2021 Transformation and Quality Strategy

March 2021

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Contents

Section 1: Transformation and Quality Program Details

A. **Project short title**: Project 1: Reducing Preventable Emergency Department Visits

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project or program

If continued, insert unique project ID from OHA: 7

B. **Components addressed**

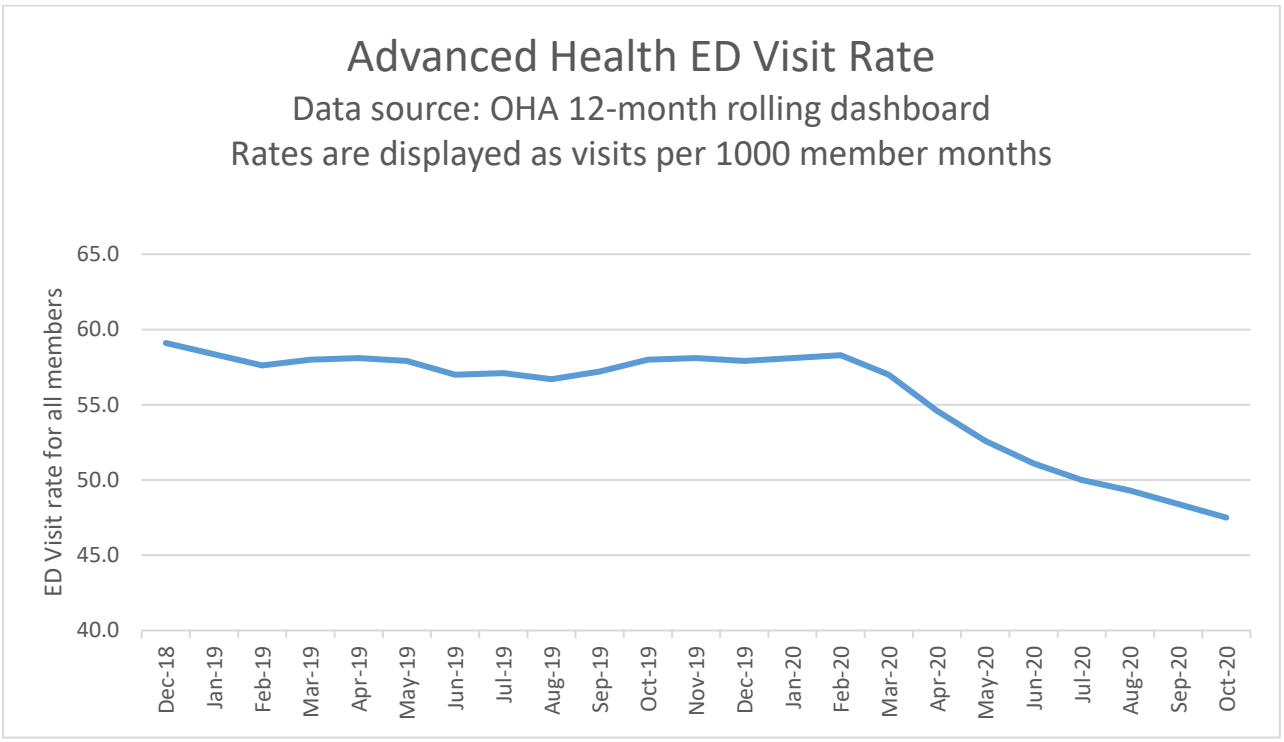
i. Component 1: Access: Quality and adequacy of services
ii. Component 2 (if applicable): Utilization review
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☐ No
v. If this project addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

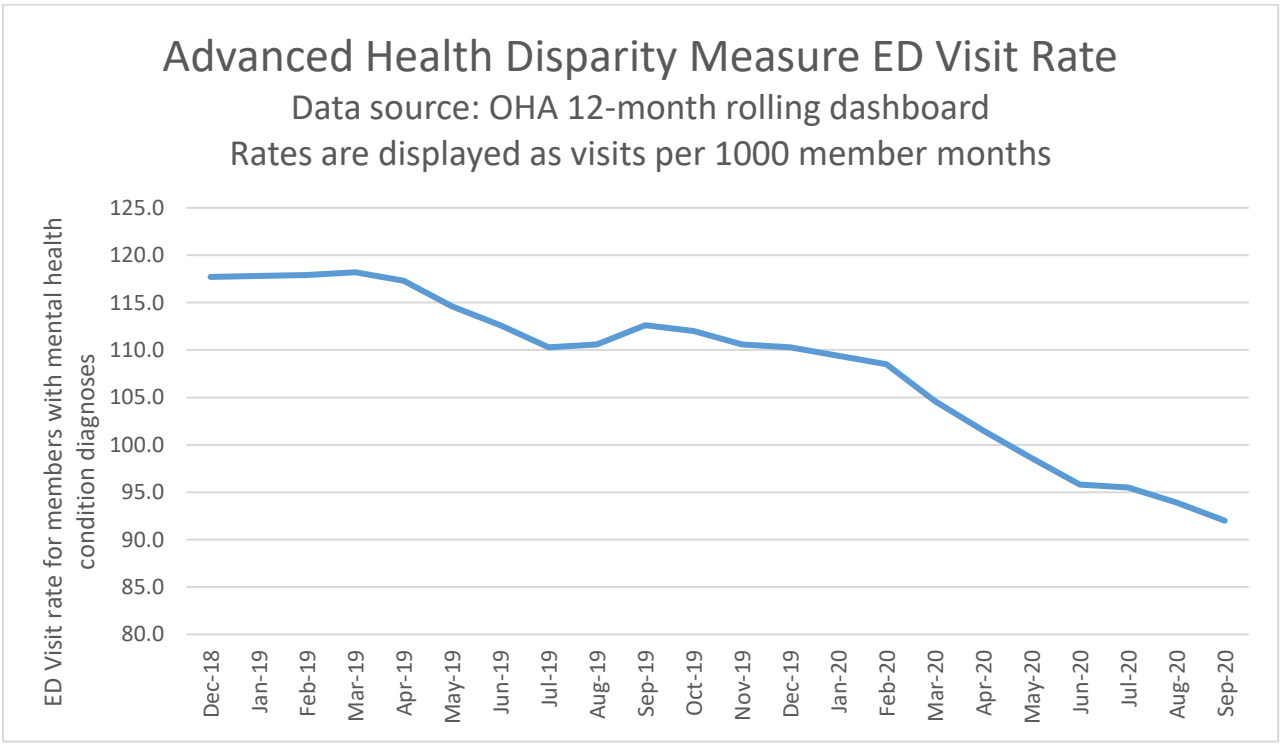
C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

Advanced Health has analyzed available ED utilization data in a variety of ways to better understand the potential drivers of over-utilization. Diagnosis data from claims reveals that several conditions, such as urinary tract infection and upper respiratory infection, which would be more appropriately addressed in a primary care or urgent care setting, are consistently in the top ten list of most common diagnoses. The rates of utilization for adults with mental health conditions are significantly higher than for the adult population as a whole, potentially indicating additional barriers or gaps for those members and opportunity to improve care coordination and integration to better serve their needs. Advanced Health's rate of ED utilization by all members in 2019 was 57.9 visits per 1000 MM and 110.6 visits per 1000 MM for members with a diagnosed mental health condition. The statewide rates for calendar year 2019 were 47.5 and 99.8 visits per 1000 MM respectively. While Advanced Health's ED utilization rates demonstrated a decrease from 2018 levels, comparison with the statewide rates indicates there is still overutilization.

When Advanced Health began this TQS project in 2018, we set interim targets for CY 2019 as well as targets for CY 2020. The 2019 and 2020 targets were selected using the methodology used in 2019 to set CCO performance improvement targets for the two ED Utilization quality incentive measures. The targets were set to reach for a 3% decrease from baseline each year. In CY 2019, Advanced Health had a rate of 57.9 visits per 1000 MM for all ED utilization and a rate of 110.3 visits per 1000 MM for the disparity ED measure. For the overall ED Utilization measure, Advanced Health was very close, but did not quite meet the 2019 target of 57.5 visits per 1000 MM. In CY 2019, Advanced Health met the 2019 target for the disparity ED measure (116.6 visits per 1000 MM) and also met the 2020 target (113.0 visits per 1000 MM) we had set.

Because of this, we needed to set a new target 2020 target for the disparity measure and likely would have kept the same 2020 target for the total ED utilization measure. However, with the onset of the COVID-19 pandemic in March of 2020, there began a trend of decreased ED use for all populations. This trend is clearly evident in the two charts below.





The most recent data from Advanced Health's 12-month rolling dashboard report from OHA is for November 2019 through October 2020. Advanced Health's rate of ED Utilization for this time period is 47.5 visits per 1000 MM for all members and 92.0 visits per 1000 MM for members with a mental health condition diagnosis.

In late 2019 and early 2020, Advanced Health expanded the care coordination services offered directly by the CCO. In addition to the Director of Care Coordination and the Traditional Health Worker Liaison positions required by the 2020 CCO contract, a number of additional staff positions were added to improve access to care coordination services, including an ICC Specialist, an additional ICC nurse, and four ICC Traditional Health Workers.

This trend of decreased utilization due to issues surrounding the pandemic is overshadowing any changes we may be able to credit to the interventions in 2020. We recognize this as a confounding factor in our ED utilization rates for 2020 and expect it will impact 2021 as well. Despite this difficulty in using these ED utilization rates as measures of the success of this project, Advanced Health still chose to focus on these interventions as a means to ensure members are well connected with appropriate preventive care. Advanced Health is working to reduce preventable ED visits in the interests of ensuring members receive the right care, at the right time, and in the right place with appropriate coordination, continuity, and use of medical resources and services. It is more important now than ever to have robust, effective systems in place to identify members in need of services and coordinate the delivery of that care in the safest manner possible.

