinical documentation.

Scope and Objectives

OHA Medicaid Section executive leadership requested this internal audit due to concerns about how the contract was operationalized and administered. We conducted a risk assessment to develop the following audit objectives:

1. Examine documentation controls and other non-clinical processes supporting IQA determinations.
2. Evaluate whether the State Plan Option, IQA contract terms, and service provided are aligned.
3. Identify opportunity to strengthen oversight, process transparency, and IQA service accessibility (individuals eligible for services are provided the opportunity to apply).

The audit scope included an examination of contract terms of the IQA service contract, IQA and OHA processes, and determinations for a period January 2022 through March 2023.

Audit methodology is described at the end of the report.

Positive Results

In our examination of IQA determinations and processes, we noted the following positive results:

- The Person-Centered Service Plans were consistently communicated in plain language and in a manner that is culturally appropriate and accessible to the individual.
- IQA staff completing the Person-Centered Service Plans and LSI and LOCUS assessments were certified as Qualified Mental Health Professionals, at a minimum.
- IQA conducted a clinical review of documents to form their decision (mental health assessment, treatment plan/residential care plan, progress notes, incident reports, individually based limitations, nurse RN delegations).
- Most determinations for Plan of Care service categories were made timely.

Data Classification: Level 2 Limited per DAS Statewide Policy 107-004-050

Findings and Recommendations

The findings presented in this audit report fall into two main themes: contract monitoring and internal processes. The IQA service contract is not effectively monitored for performance and outcomes, posing operational, legal, and reputational risks. Additionally, internal OHA processes are not sufficiently established to ensure IQA determinations are appropriately processed to produce consistent, accurate, compliant, and objective outcomes.

The IQA service contract was executed around the same time as the COVID-19 public health emergency, which may have led to this contract not being prioritized, and the contract administration function was not adequately resourced as OHA focused on responding to the public health emergency. Decision making was primarily conducted by the sole contract administrator with minimal supervision and controls. Additionally, factors that may have contributed to weak oversight of the contract include: decreased employee morale, exhaustion from the pandemic work, significant turnover in OHA Health Systems Division management, and loss of key personnel familiar with behavioral health and IQA services.

The 1915(i) State Plan Option for Home and Community Based Services specifically requires OHA to supervise, monitor and maintain accountability for the IQA's performance. Also, the Oregon Procurement Manual requires contract performance monitoring and identifies specific tasks to help effectively perform this work. OHA's core values of health equity, transparency, service excellence and partnership promote open, honest and visible actions and collaborative decision making across diverse communities to ensure everyone can reach their full health potential. By strengthening internal processes and oversight of the IQA contract, OHA has an opportunity to further embrace these values and ensure appropriate and consistent care for behavioral health consumers.

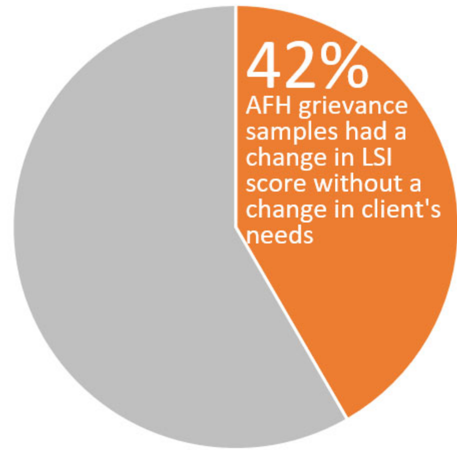
Finding 1: The IQA's administration of the Level of Service Inventory (LSI) is not compliant with the LSI manual and lacks documentation controls necessary to support the rating.

The IQA does not administer the LSI during a face-to-face interview with the individual and the provider as required by the LSI manual, IQA service contract and Oregon Administrative Rule (OAR). The LSI assessments are based solely on documentation (mental health assessments, care plans, progress notes, etc.) submitted by the provider. Although there are requirements for a face-to-face interview, there is no standardized questionnaire that can be used to determine and document the individual's ability, skill, comfort level, necessary supports and the level of assistance needed in a consistent and objective manner. Without an interview, individuals and providers do not have an opportunity to weigh-in and share their perspectives. This makes the LSI assessment out of line with the person-centered service requirements.

OAR 410-173-0005:
Level of Service Inquiry (LSI) means a person-centered assessment used to determine residential service and support needs of an individual experiencing functional deficits resulting from the symptoms of a diagnosed mental health condition.

Data Classification: Level 2 Limited per DAS Statewide Policy 107-004-050

In our examination of 12 adult foster home grievance samples, we noted 5 (42%) instances where the LSI rating for a specific service item changed without a documented change in the individual ’s level of assistance needed. For example, an individual was rated as needing *full assistance* in managing and dispensing medication in 2021, and *no assistance* in 2022. The updated Plan of Care for 2022, developed by the residential provider and provided to the IQA for LSI rating, stated that the individual is unable to dispense medication on his own and does no part of this task. LSI ratings that are not supported by evidence increase the perception of arbitrary decision making and legal risks. A lower payment rate for services based on a potentially incorrect lower LSI rating could adversely impact the provider and the level of assistance provided to the individual.



Recommendation: Develop a standard LSI questionnaire, strengthen documentation controls, and monitor for compliance.

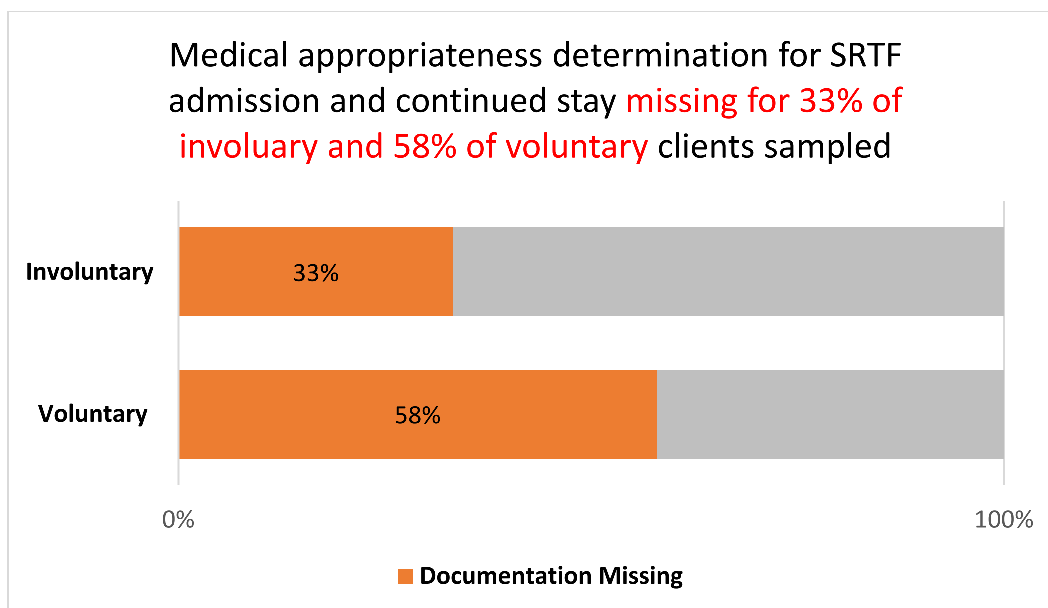
We recommend OHA:

1. Update the LSI manual and the IQA’s LSI form to include a standard question for each of the 27 service elements to ensure consistent administration of the LSI assessment.
2. Require the IQA to conduct LSI administration during face-to-face interviews and document in individual’s electronic health records, clearly identifying the respondent (individual or provider) and response provided.
3. Provide clear direction on weighing the individual and provider responses in LSI ratings.
4. Establish a monitoring and quality assurance process to ensure consistency and accuracy of LSI administration and rating.

