RFA 4690-19 Evaluation Deficiency Letter

InterCommunity Health Network

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	PASS				
Business Administration	FAIL	X		X	X
Care Coordination and Integration	FAIL	X	X	X	X
Clinical and Service Delivery	FAIL	X		X	X
Delivery System Transformation	PASS	X			
Community Engagement	PASS	X		X	

EVALUATION DEFICIENCIES BY TEAM:

FINANCE

- The care coordination plan did not have rationale for cost-effectiveness.
- While the strategy and plan were high quality, there was not enough detail to connect this plan to the goals of efficiency, cost, and quality.

BUSINESS ADMINISTRATION

Administrative Functions

- For encounter data section there was a general lack of detail, missing info on the tools used, no info on frequency of monitoring and missing detail on the encounter validation process.
- Unclear how Applicant will obtain and monitor Third Party Liability.
- Pharmacy benefit materials are not easily accessible.

- Basic functions for Fraud, Waste and Abuse were not described such as how claims data is used for FWA audits or monitoring.

Health Information Technology

- Little detail regarding current operations for EHR, plans to adopt, barriers and mitigation strategies. Also, the option they listed is not feasible (OMUTAP) as that contract just ended.
- Limited detail on the SDOH sources they would implement for HIT/VBP, no info on actionable key insights or current reports. It also appears as if they lack a connection to outside data sources.
- There are no responses describing 5-year plans.
- The response reviewed suggest a limited knowledge and limited supporting processes and infrastructure to address EHR adoption and the creation and sustainment of data-informed VBP models.

Member Transition

- Unclear how Applicant would coordinate transfer of care. Applicant stated that their few case workers would be leading this work but provided little detail on how. This meant that no detail was provided in many responses in this section. Also concerning that only a few case workers would be leading all of the activities that are needed for transferring care from one CCO to another. The deficiencies in this section were unclear as many of the responses were not adequately addressed.

Social Determinants of Health (SDOH) & Health Equity

- There was a lack of detail on how SDOH-HE data would be collected and analyzed.
- There was limited detail on SDOH communication strategies.

CARE COORDINATION

Behavioral health benefit and covered services

- Applicant's responses on behavioral health benefit were missing significant details on planned timelines and milestones.
- Reviewers identified deficiencies in both people and process among the Applicant's proposed plan for developing MOUs with CMHPs. Use of weak language showed a lack of planning and understanding of the fundamentals of this subject.
- The Applicant's failed to provide a meaningful description of LTSS, DHS and behavioral health relationships.
- No process was provided for identifying members ready to transition of lower levels of care.
- More information needed on planned timelines for review and updating of care coordination plans as well as processes in place to maintain low caseloads.

Care Coordination

- Care coordination responses failed to provide information on planned relationships with both tribes and community organization.
- No reference was made to usage of event notifications; the Applicant provided limited detail on tracking mechanisms and follow up activities.
- No plan was provided for oral health referrals for special populations.

Care Integration

- Care integration responses were lacking detail for plans to engage with tribal populations, Indian health providers and plans/processes for care integration activities.

Health Information Exchange

- Applicant's ability to support Health Information Exchanges (HIE) was unclear from both financial and technical perspectives.

CLINICAL AND SERVICE DELIVERY

Administrative Functions

- The network adequacy questions, physical, behavioral and oral health providers were discussed separately however some their ratios appeared to indicate network adequacy gaps and there was no information on how Applicant will address these gaps.
- Processes to manage the data in this section, are missing.
- For the grievance and appeal section it appears as if Applicant does not monitor their subcontractors at all, for the appropriate application of medical necessity criteria.
- Applicant is only using the complaint data and not any of the other G&A data to improve their network.

Behavioral Health Benefit

- There was limited information in the about billing barriers for Duals members.
- Details on how to assess needs for in-home services, was missing.
- The response for Warm handoff billing barriers was also missing certain components.

Behavioral Health Covered Services

- For care coordination, no information on how Applicant matches members to different levels of care coordination or if those levels are present in their system.
- No indication of how members are notified of care coordination services and reports were the only data source used to identify members needing care coordination – no assessment process was mentioned.

Service Operations

- The answers to the utilization management section had limited detail on policies for appropriate utilization management and there was little detail on how UM was monitored throughout the network.
- For the pharmacy section, the responses for medication management services was very vague – there appeared to be no processes in place.
- For the DHS/LTSS questions, responses were missing detail and two questions were missed entirely.
- Care coordination was not addressed for members receiving LTSS services and it was not clear how Applicant would work with APD or other care delivery systems.

DELIVERY SYSTEM TRANSFORMATION

Accountability and Monitoring:

- *Accountability* – Applicant failed to provide details describing the measurement and reporting system, such as descriptions of quality measures and how standards and expectations are communicated and enforced with providers and sub-contractors. Lacking sufficient information about the role and administration of the reporting program.
- *Quality Improvement Program* – Lacking sufficient information about referrals and prior authorization processes, including coordination of care.
- *CCO Performance* - Lacking sufficient information about the process to continuously improve quality and outcomes while focusing on value and efficiency. Lacking sufficient information about 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* – Applicant failed to provide details describing data collection and how it is incorporated into quality improvement activities. Lacking sufficient plan to collect data by sub-categories (by REALD).
- *Transforming Models of Care* – Applicant failed to provide details describing PCPCH, such as provider type and oversight.

COMMUNITY ENGAGEMENT

- Community Engagement Plan did not describe barriers to engagement, no mention of member role in Quality Improvement.

- Insufficient details for aligning CAC population with demographics, limited detail on collaborating with CACs from other CCOs, no reference to reporting governance decisions made on CAC recommendations back to the CAC.
- Community engagement with partners was lacking detail on how to build relationships with stakeholders and lacking detail on which stakeholders have input into decision making besides CAC and how Applicant will engage community to addresses disparities.
- Doesn't include all priorities across CHPs
- Over-reliance on CAC to elevate member voice
- No mention of plan for engaging with tribes/tribal committees
- No mention of which publicly-funded partners were involved in development of the application, or agreements with county governments.
- No explicit role for the CAC and tribes in HRS CBI decisions
- No reference to how Applicant will ensure an equitable process when awarding the SDOH funding and insufficient detail on how projects will be evaluated and outcomes shared.
- Insufficient detail on how member engagement and care planning is culturally or linguistically appropriate

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.