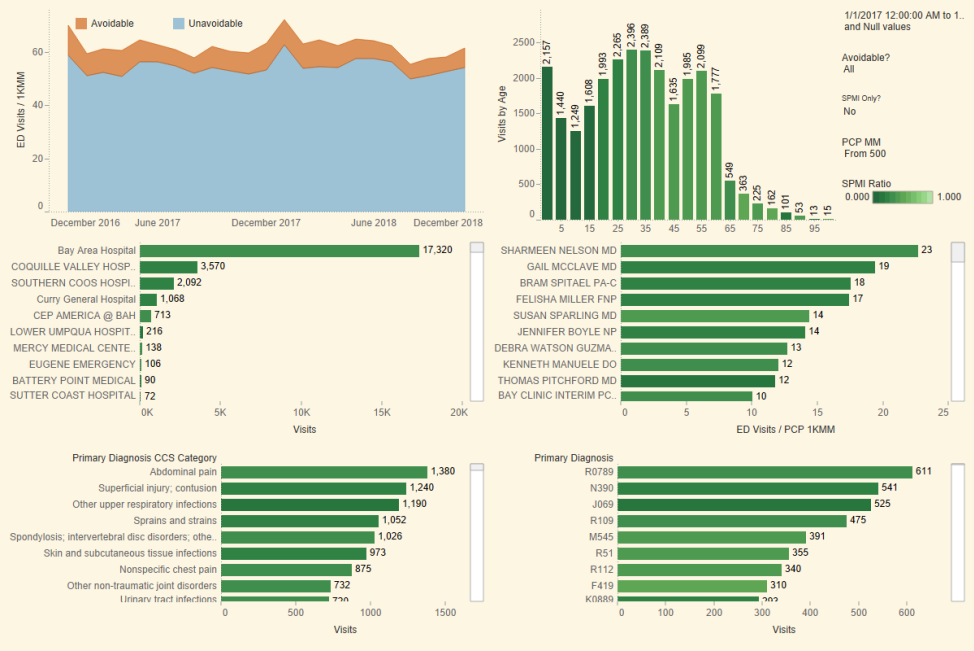
D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

Interventions and programs aiming to decrease preventable ED visits are highlighted below:

- Several of the Quality Innovation Incubator Fund projects for 2016, 2017, and 2018 were aimed at increasing the use of primary care health care teams, including navigators and care managers to expand the reach of our primary care providers. Most of these programs supported through the Incubator Fund became fully operational in 2017 and we began to see the results of these projects in 2018.
- Advanced Health care management staff participate with a community care management group that includes representation from clinics in our provider network and community partners in both Coos and Curry counties. This group meets twice a month to share best practices to coordinate care across the continuum of health care services and community resources, as well as consult on particular cases as needed.
- Two large clinics in Advanced Health's provider network, Bay Clinic and North Bend Medical Center, are participating in the CPC+ program. In 2017 these clinics began monitoring and working to improve their rate of 7 day follow up after an ED visit for their patient populations. They are now using Collective Medical (formerly PreManage) to monitor for ED visits among their patient populations.
- Advantage Dental, Advanced Health's provider for oral health services, uses Collective Medical to monitor for ED visits related to oral health concerns. Case Management staff reach out to members and work to connect them with their primary care dentist for follow up and management of their oral health needs.
- Advanced Health implemented Collective Medical for Intensive Care Coordination staff in mid-2017. Collective Medical is a health information exchange solution focused on emergency department and hospital admissions. It allows ED and hospital admissions personnel to receive care plan information when a patient is admitted. It also allows case management personnel to receive notifications when a patient is admitted to the ED or hospital for an inpatient stay. Advanced Health's IT manager is facilitating implementation of Premanage within the Advanced Health provider network.

In 2018, Advanced Health formally adopted reducing ED utilization as a Performance Improvement Project (PIP) topic with progress monitored and reported quarterly to OHA as a contract deliverable. Efforts focused on improving coordination between all the current interventions in progress within the provider network, delegate organizations, and community partners. We have been working through the Interagency Delegate and Provider Quality Committee as well as the Clinical Advisory Panel to better understand the trends in utilization, determine potential root causes behind the trends, determine the impacts of current interventions, and develop new interventions for implementation.

Below is a view of our new ED Utilization dashboard for all members and all ED visits from January 2017 through November 2018. This Tableau dashboard allows us to dynamically analyze and rapidly filter the displayed data.



In reviewing the ED utilization rates by assigned primary care provider, we have found that the providers with the highest rates are primarily providers with small panels and providers who are new to our network. Because the rate is displayed as a number of ED visits per 1000 member months, when a provider is new or carries a small patient panel, they have a small denominator number of member months to be included in the metric calculation. These rates calculated with small denominators are not credible and so are not useful for determining interventions.

Also, when reviewing the ED utilization rates by assigned primary care provider, we find that the rate is strongly correlated with the type of primary care practice (pediatric, family medicine, or internal medicine) and the risk stratification value of the provider's panel. Some care must be exercised when using these rates to design interventions, but they may be useful to monitor effectiveness of interventions applied across organizations or between similar practices.

Advanced Health did not meet the 2018 measurement year CCO quality incentive measure improvement targets for either the general ED Utilization measure or the ED Disparity measure.

Throughout 2019, Advanced Health continued to support the other initiatives (noted above) to reduce preventable ED use, and continued to report quarterly on the efforts to OHA through a Performance Improvement Project. We saw a downward trend in both ED utilization quality performance measures during 2019. The steady work of our provider network partners in physical, behavioral, and oral health is evident. For the overall ED Utilization measure, Advanced Health was very close, but did not quite meet the 2019 target of 57.5 visits per 1000 MM. Advanced Health's final rate in 2019 was 57.9 visits per 1000 MM. In CY 2019, Advanced Health surpassed the 2019 target for the disparity ED measure (116.6 visits per 1000 MM) and also met the 2020 target (113.0 visits per 1000 MM) we had set. The 2019 rate for the ED disparity measure was 110.6 visits per 1000 MM.

Many plans were put on hold in March of 2020 when COVID-19 was recognized as a global pandemic. Oregon's health care delivery systems have been operating under a state of emergency since then. Overall utilization of services declined precipitously as a result of public health measures put in place in response to the pandemic. Most initiatives with our provider network partners were placed on hold due to the provider network capacity to manage the pandemic response. Advanced Health instead focused on strengthening internal teams and structures to better support the provider network. The Advanced Health analytics team updated our internal ED utilization monitoring dashboard to indicate members seen in the Emergency Department who have a diagnosis of SPMI or Substance use. The Intensive

Care Coordination team has worked with physical health and behavioral health care providers in an effort to help them understand and identify the members assigned to them who are high risk utilizers of the Emergency Department, focusing on use of the Collective Medical platform.

The measures to reduce the spread of COVID-19 prohibited face-to-face meetings, so Advanced Health's Intensive Care Coordination (ICC) Specialist began attending the local hospital's complex case management and discharge planning virtual meeting once a week. The meeting focuses on the patients in the hospital long term and the high ED utilizers. This meeting allowed for collaboration and relationship building with the RN case managers, Discharge Planners, Acute Psychiatric Unit and ICC Specialist as well as the time to problem solve care planning. The adoption of attending the virtual meetings has expanded to additional case management and care planning huddles with case management staff 3-4 times a week if not more. The ICC Specialist also attends the acute psychiatric staff meeting one to two times per week during shift change to help coordinate care planning with the Acute Psychiatric Unit. From a data perspective, the ICC specialist works with Collective Medical daily to identify who has been in the Emergency Department. She has built cohorts to look at specific demographic populations. Regarding reducing Emergency Department Utilization, the cohort identifying individuals accessing the ED 7 or more times in 3 months provided to be the most useful. By focusing on a 3-month lookback, it identified acute crisis and provided an opportunity for real-time intervention.

This in-depth care planning takes teamwork between the Emergency Department, primary care providers, behavioral health providers and various other agencies. Through use of the cohorts and the teamwork, the ICC Specialist has successfully worked with a member who utilized the Emergency Room 22 times in 3 months for minor physical complaints and was able to bring the Emergency Utilization to a stop by connecting the member with the services they most needed. The ICC Specialist also utilizes care guidelines in Collective Medical and communicates with primary care clinics. This collaborative care planning relationship has extended to care managers outside of the local region as some Advanced Health members have used services in other counties. Care Managers in other counties have seen the care planning guidelines on Collective Medical and have collaborated care with the ICC Specialist.

Beginning in 2020, Advanced Health entered Value-Based Payment contracts with two local critical access hospitals with ED utilization as the quality component. One arrangement was a LAN Category 3B with shared savings and downside risk, while the other was a LAN Category 2C without a PMPM spending target. We successfully rolled out Tableau dashboards to both hospitals for tracking ED utilization and financial targets. At the time of this report, we are still in the claims runout period. Final 2020 performance will be calculated at the end of March 2021. However, the data is clear that the 2020 targets will be met. This may be partially driven by actual intervention on the part of the hospitals, but a much larger factor is the reduced utilization and expanded enrollment resulting from the COVID-19 pandemic response. Outpatient hospital utilization dropped at the same time enrollment climbed, compounding to bring PMPM spending and ED utilization down.

E. **Brief narrative description**:

Advanced Health has and continues to support a number of initiatives aimed at reducing the number of preventable Emergency Department (ED) visits. Potentially preventable ED visits are those that could be more appropriately addressed through primary care or urgent care. Advanced Health monitors ED use through the Ambulatory Care: Emergency Department Utilization and the Disparity Measure: ED Utilization for Members with Mental Illness quality performance measures used by OHA.

The Intensive Care Coordination team will continue to use Collective Medical to identify individual with patterns of high ED use and work to coordinate their care to better meet their needs and connect them with their primary care home. The ICC Specialist will also continue to offer technical assistance to provider network organizations around the use of

Collective Medical. Advanced Health also plans to further expand the ICC team by hiring three additional Traditional Health Workers to work directly with members as Care Coordinators.

Advanced Health will continue the VBP contracting arrangements with two critical access hospitals in 2021. This has the benefit of continuing to support the financial health of local critical access hospitals, while at the same time, providing a financial incentive to pilot strategies to encourage clinically appropriate use of medical resources.

F. **Activities and monitoring for performance improvement**:

Activity 1 description : Continue to monitor, revise, and adapt interventions through the Performance Improvement Process (PIP) with quarterly reports to OHA.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Monitor Ambulatory Care: Emergency Department Utilization rate per 1000 member months for all members. Monitor Disparity Measure: Emergency Department Utilization for Members with Mental Health Conditions, rate per 1000 member months. Targets for ED utilization are difficult to set due to the effects of the pandemic on utilization patterns. The targets below are set using CY 2019 at a baseline and reducing utilization by 3% each year. 2020 rates will be well below that target, and as the public health emergency continues into 2021, those rates will likely be depressed as well.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Quarterly reports submitted to OHA in 2020 (1 report for Q1-Q3, and 1 report for Q4)	4 quarterly reports submitted to OHA for 2021	01/2021	4 quarterly reports submitted to OHA for 2022	01/2022
57.9 visits per 1000 MM (CY 2019) 47.5 visits per 1000 MM (Nov19-Oct20)	55.6 visits per 1000 MM (CY 2020)	12/2020 (reported by OHA in 6/2021)	53.9 visits per 1000 MM (CY 2021)	12/2021 (reported by OHA in 6/2022)
110.6 visits per 1000 MM (CY 2019) 92.0 visits per 1000 MM (Nov19-Oct20)	107.3 visits per 1000 MM (CY 2020)	12/2020 (reported by OHA in 6/2021)	104.1 visits per 1000 MM (CY 2021)	12/2021 (reported by OHA in 6/2022)

Activity 2 description: Monitor ED visit rate performance for value-based contract arrangements with critical access hospitals.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Continue use of quarterly performance reports to provide feedback to critical access hospitals

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Baseline performance established	Contractor 1 on track to meet 3% performance improvement target	06/2021	Contractor 1 meets 3% performance improvement target	12/2021 (reported in 03/2022)
Baseline performance established	Contractor 2 on track to meet 3% performance improvement target	06/2021	Contractor 2 meets 3% performance improvement target	12/2021 (reported in 03/2022)

Activity 3 description: Increase the proportion of members with high ED utilization who are referred to and enrolled with Advanced Health's Intensive Care Coordination team.