Finding 2: Medical appropriateness determinations for admission and continued stay of individuals in Secure Residential Treatment Facilities (SRTF) are not consistently documented by the IQA in the individual’s electronic health records.

The audit found that documentation demonstrating the completion of a medical appropriateness review was missing for 58% of sampled individuals under voluntary status for the SRTF. Documentation was also missing for 33% of sampled individuals with involuntary legal status. These sampled individuals were granted approval for SRTF admission and continued stay despite missing documentation required by the IQA contract and OAR.

Data Classification: Level 2 Limited per DAS Statewide Policy 107-004-050



Medical appropriateness reviews are necessary to determine whether the services requested meet the individual mental health treatment needs. These reviews also form the basis of Medicaid payment for behavioral health services as required in OAR 410-172-0720. The IQA established an SRTF Medical Appropriateness Review form in August 2022 but did not consistently use the form to document and retain decisions in the individual's electronic health records. The samples we examined were after the development of this form. When decisions are not documented, they lack transparency, consistency, and verifiability, making it unclear whether individuals are duly assessed for the level of care that is medically appropriate for them.

IQA Service Contract:
Medical appropriateness reviews for referral to, admission and continued stay in SRTF shall be made in accordance with OAR 410-172-0720(7) …Once the review is complete, materials relied on to make the determination, along with the recommendation to approve or deny, must be sent to OHA for final determination for an initial period specified by the agency.

Recommendation: Communicate documentation requirements to the IQA for medical appropriateness reviews and monitor for compliance.

We recommend OHA:

1. Clearly communicate expectations around documentation requirements to the IQA for medical appropriateness reviews.
2. Establish a monitoring and quality assurance process to ensure SRTF admission and continue stay requests are reviewed, decisioned and documented by the IQA for medical appropriateness.

Finding 3: Conflicting examples of supporting clinical documentation in the IQA Plan of Care Request form and the LSI Manual causes confusion among residential providers.

The LSI manual requires clinical supporting documentation to be signed by a qualified mental health professional (QMHP), but this requirement is not mentioned on the IQA's Plan of Care Request form. Additionally, the LSI manual does not include a residential care plan as an example of supporting clinical documentation, but it is required on the IQA Plan of Care Request form. This misalignment causes confusion and potential mistrust among residential providers responsible for submitting documentation for their individuals' independent assessments.

Recommendation: Establish a set of documentation standards and ensure alignment between LSI Manual and IQA forms.

We recommend OHA:

1. Develop a set of documentation standards to be used for LSI assessment to ensure consistent and comprehensive decision making.
2. Ensure alignment between the LSI manual and the IQA forms for supporting clinical documentation requirements.

Finding 4: LSI reconsideration requests lack an independent review.

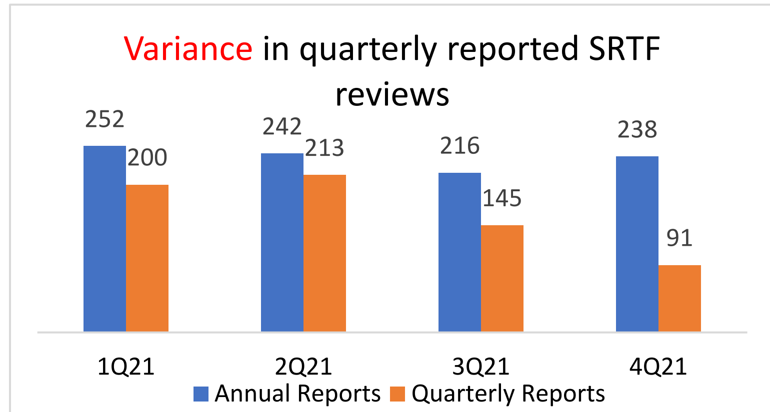
LSI reconsideration requests made by the residential provider are typically reviewed by the same IQA assessor that completes the initial assessment, which poses a potential objectivity risk. The IQA's informal procedure requires an independent review when the LSI score does not change after the reconsideration request. This control does not detect cases where a minor change is made to the LSI score, but it does not affect the provider's payment rate. For example, 2 of the 12 (17%) AFH grievance samples we examined requested a reconsideration, which caused a slight increase in the LSI score but no change to the payment rate. An objective review by an assessor who did not conduct the initial assessment may have resulted in a different outcome. Residential providers and individuals may benefit – appropriate payment rate for providers and a higher level of support for individuals – from an independent and objective review of LSI reconsideration requests. Additionally, an independent review may provide an opportunity for assessors to discuss how to score LSI items consistently.

Recommendation: Establish an independent review process for LSI reconsideration requests.

We recommend OHA:

1. Require IQA to establish a process for an independent review of LSI reconsideration requests when payment rate does not change after the reconsideration.
2. Establish a monitoring and quality assurance process to ensure compliance with the new process.

Finding 5: Variance in the number of SRTF reviews completed in quarterly and annual reports suggests that IQA reporting is unreliable.



The number of SRTF reviews completed in the annual reports were overstated by an average of 32% in calendar year 2021 and not explained and reconciled with the detailed quarterly reports for the same period. The IQA states that changes in reporting methodology, workflows, typos, or incorrect data pulls could have contributed to this variance. The accuracy and validity of the number of reviews completed impacts information integrity. Additionally, there is potential for excessive or under billing when a variance cannot be explained, and the correct numbers cannot be determined.

Recommendation: Establish a process for data tracking and monitoring.

We recommend OHA establish a monitoring and quality assurance process to ensure data presented in the quarterly and annual reports are consistent and accurate and services are billed based on accurately reported numbers.

Finding 6: The IQA is billing more than the contracted rate for medical appropriateness reviews.

Medical appropriateness reviews were billed at $181 per hour, a rate set for the development of plan of care and transition planning, for 3 out of 20 (15%) of the SRTF samples we examined. We found no documentation for transition planning or plan of care development for these samples. The payment provision in the IQA contract states $147 per hour is the billable rate for medical appropriateness reviews. Although, the medical appropriateness review can occur consecutively with plan of care development, which is billed at a higher rate, it has not been made clear to the IQA specifically when to use the medical appropriateness review rate, such as when plan of care development and transition planning are not co-occurring with a medical appropriateness review.

Recommendation: Clarify billable services and ensure services are billed using correct payment rate.

We recommend OHA:

1. Clarify to the IQA when each of the services listed in the service contract can be billed. Especially for services that can be standalone or bundled with other services such as medical appropriateness reviews.
2. Establish a monitoring and quality assurance process to ensure service are billed using correct payment rates and supported by relevant evidence.

Finding 7: The Notices of Planned Action for Personal Care Attendant (PCA) services do not include a clear and comprehensive justification for adverse determination.

