RFA 4690-19 Evaluation Deficiency Letter

Yamhill CCO

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.

OVERVIEW:

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	X
Clinical and Service Delivery	FAIL	X		X	
Delivery System Transformation	FAIL	X		X	
Community Engagement	PASS	X	X	X	

EVALUATION DEFICIENCIES BY TEAM:

FINANCE

Cost

- No mention of how case manager roles are connected to client services.

- Unclear if behavioral and physical health finances will be separated – this is a CCO 2.0 requirement.
- No explanation for how care coordination will drive cost effectiveness

Value-Based Payments

- The PCPCH policy and funding plan may not align with RFA intent. Yamhill stated they would exceed minimum required VBP levels but did not say how. Vague answers leave doubt about what applicant will do – frequent mentions of what they "could" or will "potentially" do.

CCO Performance and Operations

- HRS strategy, flex services, and program evaluation were all inadequately addressed due to lack of detail.
- The connection of HRS work to goals of cost, efficiency, and quality improvement were excessively vague.

BUSINESS ADMINISTRATION

Administrative Functions

- No CCO TPL contractors or processes were mentioned and there is no mention of how often Medicare coverage would be checked.
- There was no description of how Applicant planned to monitor their subcontractors, nor did they describe the business functions of major subcontractors.
- Large amount of missing detail on the Fraud, Waste and Abuse responses indicating that there might be missing processes or infrastructure.
- There is no mention of how often encounter data is validated, there was no timeline and no processes whereby issues seen could be elevated.

Health Information Technology

- Roadmap to EHR adoption was unclear with very high-level detail only. There was no plan for years 1-5 and no strategy mentioned. Technology gaps are likely, due to very minimal information on how Applicant would implement EHR or any other HIT process.
- Applicant named "increased risk" as an insight produced by the population health data indicating a lower level understanding of how population data can be used.
- There were minimal plans for including SDOH data into the VBP model and Applicant indicated they stored their data in "secure folders" indicating some more serious technological concerns.

Member Transition

- Several questions were missed and many of the responses are too high level and don't adequately describe the processes in place for transferring and receiving members. There is a lot of detail missing about data reception specifically.

Social Determinants of Health (SDOH) & Health Equity

- There is missing detail on the monitoring of health equity and health equity training.
- Only one subcontractor was mentioned as providing language services in Spanish however there are many more languages that would need to be accommodated.
- Applicant plans to hire a public relations firm to communicate with members but no mention of how they will hold this subcontractor responsible.
- Applicant lists a non-discrimination policy as addressing health equity issues. Work force diversity was not addressed, and it appeared they could benefit from education in this area.
- Applicant did not submit a plan for traditional health care workers as they stated that their case managers handled this work. This indicates a misunderstanding of the difference between case managers and traditional health care workers.

CARE COORDINATION

Behavioral health services

- No discussion or plans to mitigate gaps in provision of covered services.
- Roles and responsibilities of CMHPs lack detail or are undefined and no milestones or dates have been provided.
- No detailed information about housing for SPMI population.
- Member involvement in transition planning was unclear.
- Concerns were identified regarding partnership/people overseeing Children's System of Care.

Care Coordination

- No information on care coordination for dual eligible and Medicare Advantage populations. Reviewers were concerned to see the applicant describe their need to form partnerships with these populations as "not applicable."
- No specific relationships were described with ODDS.
- No clear approach was provided regarding the Behavioral health pipeline.
- Limited detail on process for tracking, screening, follow ups, use of culturally appropriate materials, and engaging families in transition planning for specific populations.
- In most responses this applicant failed to include consideration for populations with Developmental Disabilities, health disparities and Intensive Care Coordination.

Care Integration

- Limited detail in plans for performance monitoring.
- Applicant was not clear on how a successful transition would be ensured, or how a member would be involved in that transition.
- No detail was provided on how care for special needs populations would be coordinated.
- Lack of understanding of the importance of the tribal health system.

