RFA 4690-19 Evaluation Deficiency Letter

Cascade Health Alliance

This deficiency analysis is based on the items outlined in the Final Evaluation Report.

Applicants that were awarded a 1-year conditional contract will develop a remediation plan to correct deficiencies identified during the evaluation process and provide evidence to substantiate that the issues identified have been corrected to OHA's satisfaction. The timeline and submission requirements for correction will be established during the negotiation period prior to contract signing.

Where possible, deficiencies that are within the scope of the Readiness Review documentation submission will be addressed via the Readiness Review performed by OHA's contracted vendor. Items that require additional or supplementary documentation will be addressed through the remediation plan. If the Applicant fails to demonstrate sufficient progress towards resolving the deficiencies the contract will expire at the end of the 1-year term and will not renew. If the deficiencies are appropriately remedied during the term of the remediation plan, OHA will award the remainder of the 5-year contract.

OHA will schedule individual meetings with 1-year awardees to discuss the plan for remediation in more detail, including next steps for resolving issues.

Evaluation Team	Recommendation	Lacks Detail	People	Process	Tech
Finance	FAIL	X		X	
Business Administration	FAIL	X		X	X
Care Coordination and Integration	FAIL	X		X	X
Clinical and Service Delivery	FAIL	X		X	
Delivery System Transformation	PASS	X		X	X
Community Engagement	FAIL	X	X	X	

OVERVIEW:

EVALUATION DEFICIENCIES BY TEAM:

FINANCE

- Inadequate detail on PCPCH payment differentials by tier level and how these rates were developed.

- No description/examples of how programs funded by HRS services and those receiving quality pool earnings are currently being evaluated and how program quality will be ensured/measured.
- Cost – did not demonstrate understanding of Oregon's sustainable growth target goals or requirements – did not explain how applicant would reach goals and did not give the impression that their plans could be implemented.

BUSINESS ADMINISTRATION

Administrative Functions

- Pharmacy –access to non-formulary meds was not addressed and how pharmacy benefit will be communicated to members was not addressed. More detail is needed on how the prior authorization process works.
- Inadequate description of Fraud, Waste and Abuse (FWA) prevention
- Inadequate description of encounter data validation.
- No details of how Applicant would monitor and validate TPL information including Medicare coverage or share Third Party Liability information with providers.
- No examples of subcontracted activity or how subcontractors would be monitored.

Health Information Technology

- Health Information Technology/SDOH – poor responses in general, specifically, no key insights are mentioned and no indication of how they would share data information with providers.
- EHR - Almost no responses to assess regarding EHR adoption, no roadmap and no provider-specific challenges to EHR adoption mentioned (responses for all provider types are the same).

Member Transition

- No details on how Applicant will arrive at a seamless transition of care.
- Warm handoff responses were limited – no indication of how they will identify at-risk members.
- No info provided for how primary care assignments will be made, what happens when members don't match to a PCP, or how member information will be compiled and relayed to receiving CCO.

Social Determinants of Health (SDOH) & Health Equity

- Lacking a description of how to manage SDOH-HE funds.
- No information or policies on materials being offered in other languages or formats.
- No plan to address how they will adhere to ADA regulations.
- No information on recruitment or retention of personnel to increase diversity in workforce.
- No information on how Applicant would monitor any health equity trainings in their network.

CARE COORDINATION

Behavioral health services

- Failed to address gaps in covered services as well as plans to engage programs to fill those gaps.
- Failed to include strategies on how to develop patient-centered plans, especially related to SPMI needs.
- Little or vague information on their perceived responsibility in care coordination efforts.
- No strategies to reach a member who fails to respond to a screening.
- Future plans to improve access only related to specific featured clinics, not the whole system.

Care Coordination

- Failed to provide information on dual eligible populations and failed to address care coordination plans for SPMI, Children, and LTC populations as well as 1915i providers and THW duties.
- Lack of outreach strategies especially for families and found no strategies in place for reaching out across systems.
- In some areas such as APD, AAA and ODDS it was noted that care coordination strategies would not feasibly result in successful care coordination.
- The Applicant's plans regarding Transforming Models of Care rely heavily on Primary Care, no description was provided of how the Applicant will help in these efforts.

Care Integration

- No detail was provided on plans or process for communication, documentation, monitoring, transition planning and planned primary care roles.
- Limited detail on their experience providing equitable or culturally appropriate care.
- Limited detail was provided on their plans to coordinate with tribal populations.