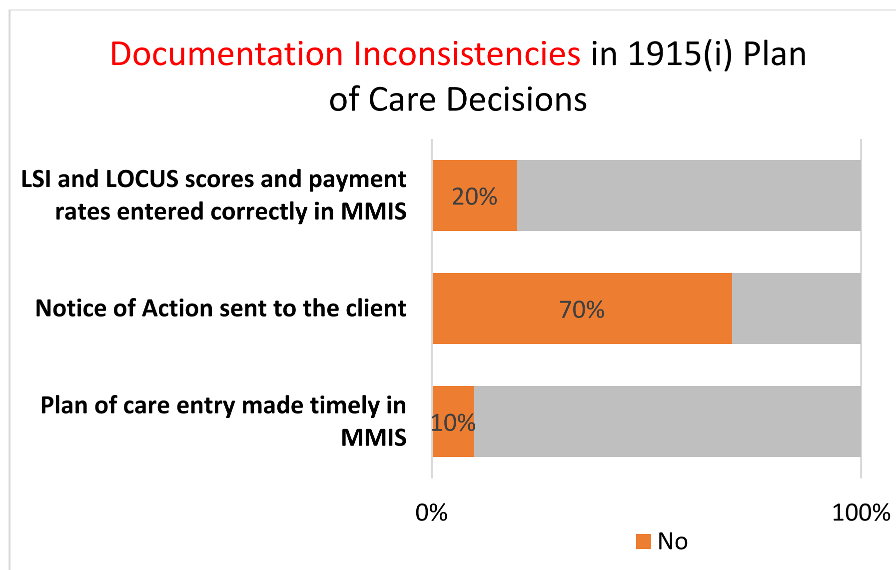
In 3 of the 7 (43%) contested PCA determinations we reviewed, the Original Notice of Planned Action did not include a clear and comprehensive justification for the reduction of allowable PCA hours. The notices stated that hours were being reduced per exceptional hours criteria but did not indicate specifically which criteria were not met to cause the reduction in hours. Corrected Notices of Planned Action were sent with more detailed justification after the individual requested an administrative hearing. These notices are sent by the IQA on OHA approved templates. The IQA's procedures require notices to provide a clear and comprehensive justification for the denial. Potential confusion, mistrust and avoidable appeals and hearings may result when individuals are unable to understand the basis of the adverse decision.

Recommendation: Ensure Notices of Planned Actions contain clear and comprehensive justification.

We recommend OHA establish a monitoring and quality assurance process to ensure Notices of Planned Action for adverse determinations contain clear and comprehensive justification for the decision.

Finding 8: IQA assessments and supporting documentation are not consistently stored in the Medicaid Management Information System (MMIS) and Notices of Planned Action regarding 1915(i) residential stays are not consistently sent to the consumers.

Of the 10 sample decisions we examined for 1915(i) Plan of Care decisions, we noted the following:



The IQA contract requires electronic storage of clinical documentation related to each 1915(i) plan of care assessment in MMIS. For 2/10 (20%) of the samples where LSI and LOCUS scores

Data Classification: Level 2 Limited per DAS Statewide Policy 107-004-050

and payment rates were not correctly entered in MMIS, we found payment rate discrepancy between MMIS and Jiva without any notes explaining the difference. When supporting clinical documentation is not consistently and correctly maintained, OHA cannot validate the IQA's decision and defend contested cases in hearings and appeals.

We also noted 7/10 (70%) of the 1915(i) Plan of Care (POC) sampled individuals were not sent a Notice of Planned Action as required in the IQA service contract. The IQA is required to update MMIS to ensure consumer notification occurs. However, OHA's instructions for plan of care entries require consumer notification be set to *No*. When consumers are not notified about the agency's decisions, they may not be able to make informed decisions about their health. Also, as these notices come with appeal rights, a lack of consumer notification denies them the due process and the ability to contest unfavorable decisions.

IQA Service Contract:
… Provide timely OHA approved Notices of Action for approval, reduction, or denial of requested service authorizations to client, provider, CHOICE contractor, OHA, and guardian or legal representative where indicated …

Recommendation: Update guidance on POC entry in MMIS for consumer notification and ensure supporting information is consistently entered in MMIS.

We recommend OHA:

1. Clarify and update guidance on the POC entry in MMIS to ensure notices can be sent to consumers.
2. Establish a monitoring and quality assurance process to ensure IQA assessments and supporting documentation and information is consistently entered in MMIS and Notices of Planned Action regarding 1915(i) residential stays are consistently sent to the consumers.

Finding 9: Person-Centered Service Plan progress is not consistently monitored by the IQA quarterly.

The Person-Centered Service Plan (PCSP) progress was not monitored at least quarterly for 4/10 (40%) of the 1915(i) individuals and 6/10 (60%) of the BH Residential Non-Medicaid sampled individuals. The IQA is required to conduct direct and indirect monitoring activities at least quarterly to ensure effective implementation of the individual's person-centered service plan and determine whether individual needs are being addressed. Inconsistent monitoring can lead to delays for individuals in achieving their goals, longer length of stays in residential facilities, and misalignment between individual needs and the services provided.

Recommendation: Consistently monitor PCSP progress at least quarterly.

We recommend OHA develop a monitoring and quality assurance process to ensure PCSP progress is consistently monitored by the IQA quarterly.

Finding 10: LOCUS assessments are not consistently completed for OSH forensic patients.

In the samples we examined, we noted 8/10 (80%) were missing LOCUS assessments. The LOCUS assessment is one of the tools approved in the State Plan Option for use in developing a person-centered service plan. Per the IQA contract and IQA work procedure, the LOCUS assessment is required for forensic patients at the Oregon State Hospital. The IQA was directed by the former contract administrator in May 2022 to not conduct LOCUS assessments for forensic patients because OSH completes its own LOCUS assessment. This creates potential non-compliance with the IQA service contract terms and the State Plan Option. Patients may not be adequately and independently assessed for 1915(i) services using criteria that is relevant to their community placement at discharge.

Recommendation: Require LOCUS assessments for OSH forensic patients.

We recommend OHA require that the IQA perform LOCUS assessments for OSH forensic patients and ensure guidance on the use of the LOCUS is consistent with contract terms and the State Plan Option.

Auditor Note: It is important to note that OHA disagrees with this recommendation and takes the position that the IQA is not required to complete a functional needs assessment on OSH identified forensic patients prior to their discharge. However, IAC finds this position is contradictory with the IQA contract terms and work procedures. LOCUS is a required tool for functional needs assessments that documents individual's need for 1915(i) services. Please refer to the OHA management response included at the end of this report for additional details.

Finding 11: Inconsistencies in reporting requirements between the State Plan Option and the IQA service contract makes it difficult to monitor performance.

The State Plan Option requires annual reporting of the actual number of unduplicated 1915(i) individuals served in a given calendar year and an estimated number of individuals in the following year. The IQA service contract does not have this reporting requirement and therefore the IQA does not report on unduplicated individuals served and their respective service categories. Additionally, the IQA service contract requires and the IQA produces annual reports on a fiscal year (July – June) whereas the State Plan Option indicates reporting on a calendar year (January – December). When reporting is not consistent with requirements, it is difficult to evaluate performance. For example, in the absence of an unduplicated participant reporting requirement, it is unclear whether the IQA is serving the expected number of individuals. Inconsistent reporting may increase the risk of federal audit findings and additional oversight.

Recommendation: Ensure IQA reporting aligns with contract terms and the State Plan Option.