☐ Short term or ☒ Long term

Monitoring activity 3 for improvement: Monitor the percentage of members with high ED utilization who have been referred to and are enrolled in ICC services with Advanced Health's care coordination staff. For this monitoring activity we are using data from both the OHA 12 month rolling dashboard and data from Activate Care, Advanced Health's ICC tracking and care planning platform.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
19% of members with 10 or more ED visits (Nov19-Oct20) referred to Advanced Health ICC	24% of members with 10 or more ED visits (Jul20-Jun21) referred to Advanced Health ICC	6/2021 (report in 11/2021 using OHA rolling dashboard for 12-month period ending 6/2021)	29% of members with 10 or more ED visits (Jan21-Dec21) referred to Advanced Health ICC	12/2021 (report in 5/2021 using OHA rolling dashboard for 12-month period ending 12/2021)
11% of members with 10 or more ED visits (Nov19-Oct20) enrolled with Advanced Health ICC	16% of members with 10 or more ED visits (Jul20-Jun21) enrolled with Advanced Health ICC	6/2021 (report in 11/2021 using OHA rolling dashboard for 12-month period ending 6/2021)	21% of members with 10 or more ED visits (Jan21-Dec21) enrolled with Advanced Health ICC	12/2021 (report in 5/2021 using OHA rolling dashboard for 12-month period ending 12/2021)

A. **Project short title**: Project 2: Social Determinants of Health (PRAPARE) Screening for Intensive Care Coordination

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project or program

If continued, insert unique project ID from OHA: 9

B. **Components addressed**

i. Component 1: Special health care needs

ii. Component 2 (if applicable): Choose an item.

iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☐ No
v. If this project addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

Despite the challenges presented in 2020 by the COVID-19 pandemic and the abrupt changes in organizational priorities as a result of the response efforts, Advanced Health's Intensive Care Coordination (ICC) team was able to deploy the PRAPARE screening as a systemic method for gathering Social Determinants of Health data for Members engaging in ICC services.

OHA data and claims data provides insight into physical health and behavioral health conditions. Adding data from PRAPARE provides a more complete picture by adding data on social factors experienced by Advanced Health Members.

Of members participating in ICC services in 2020, 28% have one or more disability, as identified by OHA's enrollment data. 58% have a mental health condition diagnosis, as defined by the code set used for the CCO Emergency Department disparity quality measure. And 90% have at least one chronic condition.

Aggregate data from the PRAPARE Assessments gathered by the ICC screening process in 2020 tells us that approximately 25% of Members screened are experiencing housing insecurity or houselessness, and nearly 34% are worried about losing their current housing. 30% of Members screened are experiencing food insecurity, and 40% reported transportation barriers have kept them from non-medical or medical appointments, work, or getting other things they need.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

In May of 2018, the Oregon Medicaid Advisory Committee released a report and recommendations entitled, "Addressing the Social Determinants of Health in the Second Phase of Health System Transformation: Recommendations for Oregon's CCO Model". The full report is available on the Oregon Health Authority's website: https://www.oregon.gov/oha/hpa/hp-mac/Pages/index.aspx. The report includes the following definitions of Social Determinants of Health and Social Determinants of Health Equity:

> ***Social Determinants of Health and Equity: Definitions for CCOs***
>
> *Most of our health is shaped by factors outside the clinic or hospital, in the places where we live, learn, work, and play.*
>
> *Social determinants of health: The social, economic, political, and environmental conditions in which people are born, grow, work, live, and age. These conditions significantly impact length and quality of life and contribute to health inequities.*
>
> *Social determinants of health equity: Systematic or structural factors that shape the unfair distribution of the social determinants of health in communities. These structural factors are evident in social norms, policies, and political systems, both historical and current. Institutionalized racism is one example.*

The fourth of five general recommendations included in the report is:

CCOs support health care teams and community partners in working together and with patients to identify and address the SDOH challenges patients face and would like help to resolve. This approach means that CCOs:

a) *Address the variety of health care team and community partner needs to impact SDOH (e.g. need for data systems or technology to track and address SDOH).*
b) *Ensure providers have the necessary SDOH data to delivery both SDOH-informed and SDOH-targeted healthcare.*
c) *Ensure two-way data flow by facilitating reporting of SDOH efforts and outcomes from health care teams and community partners.*
d) *Offer health care teams resources to help facilitate connection to or coordination with SDOH community partners*

Advanced Health has agreements with and provides support to a number of local community SDOH partners, including entities providing services to persons experiencing homelessness or housing instability, children in the foster care system and foster families, and Adverse Childhood Experiences education and training.

From the data reported in the 2018 Community Health Assessments for Coos and Curry Counties, we know that both counties have higher unemployment and poverty rates than the Oregon statewide average. According to the 2019 County Health Ranking report from the Robert Wood Johnson Foundation, which uses 2017 data, the statewide unemployment rate was 4.1%, while the Coos County rate was 5.5% and the Curry County rate was 6.1%. From the same report, the statewide rate of children living in poverty was 17%, while the Coos County rate was 27% and the Curry County rate was 25%.

Several social determinants of health and health equity factors were identified as priorities in the Coos and Curry Community Health Improvement Plans (CHIPs) in 2019. In the Coos and Curry County CHIPs, SDOH-E related priorities include:

- Housing and Homelessness
- Food and Nutrition
- Transportation
- Economic Stability
- Adversity, Trauma, and Toxic Stress
- Workforce and Economic Development

Beginning in 2018, Advanced Health began planning how to better support the necessary infrastructure in our service area to ensure data is available to identify both individual patients and connect them with resources, and aggregate data to inform system-level or policy-level changes to address SDOH at a population level. Advanced Health has recognized the need for a better system communicate SDOH screening information to primary care and other members of the care team to prevent duplication of efforts and to improve coordination of care.

After evaluating several different screening tools, Advanced Health selected the PRAPARE assessment for screening. PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences) if a standardized patient social risk assessment tool and process for addressing social determinants of health for the member. Assessment information helps document member complexity, target clinical care, and enable additional services. More information about the PRAPARE assessment tool and how it was developed and validated is available on the National Association of Community Health Centers website. http://www.nachc.org/research-and-data/prapare/about-the-prapare-assessment-tool/

The PRAPARE tool is also available in a variety of non-English languages, including Spanish, which is the prevalent non-English language in the Advanced Health service area. Other languages available include Chinese and Vietnamese, which do not meet the definition of a "prevalent non-English language" in Oregon Administrative Rule, but are the two next most common non-English languages of Advanced Health members.

Advanced Health also reviewed and evaluated several different software solutions and has selected Activate Care (formerly ACT.md) as the platform to be used to implement the screening, data collection, and data sharing with appropriate entities for Intensive Care Coordination (ICC) for CCO members who are part of a priority population as defined in OAR 410-141-3870(2) or identified as having Special Health Care Needs. The PRAPARE assessment template will be built into the Activate Care system and will be used as the comprehensive assessment for members receiving Intensive Care Coordination. Care Coordinators will be able to use the assessment to engage members to participate in the development of their ICC care plan. The PRAPARE assessment has been built into the Activate Care system and is filled out by the Care Coordinator as they work with the Member to develop the care plan. The results of the assessment and the care plan that follows can be shared through the Activate Care platform with the member's care team, including their primary care provider, behavioral health provider, specialists, case workers for long term services and supports, representatives from other social service organizations such as DHS or APD, or others, as appropriate.

In Q1 2020, Advanced Health ICC staff began the PRAPARE assessment for all Members enrolling in ICC services. In Q2 2020, the ICC team began using Activate Care and the built-in PRAPARE assessment to create and share Member care plans. The results of the PRAPARE assessment allow the Care Coordinator and Member to identify individual social needs and goals for the care plan and ensure the Member is connected with resources available to address those social needs. The PRAPARE assessment also informs a Member's Special Health Care Needs designation, as social needs are one of the three qualifiers for the SHCN definition in the CCO contract.

The measures put in place to mitigate the effects of the COVID-19 public health emergency delayed the planned implementation of Activate Care and the data monitoring tools that were planned for 2020. Staff had to swiftly adjust to remote work and halt all face-to-face interactions with Members and co-workers. At the time of the initial stay home orders, the ICC team had several new staff members in training and was on the cusp of implementing Activate Care. The full implementation was delayed several weeks as everyone adjusted to a remote work environment and adjusted processes and workflows to comply with the public health emergency precautions. The ICC team was able to continue training remotely with Activate Care and completed implementation later in Q2 2020. Unfortunately, the planned decision support tools were deprioritized due to staff resource constraints in analytics, but the data dashboard is planned for Q1 2021.

E. **Brief narrative description**:

Early in 2021, a data dashboard was deployed to allow the Director of Care Coordination to monitor aggregate PRAPARE assessment data. In Q2 2021, REALD data available from OHA's enrollment files and from the PRAPARE assessment will be available as well. This aggregate data will be used to inform priorities for further program development such as:

- Health-Related Services spending priorities, including flexible funds for individual Members' care plan needs, community benefit initiatives, and wellness programs
- Recruitment, hiring, and retention strategies for Advanced Health's Traditional Health Worker workforce, including prioritizing hiring Care Coordinators with lived experiences to ensure the workforce is representative of the populations served by the program
- Training and education planning for ICC and other Advanced Health staff, as well as for the provider network to improve the experience of care for Members with SHCN and ensure culturally and linguistically appropriate services

- Partnerships and formal agreements with community-based organizations and social service agencies
- Identify potential disparities in access to care and services for Members with SHCN

Advanced Health will continue to collect and monitor data from the ICC program and explore ways to use the information to improve services for specific populations of members, such as those with one or more disabilities or who are experiencing housing or food insecurity. Avenues for improvements will include addressing individual needs through flexible HRS spending, addressing community-level needs through HRS community benefit spending, and addressing experience of care and systemic concerns through staff and provider network training and education.