Health Information Exchange

- Applicant's ability to support Health Information Exchanges (HIE) was not clearly demonstrated. There appeared to be a significant lack of understanding in the level of technical assistance that OHA provides for this work.
- HIE tools described by the applicant were focused on CCO-to-provider sharing and not provider-to-provider sharing.
- Applicant demonstrated a misunderstanding of the role of PreManage as well as key concepts of HIE and failed to provide well developed future plans for growth in this area.

CLINICAL AND SERVICE DELIVERY

Administrative Functions

- Physical, behavioral and oral health providers were not addressed separately.
- The Applicant did not use the grievance and appeal system to monitor the correct application of medical necessity criteria and there was no mention of how they monitored subcontractors' notice of adverse benefits (NOABs). There appear to be no accountability mechanisms present and only a manual monitoring process is described – once a year or ad hoc only.

Behavioral Health Benefit

- The Applicant failed to address the BH benefit concerns of delegation.
- There was no information on barriers to warm handoffs.

Behavioral Health Covered Services

- Applicant states they monitor subcontractor with complex reporting, but no detail provided.
- Applicant defers to the subcontracted County on all BH matters ("the County handles that"). It is clear that that Applicant did not coordinate with the County on most of these responses as they are missing a lot of detail.
- Applicant appears to misunderstand what cultural and linguistic competence is and uses the wrong acronym for LGBTQ.
- For the hospital questions, Applicant focuses on ER departments only and all other hospital services are not mentioned.

- For children 1-5, PCIT or any other didactic therapy is not addressed.
- Complex case management is not addressed.
- The insurance component of the covered services questions is not addressed.
- The Applicant doesn't describe how Wraparound is monitored or how survey response rate of 35% in tracked.
- There is no description of how members know they are being enrolled in care coordination, or how Applicant is identifying unengaged members.
- It appears as if there is an assessment for new members, but no timelines are mentioned.

Service Operations

- No plan for communicating with members on pharmacy benefit.
- Hospital services- need more detail on all points especially on processes – they only say that they talk with member.
- The utilization management responses are missing detail about the prior authorization and other processes.
- Applicant did not distinguish between utilization for acute or ambulatory care.
- The responses for DH/LTSS services were confusing – it does not seem that they have much involvement with members in LTSS.

DELIVERY SYSTEM TRANSFORMATION

Accountability and Monitoring:

- *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.
- Lacked sufficient information on complaints, grievances and appeals, including how information is shared with providers and sub-contractors.
- *Quality Improvement Program* – Applicant failed to provide details describing data systems and process, specifically how data is used to improve care and delivery of services.
- Lacked sufficient information about referrals and prior authorization processes, including continuity of care and coordination.
- *CCO Performance* – Lacked 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* – Applicant failed to provide details describing data collection and analysis by sub-categories (by REALD).
- *Transforming Models of Care* – Applicant failed to provide details describing PCPCH, specifically information about members outreach strategies.

COMMUNITY ENGAGEMENT

- Missing minor and major components of Community Engagement Plan – there was not a CAC for each of the counties in the Applicant's service area and the CHA/CHP was missing entirely.
- Little detail on what current levels of engagement are, what the barriers are or what relationships need to be established.
- Housing is not mentioned as an important partner Applicant needs to engage with.
- More detail needed on how communication will work between the CAC and non-CAC members
- More detail needed regarding accountability of board decisions based on CAC recommendations
- Does not explain how they'll use Quality Improvement for the CEP, response simply states they'll do it
- SDOH-HE - Clear process needed for establishing SDOH priorities in the community, that is transparent and equitable and process for sharing project outcomes as well.
- Unclear process for recruiting diverse members, unclear if selection committee of CAC meets ORS
- Unclear if alignment between CHP and HRS/CBI spending or how the CAC is involved besides receiving a report.
- Unclear whether outreach occurs for all members, not just those receiving care
- Missing info on how providers were involved in the application, only public providers inside Yamhill county are mentioned and have agreements with the Applicant, **even though service area extends beyond Yamhill county.**

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.