We recommend OHA:

1. Require IQA reporting on unduplicated individual count per service category on a calendar year basis.

Data Classification: Level 2 Limited per DAS Statewide Policy 107-004-050

2. Establish a monitoring and quality assurance process to ensure alignment between IQA reporting, contract terms and the State Plan Option.

Finding 12: Improper use of Medicaid funds, unnecessary stay of individuals in restrictive residential settings, and potential duplicate payments to providers due to the lack of a SRTF denial process.

The audit found 2 of the 12 (17%) sampled individuals with a voluntary legal status and 8 of the 15 (53%) sampled individuals with an involuntary legal status (PSRB, civil commitment and aid and assist) were approved for a SRTF despite not meeting medical appropriateness for a restrictive level of care. Medicaid paid claims for the IQA approved stays despite the individual not meeting the SRTF criteria required for Medicaid payment outlined in OAR 410-172-0720 (7). Additionally, the two individuals with a voluntary legal status were held in an SRTF unnecessarily as they did not have a legal hold, such as a court order, requiring them to stay. When individuals are held in restrictive settings unnecessarily, it puts pressure on the overall behavioral health residential system capacity, delays other patients' access to care, and may not be in the best interest of the individuals. Significant waste of resources – money spent on eligibility determination for SRTF level of care and IQA's staff time – occur when requests are default approved.

> **OAR 410-172-0720 (8):**
> If the Division determines that a residential service prior authorization request is not within coverage parameters, the provider shall be notified in writing of the basis for the decision and shall have ten business days to provide additional written documentation to support the medical appropriateness of the admission.

Per OHA's instruction, the IQA cannot deny requests for an SRTF admission or continued stay, therefore, all SRTF admission and continued stays are approved whether medically appropriate or not. This process is inconsistent with the IQA service contract terms and OAR. Due to this default approval, providers are not notified if their individual is ineligible for Medicaid payments because they don't meet the necessary medical appropriateness criteria. Providers continue to submit claims and are potentially reimbursed with Medicaid funds for non-medically appropriate services. An alternate, informal process exists where OHA uses General Funds for SRTF admission and residential stays of PSRB and civil commitment individuals that do not meet the medical appropriateness criteria for Medicaid reimbursements. This process requires providers to submit an invoice for personal care services to OHA instead of a Medicaid claim. However, providers are not notified or given instructions on this process. Additionally, the state's financial arrangements do not allow for General Fund payments directly to an SRTF for admission and continued stay of aid and assist individuals and counties are not sufficiently funded by OHA to serve this population. OHA intends to reestablish the process for SRTF denials that was suspended during the COVID-19 public health emergency.

Additionally, the potential for duplicate payments (Medicaid and General Fund paying for the same service) exists in the absence of an established process that consistently prevents or detects duplicate payments. The non-Medicaid payment team confirms paid claims in MMIS before approving General Fund payment for SRTF personal care services. However, this control

may not be consistently implemented and effective in situations where Medicaid claims are submitted after the approval of invoices for General Fund payment.

Recommendation: Establish a process for STRTF admission and continued stay denial determinations made by the IQA.

We recommend OHA develop, implement, and monitor processes for SRTF admission and continued stay denial determinations made by the IQA by taking the following steps:

1. Track determinations that do not meet medical appropriateness criteria to ensure they are not also paid by Medicaid and that timely discharge of voluntary individuals without a legal hold requiring stay in a restrictive facility occurs.
2. Establish funding structures to pay for SRTF individuals with aid and assist orders from the General Fund when they do not meet criteria for Medicaid billing.
3. Communicate when providers need to submit an invoice instead of a Medicaid claim for SRTF services that do not meet criteria for Medicaid billing.
4. Ensure adequate preventive and detective internal controls are in place for duplicate payments (Medicaid and general fund paying for the same service).
5. Ensure the newly developed processes and practices align with Medicaid laws, OARs, and the IQA contract terms.

Finding 13: Documentation does not demonstrate that the IQA and OHA used an objective criterion for Personal Care Attendant (PCA) exceptional needs determinations and whether supplemental documentation is consistently requested by the IQA and submitted to OHA.

For 6 of the 7 (86%) contested PCA determinations we examined, we found no evidence of an objective criterion used to determine the appropriate number of exceptional needs PCA hours. This increases the perception of arbitrary decision making. For example, the IQA assessed an individual for 63 PCA hours per two-week period and submitted their assessment to OHA for final determination. OHA approved that individual for only 26 hours without any documentation of the reason for reduced hours. In another example, the IQA assessed the individual for 27 hours per two-week period, but OHA only approved 24 hours and requested the IQA to revise the individuals' exceptional needs request decision. There is no documentation or case notes in the IQA's electronic database to objectively justify the reduction in hours.

Additionally, due to a lack of sufficient oversight, for 3 of the 7 (43%) sampled contested PCA determinations, activity in the IQA's electronic database did not demonstrate that supplemental documentation is consistently requested and reviewed by the IQA and provided to OHA as required by the IQA procedures. This documentation is necessary to ensure exceptional needs requests are adequately supported by evidence and IQA decisions are verifiable.

IQA procedures identify exceptional needs consideration that are more restrictive than OAR, potentially increasing the risk of incorrect denials or reduced hours. For example, the IQA Exceptional Needs Tool requires that for exceptional hours to be approved, the consumer must

require *hands on support* each time the specific task occurs to be eligible to receive exceptional hours for that task. However, the OAR states that the tasks for PCA exceptional needs requires hands on assistance or *direct supervision and cueing* every time they occur. By not considering direct supervision and cueing for exceptional needs tasks, individuals may be adversely impacted when their service hours are incorrectly reduced by the IQA.

Recommendation: Establish documentation requirements for PCA determinations and monitor for compliance.

We recommend OHA:

1. Establish documentation requirements for PCA determinations and monitor to make sure determinations are consistent, objective and adequately supported by evidence. Also, ensure there is a requirement to document the specific reason for OHA modifying the IQA decision.
2. Require the IQA to align their written work procedures and practices with the OAR for exceptional needs to ensure due consideration is given to the tasks that require direct supervision and cueing.

Finding 14: Appeal processes for providers are not sufficiently developed, not clearly communicated, and lack transparency.

The service authorization notices that providers receive do not provide information on how they can contest adverse decisions, such as a reduced payment rate for services. An expectation exists that requires providers to contest the decision and provide additional information to OHA within 10 days. However, this process is not written on the notice to providers and thus it is unclear how to contest and where to send additional information. Similarly, the IQA has an assessment reconsideration process where providers may contest the LSI, LOCUS and PCPS assessments. Although this form is available to the public on the IQA's website, the process to request a reconsideration is not stated on provider notices. Additionally, the IQA reconsideration determination letter does not provide additional avenues for dispute or appeals.

The OHA Rate Review Committee, responsible for reviewing provider requests for a rate reconsideration, is not formally established and does not have a charter describing its function, membership, meeting frequency and how cases are selected, reviewed, and dispositioned. This committee has existed since 2019 but it is unclear how review decisions are made, documented, and communicated.

OAR 410-120-1580 and OAR 410-120-1560 give providers the right to contest the agency decisions and outline the process for appeal and administrative review. However, clarity and transparency have not been prioritized in OHA's provider appeal processes and providers may not be able to contest agency decision or must bear the burden of identifying the right avenue to contest the adverse decision. Disproportionately disadvantaged are those providers unfamiliar with the appeals process, who may not know how to request a review from the Rate Review Committee. An uncorrected adverse decision, such as a reduced payment rate for services, may impact the quality and duration of services to individuals as significant reduction

in payment rates can be synonymous with service denial. OHA potentially faces mistrust and strained provider relations due to a lack of transparent appeal processes.