F. **Activities and monitoring for performance improvement**:

Activity 1 description: Evaluate SDOH-E and REALD data for members with Special Health Care Needs participating in ICC services against Health-Related Services spending priorities.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Evaluate ICC program data and revise HRS spending priorities to ensure alignment and to address the needs populations of Members with SHCN, such as housing insecurity, food insecurity, and transportation.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Not Complete	Evaluate ICC data and compare to current HRS priorities and processes	4/2021	Revise and implement HRS priorities to address gaps identified in the evaluation	6/2021

Activity 2 description: Use aggregate data from the ICC program to inform staff and provider network training plans and revise as needed to incorporate training and education to address identified gaps in culturally and linguistically appropriate services for members with Special Health Care Needs. Work with Advanced Health human resources and provider services staff to adjust training plans as needed.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: The Advanced Health staff training plan and provider network training plan will be revised for 2021 and reported annually Health Equity Plan. The annual report will include a plan for the next year and an assessment of the previous year.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
2020 Training Plan (as reported in the 2020 Health Equity Plan)	2021 Training Plan (to be reported in the 2021 Health Equity Plan)	6/2021	2022 Training Plan (to be reported in the 2022 Health Equity Plan)	6/2022

A. **Project short title**: Project 3: South Coast Together – ACEs Training and Prevention

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project or program

If continued, insert unique project ID from OHA: 40

B. **Components addressed**

i. Component 1: Social determinants of health & equity
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☐ No
v. If this project addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☒ Social and community health
vi. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

The findings from the Adverse Childhood Experiences (ACE) study are the largest public health discovery of our time. The evidence linking childhood traumas to adverse health outcomes makes it clear that finding ways to mitigate and prevent trauma, as well as promoting resiliency for people impacted by ACEs, are key to improving the health of the community. The Master Training program and Self-Healing Communities Initiative from ACE Interface have been adopted in other state and are showing early evidence of improved outcomes.

Advanced Health's service area of Coos and Curry counties have some indicators of higher rates of traumas and ACEs than the average for the State of Oregon. The Robert Wood Johnson Foundation's County Health Rankings for 2020 place the percentage of children in poverty in Coos county at 24% and Curry county at 22%, with an Oregon statewide rate of 16%. In the 2019 Child Welfare Data Book from Oregon Department of Human Services, Coos county reported a rate of 22.4 per 1,000 children as victims of child abuse or neglect. Curry county reported a victim rate of 21.5 per 1,000 children. While Coos reported a lower rate than in 2018 and Curry's rate remained nearly unchanged from the previous year, both continue to be higher than the statewide victim rate of 15.7 per 1,000 children. Advanced Health's August 2020 Children's Health Complexity Data released by OHA and the Oregon Pediatric Improvement Partnership (OPIP) reports 43.2% of children having 3 or more indicators of social complexity. The social complexity indicators summarized in the Children's Health Complexity Data closely align with a number of indicators of trauma from the ACE study. Social complexity indicators reported in the Children's Health Complexity Data include: poverty (child or parent), foster care, parental death, parental incarceration, mental health (child or parent), substance abuse (child or parent), child abuse and neglect, potential language barriers, and parental disability.

Supporting efforts to mitigate trauma and increase resilience are priorities in both the Coos and Curry county 2019 – 2022 Community Health Improvement plans.

The COVID-19 pandemic, resulting state of emergency declaration, and protective orders issued in 2020 have likely negatively impacted many of these indicators of social complexity and adverse childhood experiences. There is still much we do not know about the long-term effects of the pandemic, but we continue to hear from our Consumer Advisory Councils, provider network, staff, care coordinators and case managers, and community partners that findings ways to mitigate and prevent trauma and build community resilience is a priority for us all.

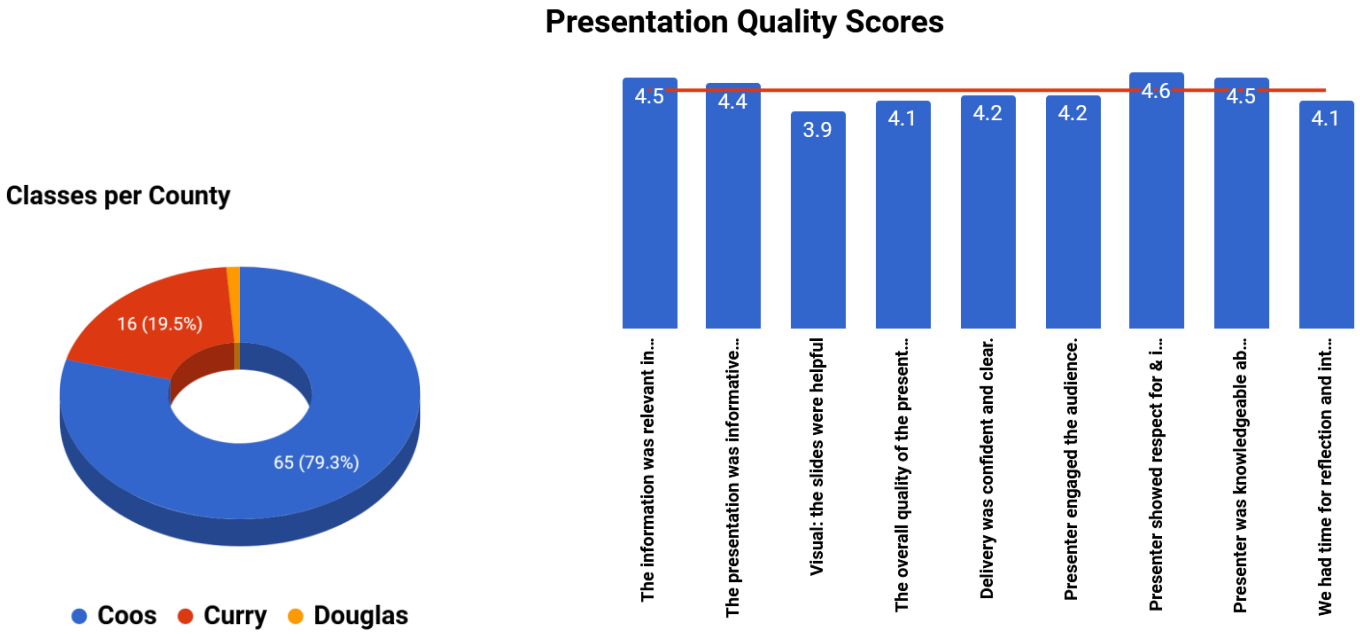
D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

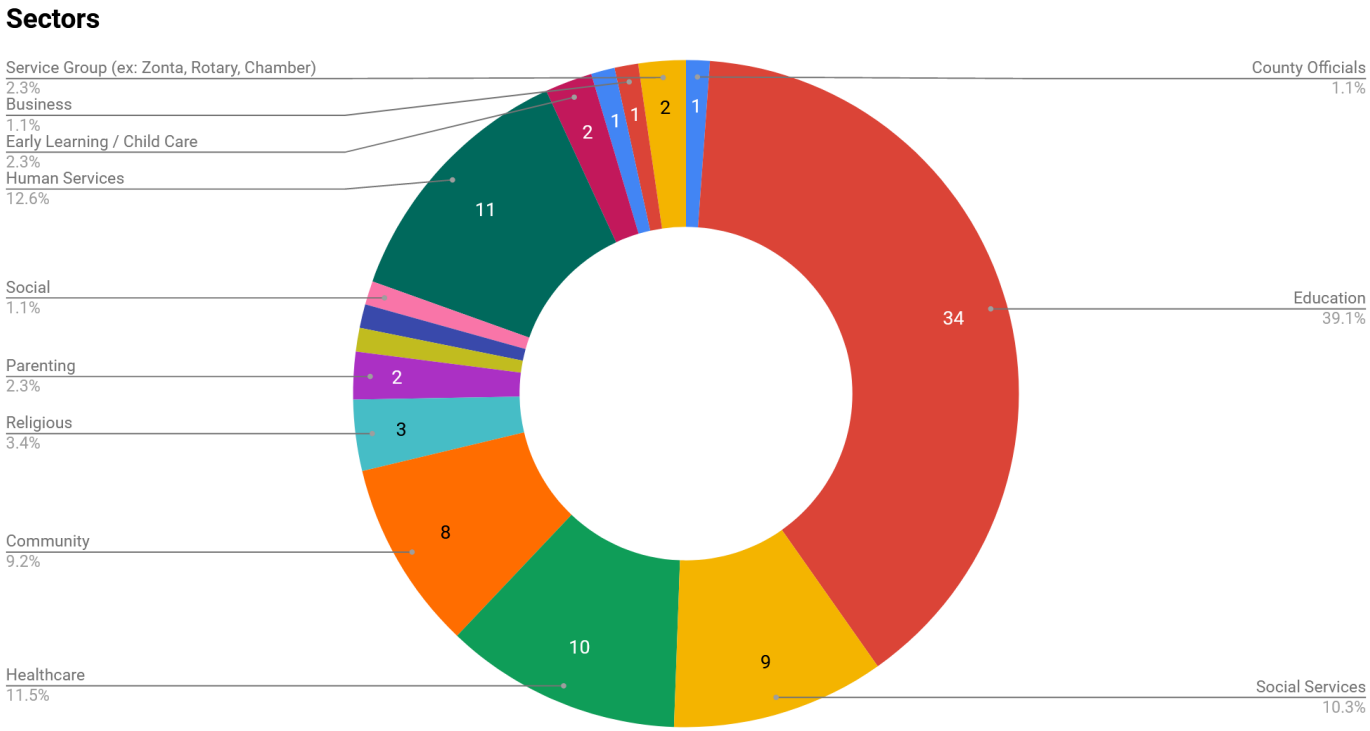
South Coast Together is a community collaborative focused on fostering resilience in Coos and Curry counties. Its goals are to engage community members as agents of change in preventing the accumulation of Adverse Childhood Experiences (ACEs) and to build resilience in children, adolescents, and families. The Steering Committee is a 15-person, multi-sector group, including community members. We also have a dedicated Trainers Group, currently made of up ACES Master Trainers (5), and Presenters (4), and a few others working towards becoming a Master Trainer.

In June 2017 Advanced Health began convening community-wide planning meetings with broad cross-sector representation, including CCO delegates and providers, as well as other community partners from early childhood education, K-12 education, the local community college, juvenile department, CASA, and domestic violence prevention, among others. The goal of these early meetings was to obtain buy-in from community stakeholders and secure funding to support the initiatives. Community agencies were recruited to contribute to a funding partnership and to nominate a staff member or partner to participate in the ACE Master Trainer program. Twelve individuals were selected from throughout Coos and Curry counties and completed the ACE Master Training. These Master Trainer candidates were then available to train in pairs and raise awareness about ACE in the community. After they completed their training and presentation requirements, they will become certified ACE Master Trainers

In November 2017 a steering committee and a metrics committee were seated to provide a cross-sector community infrastructure to guide the initiative and produce a comprehensive implementation and measurement plan for Coos and Curry counties. In 2018 a communications committee was established, and the program adopted the name South Coast Together and a logo to use on public materials and communications.

Throughout 2018, the project focused on raising community awareness and promoting education around ACEs and Trauma-Informed care. Two of the Master Trainer candidates completed the required amount of training hours and gained their ACE Master Trainer certification. Over 1,200 individuals in Coos, Curry, and Douglas county received training with reports of high impact on the training evaluations. Key informant interviews were conducted with thirty participants and focused on four topics: community overview, community partnerships and leadership, how people and organizations make decisions, and how the community learns and improves. The steering committee also provided input on perceptions of population challenges at various stages in life and served as a focus group to inform understanding of prevailing beliefs about the dynamics that contribute to those challenges. The information from the key informant interviews and input from the steering committee was synthesized by the consultants from Ace Interface into an assessment report including recommendations for continued action.





