# RFA 4690-19 Evaluation Deficiency Letter

# Eastern Oregon CCO Deficiency Analysis

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

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 over the course of the contract period as needed.

## OVERVIEW:

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

## EVALUATION DEFICIENCIES BY TEAM:

### FINANCE

- Very substantial concerns about CCO's ability to achieve:
  - Cost containment;
    - Responses focused only on fraud and abuse prevention
  - Care coordination; and
  - Behavioral health integration.
- No major concerns or deficiencies related to VBP
- CCO Performance and Operations
  - Unclear strategy for connecting payment or HRS spending to quality
- Cost
  - Inadequate information regarding care coordination and tracking services
  - Responses indicate CCO may not be adhering to requirements regarding limiting of behavioral health spending, specifically around separating funding for behavioral, oral and physical health services.

## BUSINESS ADMINISTRATION

**Administrative Functions**

- Pharmacy section was lacking info on the public facing website,
- The Fraud, Waste and Abuse response did not mention essential processes of data matching or claims review
- The encounter data section was missing information on how encounter data review processes, what tools they use to monitor and validate the information.
- There was very little data provided on the subcontractors who are performing major pieces of work, and how they are monitored.
- No description of CCO's board operations and processes.

**Health Information Technology**

- HIT plan did not cover all 5 years of the contract
- EHR adoption response too focused on metrics, lacking detail on the rest of the plan
- CCO may have misunderstood requirement for these responses

**Member Transition**

- Lacking detail continuity about:
    - How CCO will coordinate with other CCOs during transition;
    - Plan for ensuring continuity of care for all components;
    - Warm-handoff activities;
    - How to identify providers to coordinate with; and
    - Member engagement in this process.
- Data reception plan is too high-level to adequately evaluate

**Social Determinants of Health (SDOH) & Health Equity**

- No mention of policies to translate documents into other languages
    - Language translation policies may violate OHA rules
- Apparent confusion about how to implement culturally- and linguistically appropriate policies.
- CCO discusses diversity only at lower levels of the organization, not in terms of leadership or executive diversity

## CARE COORDINATION

**Care Coordination**

- Address planned support for existing PCPCH systems;
- Contain plans to coordinate for oral health;
- Include multiple specific populations (e.g., Tribes, families, and oral health providers);
- Provide robust plans to conduct transition of care; and
- Describe how CCO educates providers on interactions with social services.

- Allay concerns around existing relationships and processes for care coordination

**Care Integration**

- The CCO provided little detail on:
    - how their network of providers for members with special health care needs is formed; and
    - how coordination will happen between different elements of the system.
- Due to their unresponsive nature, it was difficult for reviewers to determine which elements could improve with a work plan.

**Health Information Exchange**

- HIE responses focused on implementation of population health management rather than the deployment of an actual HIE
- CCO should identify concrete steps to ensure access to HIE and hospital event notifications
- Oral health was not integrated into HIE solutions

## CLINICAL AND SERVICE DELIVERY

**Administrative Functions**

- Network adequacy issues:
    - No explanation for FTE calculation, rendering interpretation of provided data difficult
    - PCPs are included only in discussion of oral health
    - Lack of detail to address network adequacy concerns
- Data on grievance and appeals not detailed enough to show how improvements could emerge from that data

**Behavioral Health Benefit & covered services**

- Responses about mitigating barriers to billing did not address Dual Eligibles.
- Lack of detail on plan for provisioning covered services
- Responses did not address workforce gaps or strategies to mitigate those gaps
- No detail on relationship with Tribes.
- Care coordination:
    - No detail (other than a single mailing) on CCO reaching out to members with no utilization in the previous 6 months;
    - No timeline for identifying the needs of at-risk and other high-needs populations
    - No process for identifying members who decline ACT services
    - For ACT programs, no detail on:
        - Mitigating barriers to ACT services;

- Tracking ACT services across providers; and
- Educating providers on availability of ACT services.

  - Similar lack of clarity concerning Wraparound Services
- No details on ensuring capacity for estimated utilization rates

**Service Operations**

- More detail needed on frequency and methodology for utilization management
- Hospital readmission mitigation and tracking missing
- Access to care coordination could be more member-friendly
  - Revise so member does not need access to a telephone or computer
- Responses to LTSS showed CCO gap in understanding of these services
  - CCO could benefit from education on LTSS services

## DELIVERY SYSTEM TRANSFORMATION

**Accountability and Monitoring:**

- Accountability responses missing in the following areas:
  - Measurement and reporting system (e.g., how quality standards and expectations are communicated and enforced with providers and subcontractors)
  - Description of experience, staffing, policies, procedures, and capacity to collect the necessary electronic and other data.
  - Information about how referrals and prior authorizations are requested and how this process facilitates the continuity and coordination of care.
- Accountability detail insufficient for:
  - Processes used to administer external programs
  - Complaints, grievances, and appeals (e.g., how information is shared with providers and subcontractors)
- Quality Improvement Program
  - No description of capacity to collect electronic and other forms of data (e.g., staffing, policies, and procedures)
  - Lacking sufficient information about referrals and prior authorization processes, (e.g., continuity of care and coordination)
- CCO Performance
  - Lacking sufficient information about the process for measuring, tracking and evaluating quality of hospital services, including tracking by population sub-category (by REALD).

**Delivery Service Transformation:**

- Provision of Covered Services:
  - CCO failed to provide details describing data collection and analysis by priority populations and sub-categories (by REALD).
- Transforming models of care:

- Insufficient detail about PCPCHs:
  - Sites of PCPCHs;
  - Tier levels (response missing);
  - Oversight (response missing); and
  - Member outreach.

## COMMUNITY ENGAGEMENT

- The Regional Health Equity Collaborative is missing from the Community Engagement Plan
- CAC concerns:
  - Mechanism for CAC input in CCO decision making is insufficient (i.e., one RCAC member on CCO board, representing all 12 CACs).
  - No strategy for aligning CAC population with demographics and unsure if CAC representation complies with ORS.
    - Develop culturally- and linguistically-appropriate mechanisms for recruiting and engaging CAC members from diverse populations and ensure the CAC composition aligns with ORS
  - No description of how the CAC membership selection consistent with the ORS, requiring equal numbers of county representatives.
  - Process for Board accountability to the CAC is needed.
- Does not provide information on non-CAC member engagement, only mechanism for ongoing communication of the member voice is through the complaint and grievance system.
- No plan for engagement of Tribes, no plan for how the board will engage with OHP consumer representatives.
  - Recommendation to receive Tribal Affairs and guidance from OHA
- SDOH process doesn't include how priorities are vetted in the community beyond the CHP development process
- The process for CBIs decision-making is not clear, including the role of the CAC and Tribes in in how decisions are made, or how entities may apply.
- Ensure partnerships are developed with Tribes and local Regional Health Equity Coalitions
- Develop plan for how the community members, providers and service-delivery partners inform CCO decision making
- Need to more clearly identify how CCO will engage members in care planning beyond member onboarding
- Strengthen strategies for accountability and transparency from the board to the CAC
- Develop a more robust plan to engage the community for addressing disparities, especially racial disparities

## 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.