Recommendation: Establish provider appeal processes and ensure they are clearly communicated and transparent.

We recommend OHA:

1. Establish provider appeal processes and update provider notices to ensure they contain written appeal rights/opportunities and the process to contest agency and IQA decisions.
2. Establish a charter for the Rate Review Committee describing its function, membership, meeting frequency, how cases are selected for a review, and how review decisions are made, documented, and communicated.
3. Establish a monitoring and quality assurance process to ensure new processes are implemented.

Finding 15: Outreach efforts promoting long-term services and supports are not sufficient and formally established to help reduce the pressure on the behavioral health residential system and target underserved populations.

OHA does not have a formal outreach plan to promote 1915(i) services to behavioral health consumers that prevent their illness from advancing to a stage requiring residential care. The IQA provides eligibility determination, care planning and coordination to behavioral health patients with varying stages of illness. The State Plan Personal Care Program provides services and supports to patients in their homes. Regular standardized assessments of behavioral health patients in residential settings help ensure individuals are provided the medically appropriate level of care to live and function in their communities. One Community Mental Health Program estimated home and community-based services are provided to about 60% of all the individuals eligible for these services. When stabilizing services that potentially prevent the severity of mental illness are not sufficiently used, it increases the pressure on the residential behavioral health system that serves individuals needing a higher level of care. Targeted outreach efforts to underserved populations can help identify barriers and improve access to services.

Recommendation: Promote long- term services and supports to underserved populations.

We recommend OHA establish an outreach program to promote home and community-based services to all communities, especially those that disproportionately struggle with mental illness or barriers to care. Additionally, we recommend developing measures to track progress and outcomes of the outreach program.

Data Classification: Level 2 Limited per DAS Statewide Policy 107-004-050

Other Matters

Due to a lack of coordination and communication between OHA and the SRTF providers, security payments (additional payment to serve high-risk individuals) are not consistently requested for individuals under the Psychiatric Security Review Board (PSRB). Providers are entitled to these payments which are based on a security score assigned to individuals by PSRB coordinators. To receive these payments from the General Fund, providers need to submit an invoice to OHA, but the process to do so is not clearly communicated. Providers face adverse financial implications when they are not consistently informed about the requirements to submit an invoice for security payments. For example, the audit found SRTF providers did not receive their entitled security payments for 3 of the 8 (38%) sampled individuals with an involuntary legal status (PSRB) who were provided services in November and December of 2022. We identify this issue in other matters because it does not directly relate to the administration and functioning of the IQA contract. We suggest OHA establish, clearly communicate, and monitor the process to request security payments for providers serving individuals under PSRB.

Data Classification: Level 2 Limited per DAS Statewide Policy 107-004-050

Audit Methodology

To meet the audit objectives, we interviewed OHA staff and management, IQA management and personnel from the community mental health programs; analyzed datasets for various service categories and examined sample decisions. Additionally, we reviewed applicable laws, rules, policies and procedures, contract terms, organizational charts, strategic plans and other relevant information to better understand IQA activities and underlying processes.

To examine documentation controls and non-clinical processes, we reviewed sample IQA decisions in various service categories for timeliness, completeness, accuracy, and verifiability based on the criteria outlined in the Oregon Administrative Rules, Oregon State Plan Option for 1915(i) home and community-based services, IQA service contract terms, IQA work procedures and OHA core values. We reviewed case notes and clinical documentation maintained in Jiva – the IQA's case management system, OHA's MMIS and periodic reports produced by the IQA. Additionally, we evaluated the IQA service contract, SPA and IQA practices to ensure alignment and identified opportunities to strengthen contract oversight, transparency, and service accessibility.

Sampling Methodology

We selected a stratified random sample of the IQA decisions based on service category and decision type (approved or denied) from quarterly reports of calendar year 2022. Samples were selected from the following service categories:

Service Category	Sample Count*
BH Services	10 Approved 10 Denied
BH Personal Cate Attendants (PCA)	10 Approved
Crisis Respite	10 Approved 10 Denied
Post-Acute Intermediate Treatment Services (PAITS)	10 Approved
Enhanced Care Services	10 Approved
1915(i) Eligibility POC	10 Approved
BH Residential Non 1915(i) POC	20 Approved
BH Residential Non-Medicaid POC	10 Approved
OSH Concurrent Reviews	10 Approved 3 Denied**
OSH Person Centered Service Plan	10 Approved
OSH Forensic	10 Approved

*Only 3 service categories had denied decisions ** Population only had 3 denial cases

The small sample size in each service category reflects the objectives of this audit. Our purpose was not to extrapolate findings to the entire population of decisions, but rather to test whether basic controls were in place.

After learning about the lack of a denial process for individuals in SRTF, we expanded our testing on SRTF BH Residential Non 1915(i) POC decisions by selecting 12 random sample individuals with an involuntary legal status and 15 random sample individuals with a voluntary legal status from October – December 2022. These additional samples were selected to confirm the use of Medicaid funds for individuals that do not meet the medical appropriateness criteria

Data Classification: Level 2 Limited per DAS Statewide Policy 107-004-050

for Medicaid payments and whether any individuals with a voluntary legal status were held in an SRTF unnecessarily. Additionally, we examined all 12 individuals included in 5 AFH grievance cases disputing payment rates for services and all 7 contested IQA determinations requesting a hearing for PCA services from January 2022 through March 2023.

This audit was conducted in conformance with the Institute of Internal Auditors' International Standards for the Professional Practice of Internal Auditing.

We would like to sincerely thank the management and staff of OHA Fee for Service Operations and the IQA management for their time and cooperation in this audit. We would also like to thank CMHP representatives for taking the time to share their valuable insights on behavioral health services with us.

Management Response to the Audit

Independent and Qualified Agent (IQA) Contract Audit Management Plan

If someone needs mental health care and seeks treatment, they should be confident they will get the help they need. The Oregon Health Authority (OHA) Medicaid program requested the Independent and Qualified Agent (IQA) Contract Administration internal audit resulting in 15 audit findings to improve access to care. Audit findings show that OHA is not adequately administering the IQA contract responsible for delivering Medicaid1915i Home and Community-Based Services (HCBS) to Oregonians. Services and supports delivered through the 1915i HCBS state plan option are intended to meet the needs and choices of qualifying individuals experiencing chronic mental illness in the HCBS setting of their choice in accordance with federal Medicaid regulations.

In response to the 15 IQA Contract Administration Audit findings, OHA has developed an IQA Contract Audit Management Plan designed to improve access to and quality, amount, duration, and scope of 1915i HCBS services for qualifying individuals. The Audit Management Plan is structured to address all 15 audit findings and related recommendations through six (6) major areas of IQA contract administration improvement identified by OHA, Health Systems Division. OHA leadership has assigned Medicaid Fee-for-Service (FFS) Operations management and staff responsibility for the identified contract administration improvement areas below—specifically addressing each audit finding and recommendation with action steps and timelines.