South Coast Together work continued in 2019, with efforts focusing on expanding leadership. Leadership expansion is one of the core principals of building a Self-Healing Community. To accomplish this, we trained additional “Presenters”, supported training for Family Café facilitators and the Family Café events, and completed strategic planning for the initiative by a Core Group of multi-sector participants.

In 2019, we increased our numbers of Certified Master Trainers to five. We also held a two-day presenter training for four local presenters. Presenters are prepared to teach the basic ACEs training curriculum. By increasing our number of Presenters and Master Trainers, we can serve more people in our community and meet the demand for trainings without burdening our trainers, who mostly hold other jobs as well.

Another endeavor completed in 2019 was hosting a Family Café training. Ace Interface, our consulting group, recommended Family Café training to increase community capacity and distribute leadership in our community. We partnered with our local Pathways to Positive Parenting chapter to procure grant funds from the Oregon Parenting Education Collaborative to hire a consultant to provide the 6-hour training to 41 community member and professionals, with the request that those attending the training hold their own Family Café in the community, and to fund those café events. A Family Café is an organized event with a host, designed to facilitate communication and create space for dialogue around important issues to those in attendance. Family Café facilitators hosted at least 15 cafés in 2019, with topics ranging from “Grandparents Raising Grandkids” to “Parenting Challenges” and “Transportation Barriers “. Because of the “train the trainer” model for Family Cafés, there were Family Cafés planned into 2020 as well.

Lastly, we convened a Core Group of participants for strategic planning of the initiative including fiscal sustainability. The group determined that in order to reach some of our longer-term goals, we would need to begin applying for grants and other funding sources. This required a transition of our backbone agency to an organization that had recognized non-profit status. We also wanted to find an organization invested in work in both Coos and Curry counties, and whose mission, vision, goals, and other work aligned with that of South Coast Together. A multi-month process occurred, which eventually led to the transition of the South Coast Together initiative and its current funding to our regional South Coast Education Services District (ESD). In January 2020, South Coast Together completed the transition to the South Coast Education Services District as the new backbone agency.

2020 marks the fourth year of the collaborative, and although some plans and goals changed due to the Covid-19 Pandemic, South Coast Together still found relevancy and opportunities to promote its objectives. Training community members and professionals on the science of Adverse Childhood Experiences (ACES) science, through curriculum from ACE Interface, has been at the foundation of group’s work. We decided to use some of our funding to purchase an additional three years on the license for our ACE interface curriculum. From this curriculum, we delivered 19 trainings in 2020. Trainings at the beginning of the year were in person, and later we switched to a zoom/virtual training platform. Three of the trainings were for medical facilities, 11 were for school districts and the regional education services district, five were for community organizations. We have trained over 1,400 individuals in total in our communities.

Another goal we had for 2020 was to host a community event around ACES awareness. It quickly became evident that an in-person event would not be possible this year. Our Steering Committee decided to host several virtual “Community Zoom Sessions”. We used some funding to pay for national expert and consultant, Laura Porter, to facilitate the sessions. The first one occurred in May and the focus was “Covid Conversation”, we had approximately 30 attendees. Our agenda included time for participants to reflect on the impact of Covid on themselves personally and in the community, followed by education from Laura Porter around community capacity development, and then short comments from four community leaders around the question: “What are two or three themes you are seeing in your role that other may benefit from knowing?”. We discussed emerging resources and partnerships as a large group, and then finished with a reflection around what participants are taking away from this event.

We held another event in August, the theme was around Supporting Families. Many of the participants work in schools or directly with children, so we wanted to help prepare them for returning to school in the fall.

Again, we provided time for reflection at the beginning of the event, "identify one word or feeling that comes to mind when you think about responding to children given the significant and various stressors that families are under". Laura Porter next provided information about the impact of stress from the science and early learning specific to Covid from other communities and countries. Time was provided for five speakers from various organizations to talk about strategies, partnerships, and resources available or emerging to support families. The participants were then moved into virtual break-out groups for small discussions, and then a final report out to the whole group at the end. There were about 40 participants for this event.

Our last event was held in October and took a deeper dive into lesser-known resources in the community available to support children and families, as well as a discussion on reducing silos. Then we spent time discussing how to generate empathy when we are all experiencing stress. We did some moderating and facilitating as a group, and then had smaller breakout groups again. The themes were picked by getting feedback from participants in the previous sessions. We had again about 30 participants.

The last project we spent time on in 2020 was the creation of a Parenting Guide based on brain science. We are calling it the "Help that Helps" guide. A small group of South Coast Together participants, along with consultants from Lieberman Group and Ace Interface, have been working on the guidebook for several months. It is nearly complete and will also feature artwork by a youth. Grant money from the United Way and the Advanced Health Community Health Improvement Plan was used to fund consultation and printing costs. The guide will be useful for parent trainings, presentations, and other workshops. The guide should be complete in the first half of 2021.

E. **Brief narrative description**:

South Coast Together chose The Self-Healing Communities Initiative as the framework for the communities of Coos and Curry Counties to work toward building resiliency to mitigate the effects of ACEs for those who have already experienced trauma and to prevent traumas for future generations. Its goals are to engage community members as agents of change in preventing the accumulation of ACEs and to build resilience in children, adolescents, and families. Efforts to promote community awareness of ACEs, neuroscience, and resiliency practices across a broad swath of sectors, including the public, will continue, with presenters adjusting and adding to trainings in response to feedback from the community members, organizations, and service systems receiving training.

F. **Activities and monitoring for performance improvement**:

Activity 1 description (continue repeating until all activities included): Continue to provide ACE trainings and follow-up trainings for free to the community, across all sectors, including health care, education, law enforcement, social services, parent groups, spiritual communities, and local tribes.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Number of training sessions completed

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
40 sessions in 2019 20 sessions in 2020	20 sessions in 2021	12/2021	20 sessions in 2022	12/2022

Monitoring activity 1 for improvement: Add new Presenters to the training team to support training schedule and reach new audiences.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
0 as of 1/2019 4 as of 3/2020	5 more Presenters trained	12/2021		

Activity 2 description: Support trauma-informed school initiatives by presenting to all school districts in the region and providing follow-up sessions to support implementation of trauma-informed strategies during the 2021-2022 academic year.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Monitor the percent of school districts in the region receiving education and follow-up sessions during the 2021-2022 academic year.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
0% of districts	50%	12/2021	100%	06/2022

Activity 3 description: Create and publish a "Help That Helps" parenting guide based on brain science to be used for parent trainings, presentations, and other workshops.

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement: Complete, print, and begin using "Help That Helps" parenting guide.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
In development	Complete	5/2021	In use	6/2021