Health Information Exchange

- Plans to facilitate hospital event notifications relied on an email list from one hospital—it was unclear how integration will occur moving forward.
- No plan was provided to implement and utilize additional HIE tools or to ensure that providers have access to tools.
- No strategy for behavioral health or oral health adoption of HIE tools was provided.
- Little indication on the HIT roadmaps of how HIE adoption would expand across provider types
- No roadmap was provided for oral health.

CLINICAL AND SERVICE DELIVERY

Administrative Functions

- The network adequacy section didn't address frequency or how fluctuations in network adequacy would be managed.
- They also don't address the impact of network adequacy gaps on members or how they would address any identified gaps.
- The grievance and appeal section was missing a lot of detail and solutions stemming from the G&A data appear to be based on complaints only, rather than using all of the data.

Behavioral Health Benefit

- There was a lack of detail on barriers to access BH services
- There was no plan for coordination of BH services or discharge planning

Behavioral Health Covered Services

- There was no process to identify members who need care coordination. Applicant did mention planning on creating a plan to identify members needing care coordination but there was no timeline or details.
- The Applicant stated that care coordination would be provided with "focused resources, data-driven tools and proven methods" but didn't provide any detail on their exact methodology.

Service Operations

- For the hospital service questions, there no indication of relationships with outside providers, inappropriate hospital readmissions were not defined, there was no methodology to the frequency and monitoring of hospital services and there was no distinction between ambulatory and acute care.
- For the pharmacy questions, it was not clear how the benefit would be communicated and there was no description of the medication management program.
- For the Utilization management questions, there was no mention of medical necessity criteria
- No mention of care models for congregate settings

DELIVERY SYSTEM TRANSFORMATION

Accountability and Monitoring:

- *Quality Improvement Program* – Applicant failed to provide details describing data systems and process, such as collecting data, performance benchmarks, and using the data to demonstrate and incentivize quality care.
- Lacking sufficient information about referrals and prior authorization processes, including continuity of care and coordination.

- *Accountability* – Applicant failed to provide details describing the measurement and reporting system, such as how standards and expectations are communicated and enforced with providers and sub-contractors.
- Lacking sufficient information about how providers are graded.
- Lacking sufficient information about how the system provides data to share among all stakeholders.
- *CCO Performance* – Lacking sufficient information about internal measures and utilization measures, including description about how to measure, track and evaluate the quality of care for clinical and ED utilization.

Delivery Service Transformation:

- *Provision of Covered Services* – Applicant failed to provide details describing data analysis for priority populations, such as types of data will be used to improve quality of care for members with SPMI. Lacking sufficient information about addressing gaps, specifically the ratio of providers to SPMI members.
- *Transforming Models of Care* – Applicant failed to provide details describing PCPCH, such as oversight, member and provider assignment data, and engagement of members and potential new PCPCH providers

COMMUNITY ENGAGEMENT

- No plan to ensure continual quality improvement of the Community Engagement Plan
- Insufficient details for how CAC aligns with defined population, including culturally specific strategies for alignment, county government and community members representation
- Doesn't mention how non-CAC members will inform CCO decision making, or how any input informs CCO decision making
- Insufficient mechanism to elevate member voice, including members with limited English proficiency (i.e., CAC Chair sitting on the CCO board is the only mechanism identified
- Doesn't mention how the CCO board will engage with tribes and/or the tribal advisory committee
- Some SDOH priorities that were listed don't count, per OHA definition and no description for ensuring a transparent and equitable process in SDOH funding decisions
- Lacking details in how applicant strengthen relationships with organizations identified
- Doesn't address culturally and linguistically appropriate strategies for involving members in care planning
- Insufficient detail on experience in engaging the community and providers in addressing disparities
- Insufficient SPMI and member receiving LTC services on CCO board
- Unclear whether CAC and tribes have a role in HRS decision making, based on the inclusion of the Community Projects Advisory Committee – lacking detail on how HRS spending will align with CHP.
- Information provided could be used for a metric, but doesn't include a metric
- Limited plan for disseminating outcomes of funded projects

HIT ROADMAP

- HIT Roadmap deficiencies will be addressed in a separate communication from the Office of Health Information Technology. The letter will identify whether the HIT Roadmap was approved as submitted or whether the CCO will be required to develop a work plan for the submitted roadmap.