- **Level of service determination processes (LSI, LOCUS tools)**
  - Findings 1,3,4 & 10
  - *Medicaid Behavioral Health Policy and Program Manager (Donny Jardine)*
  - *Home and Community Based Setting Policy Analyst (Stanlee Menniti)*
  -
- **Secure Residential Treatment Facilities (SRTF) processes**
  - Findings 2 ,5 & 12
  - *Medicaid FFS Operations and Quality Assurance Manager (Spencer Delbridge)*
  - *Behavioral Health Clinical and Quality Assurance Strategist (David Sant)*
- **IQA contract administration & oversight**
  - Findings 6,8,9,10 & 11
  - *Medicaid FFS Quality Assurance Manager (Spencer Delbridge)*
  - *1915i Policy Analyst and Comagine Contract Administrator (Steph Baer)*
- **Personal Care Attendant (PCA) support**
  - Findings 7 & 13
  - *Medicaid Behavioral Health Policy and Program Manager (Donny Jardine)*
  - *1915i Policy Analyst and Comagine Contract Administrator (Steph Baer)*
- **Appeals process for providers**
  - Finding 14
  - *Medicaid FFS Quality Assurance Manager (Spencer Delbridge)*
  - *Behavioral Health Clinical and Quality Assurance Strategist (David Sant)*
- **Home and Community Based Services (HCBS) outreach**
  - Finding 15
  - *Medicaid Community Engagement Manager (Jessica Deas)*

The Medicaid Fee-for-Service (FFS) Operations and Quality Assurance Manager (Spencer Delbridge) will provide a Monthly Progress Report on IQA Contract Audit Management to OHA leadership (starting on November 1, 2023) and a Final IQA Audit Management Report to OHA leadership detailing all completed work to address all 15 audit findings and related recommendations by October 31,2024.

**Italicized text are OHA additions to the report recommendations*

Level of service determination processes (LSI, LOCUS tools)

Finding 1: The IQA's administration of the Level of Service Inventory (LSI) is not compliant with the LSI manual and lacks documentation controls necessary to support the rating.
Finding 3: Conflicting examples of supporting clinical documentation in the IQA Plan of Care Request form and the LSI Manual causes confusion among residential providers.
Finding 4: LSI reconsideration requests lack an independent review.
Finding 10: LOCUS assessments are not consistently completed for OSH forensic patients.

OHA acknowledges and agrees with the feedback of members, providers, provider associations, Oregon State Hospital, and other partners that the current functional needs assessment does not adequately capture individual services and support needs. Additionally, providers have expressed concerns the current functional needs assessment is not appropriate to determine a rate for individuals discharging from a hospital setting.

OHA's Medicaid team has contracted with Optumas, a national actuarial and consultation firm, to review alternative, comprehensive functional needs assessment tools in use by other states to replace the Level of Service Inquiry (LSI) and Level of Care Utilization System (LOCUS). Based on the criteria set by OHA's Medicaid Section and Office of Behavioral Health, Optumas began a national search for assessment tools that have been tested and normed to assess individuals' needs in activities of daily living, instrumental activities of daily living, medical complexities, and forensic risk areas. Optumas has identified three different assessment tools for consideration – The Adult Needs and Strengths Assessment, The InterRAI Community Mental Health, and The InterRAI, Mental Health for In-Patient Psychiatry.

Over the remainder of 2023 and the first quarter of 2024, OHA will engage individuals, providers, provider associations, hospitals, and other interested parties to inform selection of the tool and ensure the chosen tool(s) captures the appropriate elements to comprehensively assess the functional needs of individuals. OHA will complete a budget analysis for projected costs of a new assessment tool, which will include training components, licensing agreements, data sharing platforms, and technical support for updated and improved versions of the tool.

Adoption of a new functional needs assessment tool will require approval from the federal Centers for Medicare and Medicaid Services (CMS). Upon selection of the new tool, OHA must submit a state plan amendment to CMS for approval. The negotiation process may take several months. Once approved, OHA will also provide robust training and technical assistance to the IQA, providers, members, and other interested parties. OHA will ensure the functional needs assessment tool aligns with federal HCBS regulations and Oregon Administrative Rules (OARs).

OHA's work to identify a new functional needs assessment will occur concurrent with process improvements for the use of the current tools identified in OHA's requested internal audit. Operational improvements made to the current functional needs assessment, the LSI and LOCUS, will be communicated to the IQA, along with expectations for assessment delivery and reporting mechanisms.

OHA respectfully disagrees with recommendation 10. The IQA is not required to do functional needs assessments on forensic patients at OSH. OSH is required to do LOCUS assessments on their patients in certain situations under their own regulatory authority. Furthermore, individuals residing in OSH are not eligible for 1915i State Plan Option services and are therefore not subject to Medicaid IQA requirements. OHA had attempted to have the IQA do LSI assessments when patients were ready to place from OSH as an incentive for providers and to encourage quicker placement, but it has not proven helpful for multiple reasons. In all

scenarios, the IQA has 30 days to complete a functional needs assessment once an individual is placed in a setting that meets 1915(i) criteria and that is often a better assessment once the individual has been removed from a secure facility. While patients are in the State Hospital, OSH is responsible and has authority to determine when their patients will receive LOCUS assessments. Per the terms of the contract, OSH also has the authority to determine when to use the IQA contractor to complete the LOCUS assessment. OSH has moved away from this practice and performs their own LOCUS assessments most frequently. However, OHA recognizes the confusion caused by our prior attempt to place individuals more quickly and will work with OSH to determine the best way to support their patients. OHA, Medicaid, and OSH will document a collective plan by 12/30/2023.

Milestones	Agree/ Disagree	Owner / Contributor	Due Date
1.1 Update the LSI manual and the IQA's LSI form to include a list of standard question for each of the 27 service elements to ensure consistent administration of the LSI assessment. - *IQA to provide report of internal quality and process reviews that ensure consistency and monitoring of determinations.* - *Provide technical assistance for IQA to ensure documentation of discussions are relevant to individual and provider needs. Incorporate clinical knowledge in decision making.*	Agree	Donny Jardine / Stanlee Menniti	12/30/2023
1.2 Require the IQA to conduct LSI administration during face-to-face interviews and document in individual's electronic health records, clearly identifying the respondent (individual or provider) and response provided	Agree	Donny Jardine / Stanlee Menniti	11/1/2023
1.3. Provide clear written direction on weighing the individual and provider responses in LSI ratings. - *Technical assistance in documentation* - *Qualitative information as part of assessment narrative* - *Review should include responses of everyone participating in the assessment and planning for the individual.*	Agree	Donny Jardine Stanlee Menniti	11/1/2023
1.4 Establish a monitoring and quality assurance process to ensure consistency and accuracy of LSI administration and rating.	Agree	Donny Jardine / Steph Baer, Stanlee Menniti	11/1/2023
Investigate and select a functional needs assessment tool that addresses medical complexities and forensic risk areas in addition to activities of daily living and instrumental activities of daily living. - *Identify assessment tool* - *Gather feedback from the providers and individuals accessing the service* - *Identify fiscal impacts associated with the new assessment* - *Gather funding from OHA budget, or submit legislative ask* - *Complete amendments to Medicaid State Plan and OARs to implement a new assessment tool* - *Ensure there are no lower payments made to providers as a result of the updated functional needs assessment*	-	Donny Jardine / Stanlee Menniti, Steph Baer	12/30/2024