A. **Project short title**: Project 4: Member Grievance System Improvements

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project or program

If continued, insert unique project ID from OHA: 42

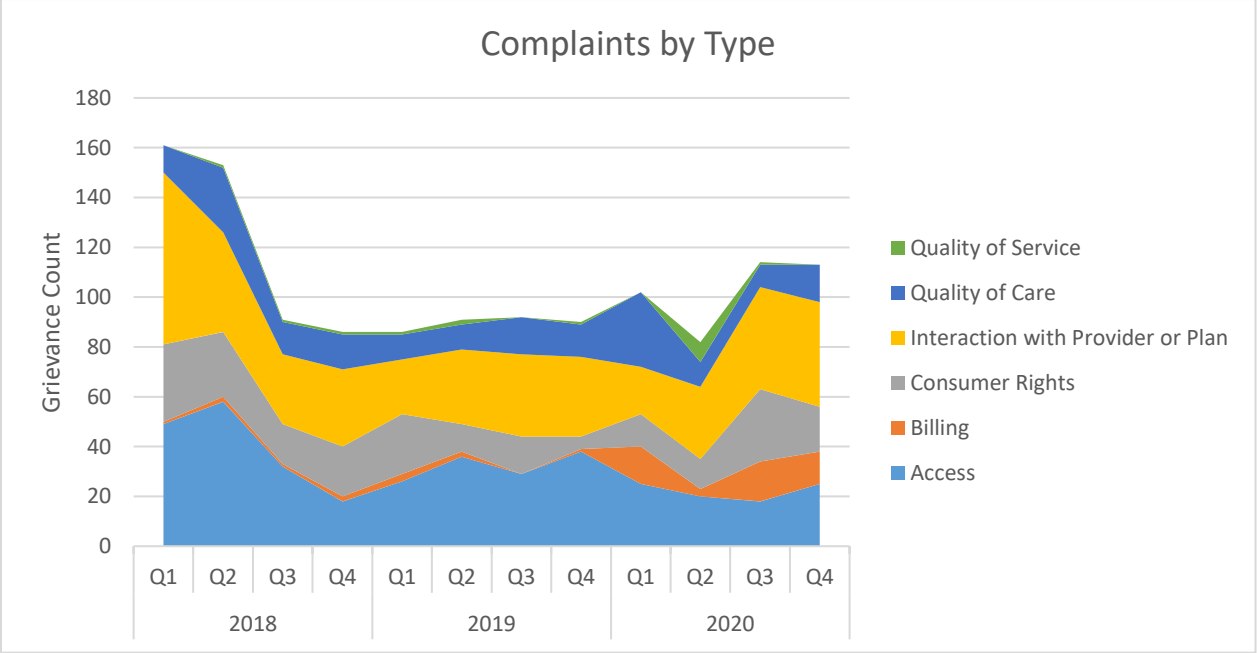
B. **Components addressed**

i. Component 1: Grievance and appeal system

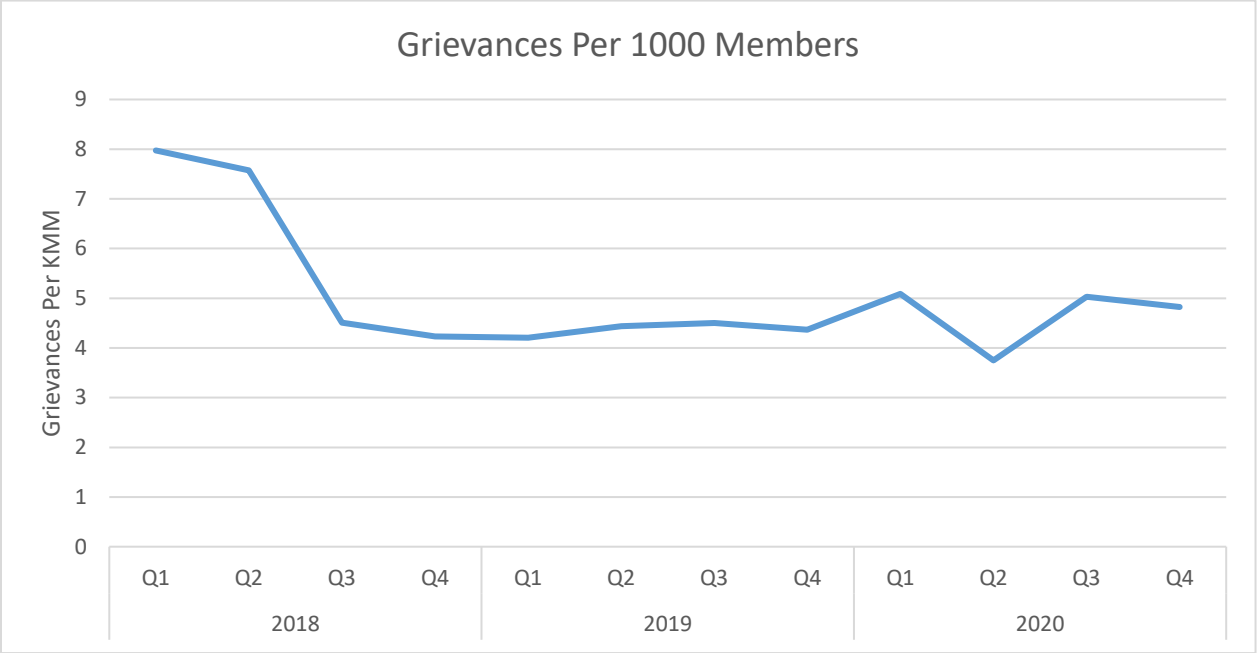
ii. Component 2 (if applicable): Health equity: Data
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☐ No
v. If this project addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

Advanced Health monitors data from the Member Grievance System closely for trends that can be addresses through systemic quality improvement efforts. The sharp decrease in total complaint volume in Q2 2020 is likely the result of the stay home orders issued in response to the COVID-19 public health emergency. Some services were closed or restricted for a time and people did not expect to receive those services. Complaint volumes increased in Q3 and Q4 as stay home orders were eased and in-person services reopened with modifications and additional safety precautions in place.



Much of the reason for the increase in overall complaint volume in Q3 and Q4 2020 was likely due to the increase in enrollment, another effect of the COVID-19 response by OHA. When we review the rate of complaints per 1000 members, we see that Q3 and Q4 rates are close to Q1 2020 rates. However, they still show a slight increase over 2019 rates.



Advanced Health tracks grievances related to cultural sensitivity by both the provider and the plan. We have had no grievances related to cultural sensitivity in the past eight quarters. We will continue to work to maintain low complaints in this category.

Advanced Health currently serves nearly 24,000 Oregon Health Plan Members in Coos and Curry Counties on the Southern Oregon Coast. 52% of Advanced Health Members are female and 48% are male. Nearly 7%, approximately 1,600 members, have one or more disabilities.

In 2020, 15% of the complaints tracked by Advanced Health were for members with one or more disability. This is a higher proportion of complaints than expected and will require further investigation in 2021 to determine potential causes and actions to improve the experiences of members with disabilities.

Current race and ethnicity demographic data available from OHA for Advanced Health's membership shows nearly 41% as "not provided." The percentage of race and ethnicity data that is not provided or unavailable has waxed and waned over the past several years, and unfortunately has begun increasing again in 2020. As part of our 2020 Health Equity Plan, Advanced Health is working to improve the race and ethnicity demographic data that is available. Of the members with race or ethnicity data available, less than 1% are Native Hawaiian or Pacific Islander. Members who are Black, Asian or Pacific Islander, or who identify as another race or ethnicity each make up about 1% of the Advanced Health population. Members who identify as American Indian or Alaskan Native comprise 2% of the Advanced Health population, and Hispanic members make up another 5% of the population. The remaining 90% of Advanced Health members are Caucasian.

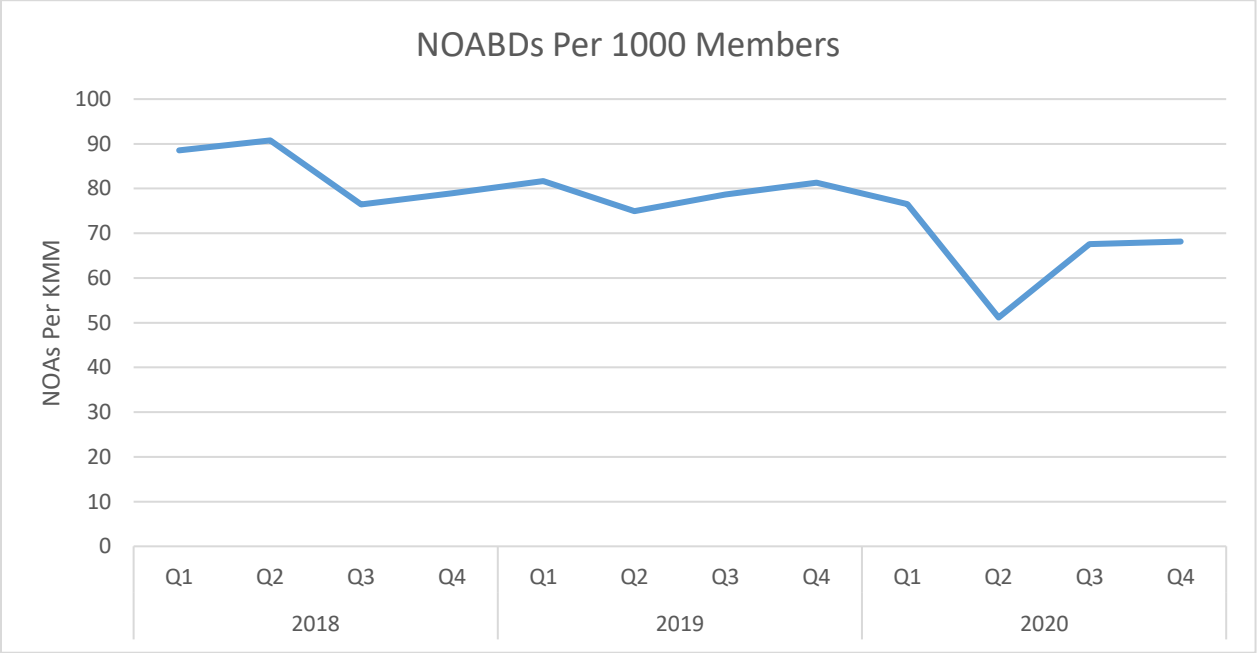
Of the complaints logged by Advanced Health in 2020 where the Member's race or ethnicity information is available, 0.4% were from Members who are Black, 1.5% were from Members who are American Indian or Alaskan Native, and 4.1% were from Members who are Hispanic or Latino. The remaining 93% of complaints were from Members who are White. This analysis indicates that further, in-depth review is warranted to ensure that members who are not White have full access to the Member Grievance system and are able to make use of it.

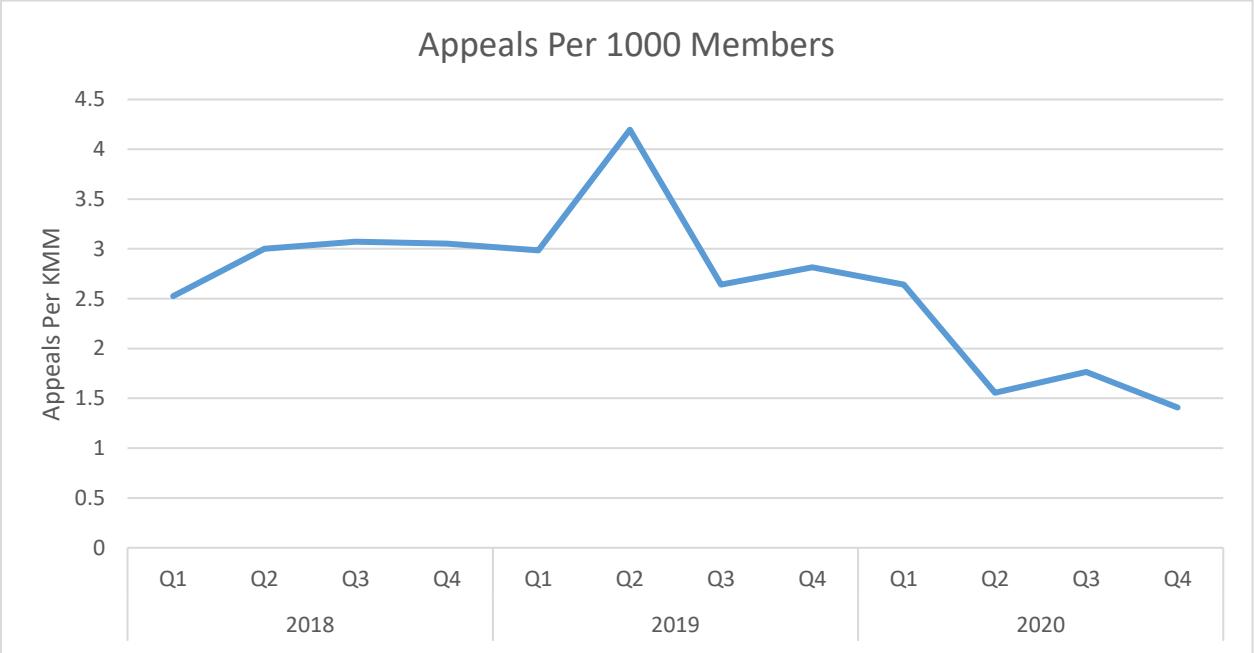
Spanish is the prevalent non-English language spoken by Advanced Health Members, with 1.2%, or about 280 Members, indicating that their primary language is Spanish. While some language data is unavailable (marked as "undetermined,"

"other," or "declined to answer") it is not nearly as big a gap in the data as the race and ethnicity data noted above. At least 43 more Advanced Health Members primarily speak a language other than Spanish or English.

Advanced Health member population is 97% English language speakers. 1.2% are Spanish language speakers. The next three highest categories of "Undetermined," "Other," and those that "Declined to Answer" make up 1.6%. In 2020, 96.3% of complaints received were from members whose primary language is English. 2.0% of complaints were from members whose primary language is Spanish. And 1.7% of complaints received were from members whose primary language was listed as "other" or "undetermined." This data is encouraging in that it appears that members with limited English proficiency are to be accessing the complaint process in similar proportions to the English-speaking Advanced Health population.

The rate of Notices of Adverse Benefit Determination (NOABDs) per 1000 Members and Appeals per 1000 Members both declined in 2020. The abrupt decrease in volume in Q2 was due to the shutdown of facilities, cancellation or postponement of elective procedures, and the stay home orders in response to the COVID-19 pandemic. Providers were not able to see as many patients or provide as many services as usual in Q2 2020, and so the overall volume of services requested, and services performed was lower. Many of the initial restrictions in response to the pandemic have been lifted or modified, the overall volume of prior authorization requests has returned to pre-pandemic levels.