tool through the timeframe identified in the American Reconstruction Plan Act - *Train IQA and provider on the new functional needs assessment tool and electronic platforms to collect data* - *Pilot New functional needs assessment tool in a statewide sample*			
IQA to do comprehensive stratified assessment of their reviews and report back to OHA the status of their findings. OHA to conduct randomized audits as part of the Quality Assurance Plan.	-	Donny Jardine	4/1/2023
Finalize development of an ongoing contract administration workplan & map for IQA contract	-	Steph Baer	12/15/2023
3.1 Develop a set of documentation standards to be used for LSI assessment to ensure consistent and comprehensive decision making.	Agree	Donny Jardine	11/1/2023
3.2 Ensure alignment between the LSI manual and the IQA forms for supporting clinical documentation requirements. Make revisions as necessary.	Agree	Donny Jardine	12/1/2023
Develop and inform trainings OHA and the IQA will offer individuals and providers to educate around a variety of topics, as informed by individuals, internal/external partners and requests for technical assistance.	-	Donny Jardine	4/1/2023
Develop Quality Assurance plan	-	Donny Jardine / Spencer Delbridge	12/30/2023
4.1 Require IQA to establish a process for an independent review of LSI reconsideration requests when level of service and payment rate do not change after the initial reconsideration.	Agree	Donny Jardine	12/1/2023
4.2 Establish a monitoring and quality assurance process to ensure compliance with the new process.	Agree	Donny Jardine	4/1/2024
10. Require the IQA to perform LOCUS assessments for OSH forensic patients and ensure guidance on the use of the LOCUS is consistent with contract terms and the State Plan Option	Disagree	-	-
OHA will develop plan with OSH to determine how we can be in alignment regarding the functional needs assessments .	-	April Gillette, Donny Jardine / Michael Oyster	12/30/2023

Secure Residential Treatment Facilities (SRTF) processes

Finding 2: Medical appropriateness determinations for admission and continued stay of individuals in Secure Residential Treatment Facilities (SRTF) are not consistently documented by the IQA in the individual's electronic health records.
Finding 5: Variance in the number of SRTF reviews completed in quarterly and annual reports suggests that IQA reporting is unreliable.
Finding 12: Improper use of Medicaid funds, unnecessary stay of individuals in restrictive residential settings, and potential duplicate payments to providers due to the lack of a SRTF denial process.

In 2020, during the height of the COVID-19 pandemic, OHA paused the use of denials for individuals receiving care in Secure Residential Treatment Facilities (SRTF) to avoid discharges to houselessness. During this period, there were significant efforts made across the continuum of care to ensure that vulnerable individuals experiencing mental illness were not unnecessarily harmed further by other throughput issues in HCBS settings. This ultimately led to the IQA receiving guidance to continue to approve stays of care in SRTFs even if the individual no longer met medical necessity criteria for care and to focus on other levels of support to avoid houselessness. OHA will require the IQA to resume assessments for medical appropriateness for individuals in Secure Residential Treatment facilities while also working to ensure that those individuals have safe and reasonable transition plans. OHA will also create a quality assurance strategy and practices which will address the following milestones as well as other standards of care critical to individual well-being and success.

OHA will engage with the IQA to develop a clear communication plan regarding expectations as designed in the contract and in rule. This will be amplified though the use of both scheduled and random audits of the milestones listed below as well as the development of standard work to align expectations with the tasks required for implementation.

Milestones	**Agree/ Disagree**	**Owner / Contributor**	**Due Date**
2.1 Clearly communicate expectations around documentation requirements to the IQA for medical appropriateness reviews.	Agree	David Sant	11/15/2023
OHA clinical lead will communicate expectations and send out written process as established in milestone 2.2.	-	David Sant	11/15/2023
Update denial letter and utilize denial letter in compliance with OAR 410-172-0720(7)	-	David Sant / Donny Jardine	11/15/2023
2.2 Establish a monitoring and quality assurance process to ensure SRTF admission and continued stay requests are reviewed, decisioned and documented by the IQA for medical appropriateness.	Agree	David Sant	11/15/2023
Develop quality metric for medical appropriateness for SRTF for admissions and continued stays (timeliness and based upon national best practices)	-	David Sant	11/15/2023
5.1 Establish a monitoring and quality assurance process to ensure data presented in the quarterly and annual reports are consistent and accurate and services are billed based on accurately reported numbers	Agreed	David Sant / Steph Baer	11/15/2023

Require quarterly reports and monthly monitoring of clinical services for SRTF admissions and continued stay from IQA and verify with financial information from MMIS and CFAA contract	-	David Sant / Steph Baer	11/15/2023
12.1 Track determinations that do not meet medical appropriateness criteria to ensure they are not also paid by Medicaid and that timely discharge of voluntary individuals without a legal hold requiring stay in a restrictive facility occurs.	Agreed	David Sant / Steph Baer	11/15/2023
12.2 Establish funding structures to pay for SRTF for individuals with aid and assist orders from the General Fund when they do not meet criteria for Medicaid billing.	Agreed	David Sant	11/15/2023
12.3 Communicate when providers need to submit an invoice instead of a Medicaid claim for SRTF services that do not meet criteria for Medicaid billing.	Agreed	David Sant	11/15/2023
12.4 Ensure adequate preventive and detective internal controls are in place for duplicate payments (Medicaid and general fund paying for the same service).	Agreed	David Sant	11/15/2023
12.5 Ensure the newly developed processes and practices align with Medicaid laws, OARs, and the IQA contract terms.	Agreed	David Sant	11/15/2023

Contract Administration & Oversight

Finding 6: The IQA is billing more than the contracted rate for medical appropriateness reviews.
Finding 8: IQA assessments and supporting documentation are not consistently stored in the Medicaid Management Information System (MMIS) and Notices of Planned Action regarding 1915(i) residential stays are not consistently sent to the consumers.
Finding 9: Person-Centered Service Plan progress is not consistently monitored by the IQA quarterly.
Finding 11: Inconsistencies in reporting requirements between the State Plan Option and the IQA service contract makes it difficult to monitor performance.

OHA has recently hired additional staff to improve the oversight and monitoring of the IQA contract and will establish clear processes recommended by auditors to improve quality. The contract between OHA and the IQA states that the IQA is to send invoices to the Contract Administer and that the IQA develop quality control to prevent inappropriate billing. Upon receipt of billing invoices, the Contract Administrator will review the invoices for billing compliance prior to payment being issued. The Contract Administrator will work with the IQA to determine the date the invoice will be received by the Contract Administrator to allow for adequate time to review the accuracy of the invoice and approve payment while ensuring timeliness of payment to the IQA. The Contract Administrator will identify incorrect billing of services and communicate the billing expectations with the IQA. The Contract Administrator will request from the IQA documentation of the quality control and service duplication/inappropriate billing prevention system they have in place.

The Contract Administrator has confirmed that MMIS does have the ability to send notices to consumers when services are approved or reduced. Whether a letter is sent to the consumer or not is dependent on the process followed by the IQA when entering the Plan of Care (POC) into MMIS. The Contract Administrator will request documentation of the process followed and the training provided to IQA employees when entering the POC into MMIS. For quality monitoring and assurance, the Contract Administrator will request a report from the IQA that provides information for all POC's that have been entered. The Contract Administrator will review the information provided to ensure that POC's that have been entered into MMIS include supporting documentation and to also monitor consistency of the information provided by the IQA into MMIS. This quality process includes the ability to confirm that letters have been sent to consumers. The Contract Administrator will notify the gaps identified and require the IQA submit documentation that the gaps have been addressed.