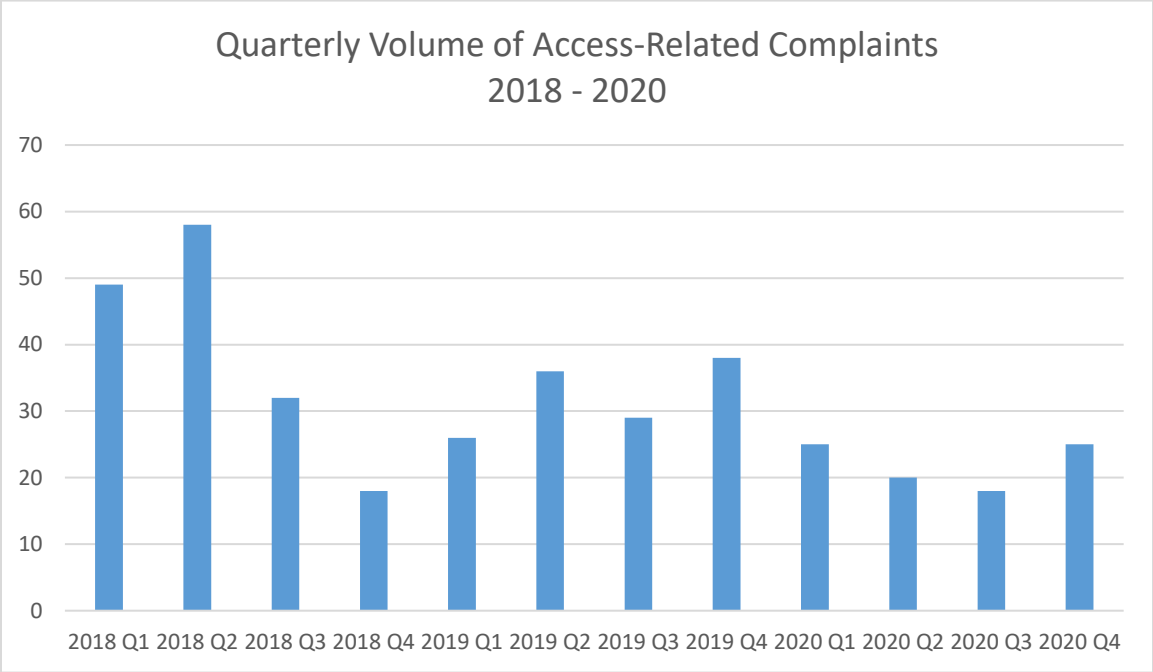
D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

Advanced Health has undertaken several quality improvement efforts aimed at decreasing the rate of member complaints, especially those related to access and interactions with provider and plan.

Advanced Health has employed a dedicated staff position for the Member Grievance System late 2016. This position is responsible to assist members in accessing the Grievance System, responding to complaints and appeals, monitoring data, presenting analysis, and implementing systemic improvements based on trends in the data. Our current Grievance System Coordinator is an experienced Traditional Health Worker and coordinated care navigator. The Grievance System Coordinator ensures our Member Grievance and Appeals System is responsive to the needs of our members. This person monitors the details of all complaints, appeals, and hearing requests for issues related to cultural considerations and health equity. She participates in the annual Grievance and Appeals audit of our contracted provider organizations.

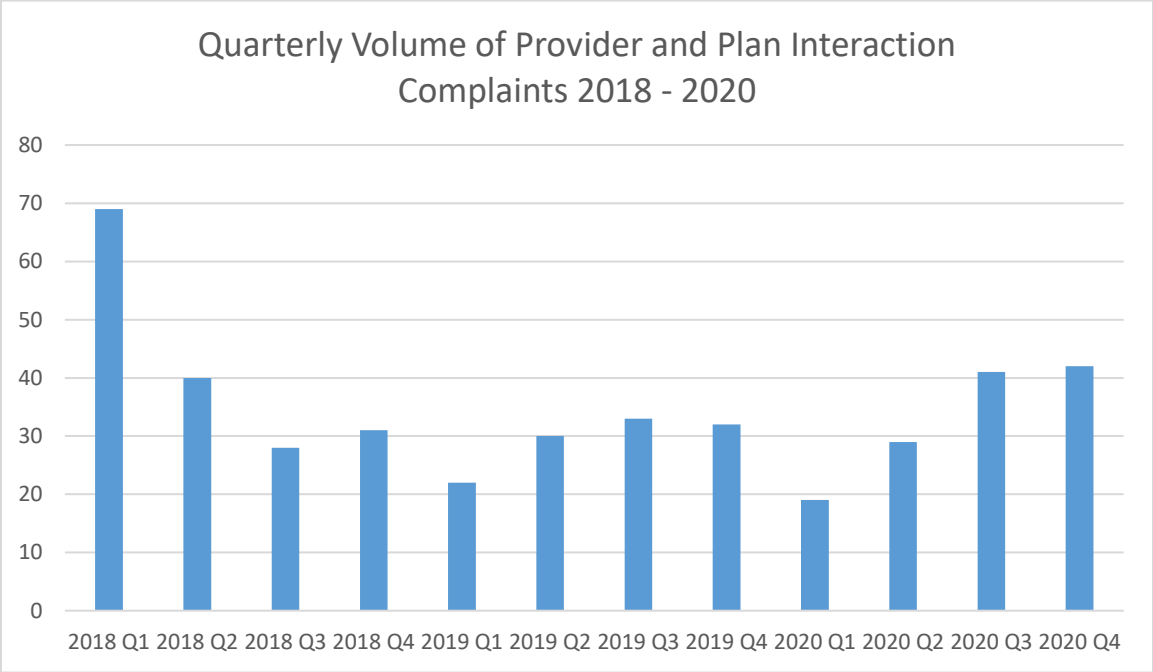
The Grievance System Coordinator assists in the preparation of our Grievance System Report and Exhibit I deliverables to OHA. This information is also presented quarterly to our Interagency Quality Committee, and bi-annually to our Clinical Advisory Panel. Any trends, and special actions taken, are discussed in the quarterly Grievance System Report submitted to OHA. The PCP Assignment Committee is an interdisciplinary team that specifically works on improving access to PCP services for Advanced Health members.

Some effects from the work from these committees are evident in the decrease of our access related complaints. PCP access is an issue affecting all patients in the region, not just Advanced Health members. In fact, we continue to have better access for our members than patients with traditional Medicare or even commercial insurance. In 2017, access complaints decreased by 25% compared to calendar year 2016. Access complaints decreased by a further 46% in 2018 compared to 2017. And the total decreased by an additional 18% from the 2018 total to the 2019 total. The total number of access complaints decreased again in 2020, by 32%, from 2019. However, some part of that decrease is likely driven by the stay home orders and the overall decrease in utilization pattern since the start of the COVID-19 pandemic response.



The Grievance System Coordinator works also with our Provider Relations Specialist to review trends and assist provider offices that are generating a high rate of complaints related to patient-provider interactions. Offices are offered evaluation, coaching, and support to improve their interactions with Members. However, in 2020 this process was limited due to the restrictions imposed by the COVID-19 pandemic response. Meetings with providers and their staff were limited to phone calls or virtual meetings and only for the more extreme cases or trends.

In addition to reduction in access complaints, Advanced Health saw a decrease in complaints related to interaction of members with their providers. Complaints in this category dropped 20% from 2016 to 2017, and another 37% from 2017 to 2018. The total decreased by an additional 30% from 2018 to 2019. However, this category of complaints rose by 11% in 2020. The reduction in regular feedback to providers and their office staff, discussed above, may be contributing to the increase in complaints in this category in Q3 and Q4 of 2020.



As a result of this work, Advanced Health had a complaint rate similar to the statewide average during the second half of 2018 and throughout 2019. Advanced Health will continue to monitor complaint capture and resolution processes to ensure members are able to access the system. Advanced Health will also continue to monitor data for trends and offer feedback and support to delegates, clinics, and individual providers as needed to address member concerns and drive improvements.

The Grievance System Coordinator monitors the details of all complaints twice weekly along with the lead Member Services staff and is working to streamline the process of providing oversight of complaint and resolution information from delegated entities. Complaints and appeals are monitored closely for any issues related to obtaining a second opinion, member billing, consumer rights, health equity, and fraud, waste, and abuse. Any trends and actions taken are discussed in the quarterly Analysis of Grievances report submitted to OHA.

In 2020, the Grievance System Coordinator made many improvements to the Grievance System written notices to members. All letter templates were revised and standardized to eliminate potentially confusing language and improve readability and tone, as well as ensuring all required information was included. All letter templates were approved by OHA by late February 2020. Full implementation of all letter templates was delayed by the initial pandemic response (staff and resource priorities redirected) and the time required to adjust staff to working remotely. All the revised letter templates were fully implemented by Advanced Health and its contractors by the end of Q2 2020.

E. **Brief narrative description**:

As noted above, the trends noted in 2020 complaint and appeal data are driven largely by the COVID-19 pandemic response and the resulting changes we are seeing in the health care system. It is difficult to separate the effect our actions may have from the larger impact of the pandemic. Rates of complaints and appeals will continue to be monitored closely and reported to the Interagency Quality Committee quarterly.

Advanced Health staff will also stratify data in the quarterly report to the Interagency Quality Committee by demographic factors to monitor for potential disparities in access or utilization of the Member Grievance System. In addition to the 2020 baseline analysis of complaint data, a similar analysis will be made for NOABD and Appeal data. Due to the higher rate of complaints by members with one or more disabilities, staff will conduct a focused review of those

complaints. And the complaint process will be reviewed for potential underutilization by members of racial and ethnic minorities.

The revisions to the Grievance System template letters and member communications in 2020 seemed to have a positive effect and the Grievance System Coordinator has received good feedback from members. Advanced Health will continue to make improvements in 2021. Advanced Health's Grievance System Coordinator will be participating in the OHA workgroup convened to make improvements to NOABD and NOAR templates in particular. Consumer members of the Coos and Curry CACs have been asked to review the current NOABD and offer their input for changes that Advanced Health will put forward in the workgroup. The Grievance System Coordinator will continue to monitor the rate of Appeal Requests per 1000 members and report quarterly to the Interagency Quality Committee. Trends will be monitored to see if the revisions help members better understand the process and the reasons for the CCO's decisions.

The Coos County Community Advisory Council is interested in reviewing the Grievance system and related communications more closely and will discuss the process at their January 2021 meeting. We will work to implement recommendations from the CACs.