Milestones	Agree/ Disagree	Owner / Contributor	Due Date
6.1 Clarify to the IQA when each of the services listed in the service contract can be billed. Especially for services that can be standalone or bundled with other services such as medical appropriateness reviews	Agree	Steph Baer / David Sant	11/15/2023
6.2 Establish a monitoring and quality assurance process to ensure service are billed using correct payment rates and supported by relevant evidence.	Agree	Steph Baer / David Sant	11/15/2023
8.1 Clarify and update guidance on the POC entry in MMIS to ensure notices can be sent to consumers.	Agree	Steph Baer / David Sant	3/30/2024
8.2 Establish a monitoring and quality assurance process to ensure IQA assessments and supporting documentation and information is consistently entered in MMIS and Notices of Planned Action regarding 1915(i) residential stays are consistently sent to the consumers.	Agree	Steph Baer / David Sant	3/30/2024
9. Develop a monitoring and quality assurance process to ensure PCSP progress is consistently monitored by the IQA quarterly.	Agree	Steph Baer / David Sant	12/1/2023
11.1 Require IQA reporting on unduplicated individual count per service category on a calendar year basis.	Agree	Steph Baer / David Sant	3/30/2024

11.2 Establish a monitoring and quality assurance process to ensure alignment between IQA reporting, contract terms and the State Plan Option.	Agree	Steph Baer / David Sant	3/30/2024

Personal Care Attendant

Finding 13: Documentation does not demonstrate that the IQA and OHA used an objective criterion for Personal Care Attendant (PCA) exceptional needs determinations and whether supplemental documentation is consistently requested by the IQA and submitted to OHA.
Finding 7: The Notices of Planned Action for Personal Care Attendant (PCA) services do not include a clear and comprehensive justification for adverse determination.

OHA has created a new tool based upon similar tool used by Oregon Department of Humans Services (ODHS). The tool utilizes national research and best practice to determine a consumer's exceptional needs effectively and objectively. The new tool, the Personal Care Assessment and Planning System (PCAPS), will be in use by the IQA effective November 1, 2023. IQA staff are currently being trained on how to use the tool for assessments and will also receive additional training when there are changes to the PCAPS tool or process. New IQA employees who will perform assessments will be required to attend PCAPS training provided by OHA prior to performing assessments. OHA will develop a process to monitor IQA compliance with this requirement. The design of the PCAPS tool lists the OAR language that pertains to the skill(s) being accessed and provides clear definitions of the different types of support needs, hands-on, cueing or supervision.

OHA acknowledges that there is not a consistent process to ensure that Notices of Planned Action are clear and provide comprehensive documentation to justify decisions that have been made regarding changes to a consumers benefit or the decision by OHA to modify a decision made by the IQA. Current process is that once OHA has approved the request for exceptional hours, the IQA sends a Notice of Planned Action (NOA) to the consumer. OHA will modify this process and communicate to the IQA that every NOA that is created by the IQA is reviewed by OHA to confirm that the information in the NOA is clear and provides a comprehensive justification for the action being taken. Once OHA has reviewed, OHA will notify the IQA that the NOA can be sent to the consumer. OHA will identify gaps in the completion of the NOA and work with the IQA to close those gaps: this is a metric that can be added to the bimonthly PCA/IQA meeting agenda. To ensure training materials used by the IQA are in line with OHA OAR's and processes, the Contract Administrator will request the training materials used by the IQA for initial and on-going training and work with the IQA to ensure that OHA and the IQA are in alignment with contractual agreements.

Milestones	Agree/ Disagree	Owner / Contributor	Due Date
7. Establish a monitoring and quality assurance process to ensure Notices of Planned Action for adverse determinations contain clear and comprehensive justification for the decision.	Agree	Steph Baer / David Sant	11/15/2023
13.1 Establish documentation requirements for PCA determinations and monitor to make sure determinations are consistent, objective and adequately supported by evidence. Also, ensure there is a requirement to document the specific reason for OHA modifying the IQA decision.	Agree	Steph Baer / David Sant	11/15/2023
13.2 Require the IQA to align their written work procedures and practices with the OAR for exceptional needs to ensure due consideration is given to the tasks that require direct supervision and cueing.	Agree	Steph Baer / David Sant	11/15/2023

Appeal Processes

Finding 14: Appeal processes for providers are not sufficiently developed, not clearly communicated, and lack transparency.

OHA will clarify the various levels of review processes available to providers in publicly accessible documents on the OHA website. OHA will also train providers on the appeal process so that they can adequately access the information they need to engage the process. OHA will work with the IQA and provider when the provider is concerned about an administrative error. OHA will make the Rate Review Committee process transparent and accessible for exceptional needs and unique circumstances. As part of the Quality Assurance Plan for the IQA contract, OHA will include process changes such as these in the routine review.

Milestones	Agree/Disagree	Owner / Contributor	Due Date
14.1 Establish a provider appeal process and update provider notices to ensure they contain written appear rights/opportunities and the process to contest agency and IQA decisions. - *Develop communication to all providers and IQA regarding provider administrative review rights*	Agree	Donny Jardine / David Sant	11/1/2023
14.2 Establish a charter for the Rate Review Committee describing its function, membership, meeting frequency, how cases are selected for a review, and how review decisions are made, documented, and communicated.	Agree	April Gillette / Richelle Murray	11/1/2023
14.3 Establish a monitoring and quality assurance process to ensure new processes are implemented.	Agree	Spencer Delbridge	11/1/2023

Home and Community Based Services Outreach

Finding 15: Outreach efforts promoting long-term services* and supports are not sufficient and formally established to help reduce the pressure on the behavioral health residential system and target underserved populations.

The Medicaid community engagement manager leads a team of analysts and a communication specialist working specifically to engage Oregon's communities and ensure partner and community needs are heard and considered within Medicaid rule promulgation, policy updates, billing guidance, and technical assistance. This team, in collaboration with subject matter experts and additional communications staff, are building an external communications, outreach, and engagement plan to reduce pressure on the behavioral health residential system by promoting Home and Community Based Services and building connections with an equity lens.

OHA will work with key partners to develop and deepen relationships with communities serving Oregon's most underserved populations using a continuous engagement model. Outreach will include opportunities to learn from, educate, and build solutions with individuals, providers, and advocates about services available to Oregonians who are eligible to receive Home and Community Based Services.

OHA will ensure transparency with processes impacting home and community-based services and adult mental health residential services. Additionally, OHA will develop training opportunities to ensure awareness of billing processes, documentation standards, and opportunities to request technical assistance.

As a part of an evolving communications plan, OHA will amend the public facing webpages with information about the services and supports available for individuals eligible for the 1915(i) services and supports. The webpage will contain information around the following:

- Overview of the intent of the webpage
- Hearings processes for individuals accessing services and supports
- Administrative review processes for providers to appeal assessment decisions
- Processes to request additional supports and services for items not covered in the functional needs assessment, through the Rate Review Committee
- Data Utilization Dashboard
- Links to training videos and documents
- Links to additional webpages to ensure most updated information is available

Milestones	Agree/ Disagree	Owner / Contributor	Due Date
15. Establish an outreach program to promote home and community-based services to all communities, especially those that disproportionately struggle with mental illness or barriers to care. Additionally, develop measures to track progress and outcomes of the outreach program	Agree	Jessica Deas / Donny Jardine	12/15/2023