F. **Activities and monitoring for performance improvement**:

Activity 1 description: Grievance System Coordinator will provide quarterly Grievance System reports to the Interagency Quality Committee. Reports will include both quantitative data from the Grievance System and qualitative data from member feedback and observations about the changes to the Member letter templates after they are implemented. The quarterly report to the Interagency Quality Committee will also include data stratified by demographic characteristics including race and ethnicity, language, and disability.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Quarterly trend reports, including data stratified by demographic characteristics, and results of focused reviews, delivered to Interagency Quality Committee.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Data not stratified by demographic characteristics in 2020 reports	Stratified report for Q1 2021 that includes Q1-Q4 2020 baseline data for comparison	6/2021	4 stratified reports for Q1 – Q4 2021	3/2022
No focused review reports of demographic trends	Focused review report complete for 2020 complaints by members with one or more disabilities	6/2021	Determine need for additional focused review reports based on stratified quarterly data reports	3/2022

Monitoring activity 1 for improvement: Maintain current performance or better on the quarterly rate of member complaints per 1000 member months. (Total number of complaints for the calendar quarter divided by the average monthly enrollment for the quarter times 1000.) This is the complaint rate reported by all CCOs in the quarterly grievance system report.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Current: 4.8 complaints per 1000 members in Q4 2020	<5 grievances per 1000 members	12/2021 (Q4 2021 rate to be reported in 2/2022)	<5 grievances per 1000 members	12/2022 (Q4 2022 rate to be reported in 2/2023)

Monitoring activity 1 for improvement: Monitor Appeal rates per 1000 members for changes.

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
Current: 1.4 Appeal Requests per 1000 members in Q4 2020	<2.5 Appeal Requests per 1000 members	12/2021 (Q4 2021 rate to be reported in 2/2022)	<2.5 Appeal Requests per 1000 members	12/2022 (Q4 2022 rate to be reported in 2/2023)

Activity 2 description: The Grievance System Coordinator will review, revise, and secure OHA approval for all member letter templates for the Grievance and Appeal System. Revision suggestions will be collected from consumer members of the CACs and presented to the NOABD/NOAR workgroup for consideration.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Add text here

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
2020 versions approved by OHA and fully implemented	2021 versions approved by OHA	5/2021	2021 versions fully implemented across systems and contractors	06/2021

Activity 3 description: Present the Grievance System process to CACs for review and discussion, including cultural and linguistic appropriateness of member information available in the Member Handbook and on the Advanced Health website. Review feedback and recommendations and develop a plan for implementation of recommended improvements.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Add text here

Baseline or current state	Target / future state	Target met by (MM/YYYY)	Benchmark / future state	Benchmark met by (MM/YYYY)
No CAC input in 2021	Present grievance system process and member information to CAC	2/2021	Review feedback and develop plan for implementation of improvements	3/2021

A. **Project short title**: Project5: Oral Health Integration for Members with Diabetes

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project or program

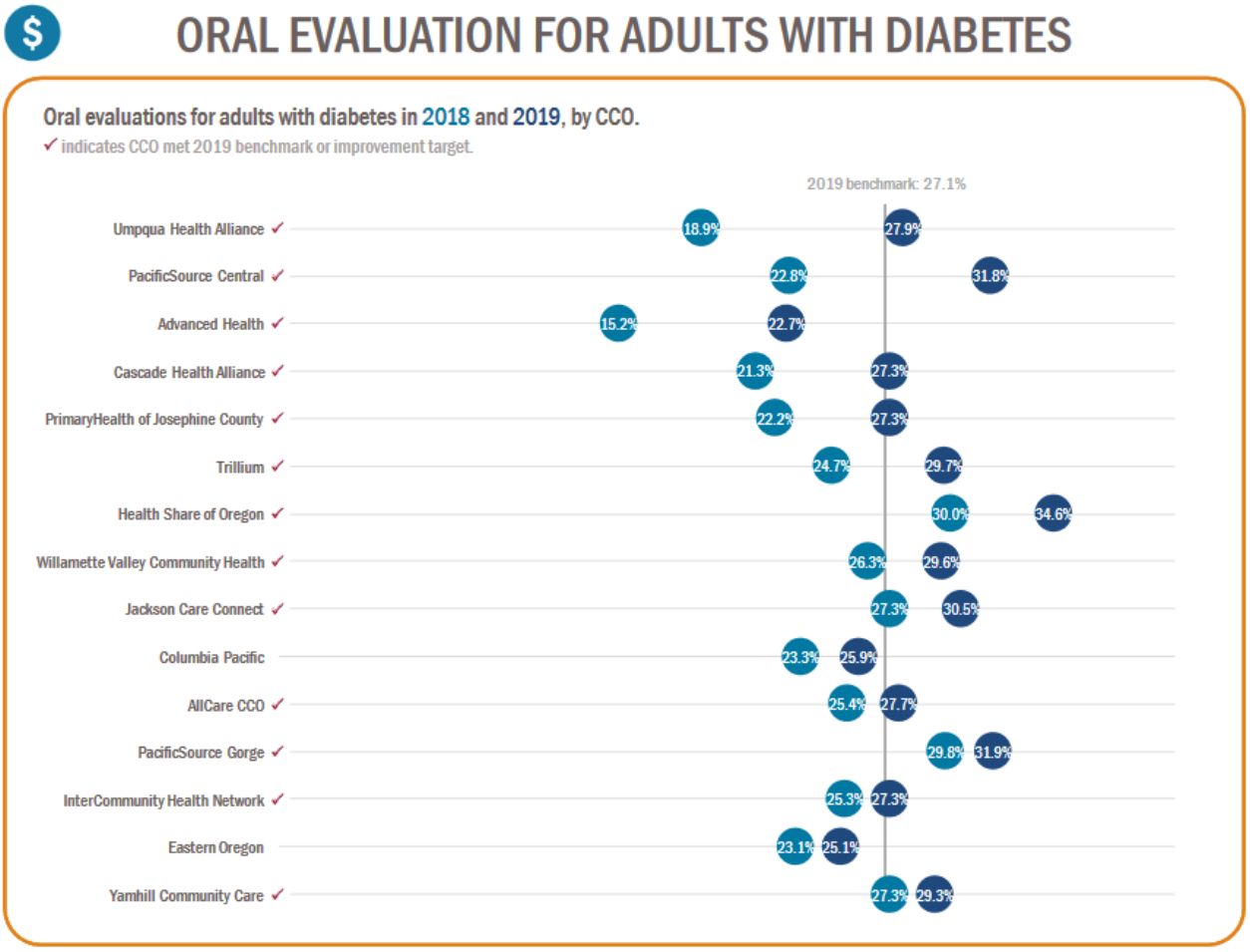
If continued, insert unique project ID from OHA: 43

B. **Components addressed**

i. Component 1: Oral health integration
ii. Component 2 (if applicable): Utilization review
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☐ No
v. If this project addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

Advanced Health continues to have a relatively low rate of oral health assessments for members with a diagnosis of diabetes compared to the Oregon State average for CCOs. The state-wide benchmark for this measure in 2020 is 26.8% and is based on the 2018 CCO 75th percentile. Advanced Health's 2018 rate was 15.2%. Advanced Health's 2019 performance was 22.7%. Although this shows a significant increase of 5.5 percentage points from 2018 performance, it is still below the 2020 state-wide benchmark of 26.8%.



Preliminary data from Advanced Health's internal quality measure dashboard shows 17.1% of members with diabetes received an oral health evaluation in 2020. The most recent data available form the OHA 12 Month Rolling Dashboard for November 2019 through October 2020 shows a rate of 16.7%.

Utilization of services was curtailed in 2020 due to the COVID-19 pandemic response, especially dental services as many dental offices closed to all but emergencies in March 2020. Even after reopening, many physical health and oral health services to were altered to ensure safety of patients and health care workers, including reduced capacity for routine and preventive services and adjusting many services to telehealth.

Advanced Health recognizes there is still room for improvement to ensure appropriate level of service utilization for oral health assessments for members with a diagnosis of diabetes.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

Evidence shows patients with diabetes who have good oral health care have improved HbA1c blood sugar control. In turn, diabetic patients with better controlled HbA1c levels have better outcomes for their oral health care. Periodontal disease outcomes and diabetic health outcomes are linked. To this end, early in 2018 Advanced Health sponsored a collaborative quality improvement project between Advantage Dental and Coos Health and Wellness. It was implemented to make dental assessments more accessible to patients with severe and persistent mental illness (Advanced Health contracts dental services to Advantage Dental and behavioral health services in Coos county to Coos Health and Wellness (CHW)). Through this collaborative project an Advantage Dental advanced practice hygienist provided dental assessments for clients engaged with behavioral health services at CHW. Advantage Dental seeks to provide services to vulnerable populations in a setting which is more comfortable to the patient by increasing participation in screenings and prevention in the community setting. The Advantage Dental risk-based care and medical management strategy, when employed in the community setting, reduces barriers to access, allows for identification of emergent oral health issues and establishes a care coordination pathway for individuals to receive needed care and prevention. The partnership with CHW and Advantage Dental provided an opportunity to serve individuals in the environments in which they are already comfortable, which was critical for the patient population being targeted.

Coos Health and Wellness implemented the Physical Health Integration Team (PHIT) early in 2018 allowing for the integration of physical health services into the behavioral health services setting. PHIT created the ideal structure to support integrating the additional services of an Advantage Dental advanced practice hygienist onto the team and also to include a focus on patients with diabetes, as well as severe and persistent mental illness, to improve their access to comprehensive, integrated, whole-person care.

PHIT aimed to make physical and dental health services more accessible to patients, especially those with serious and persistent mental illness, who may not otherwise be well-engaged with the health care system or who were high utilizers of services. The goal was to meet the patients' immediate care needs in a culturally appropriate and trauma-informed setting, while also working to connect patients to their primary care homes and dental homes as needed. According to the CHW program director, both immediate and long-term feedback received from patients and staff was overwhelmingly positive throughout the program and many targeted patients showed a dramatic improvement in their overall health. CHW's high-risk clients established trusting relationships with the PHIT care team over time. Many of the patients they served would just show up to be seen at CHW, without appointments, on PHIT days and the team would work them in (no one was ever turned away). In addition, although 45 minute appointments were originally allotted to give these patients additional time due to communication challenges arising from complex physical and mental health issues, by the end of the program many did not require 45 minute appointments, often only needing 15-20 minutes due

to the caring communication of the team, the trust relationships the team had developed with the patients, and the continuity and consistent easy access to care. Although PHIT was suspended the end of February 2020 due to lack of funding, because of its overwhelming success and improvement of the participants overall health and quality of life, Coos Health and Wellness is now working on a sustainability plan to implement the PHIT team permanently in 2021. The plan is to hire two full time medical providers and dedicate them two days a week to the PHIT program. By bringing them on full time Coos Health and Wellness can re-structure PHIT as an in-house program which will also allow them to bill for their provider services whereas previously the program depended on a contracted provider from a local clinic whom they paid for services without the ability to bill insurance for reimbursement. Of note, while CHW works to restructure PHIT, the Advantage Dental advanced practice hygienist will continue to see patients at CHW for a minimum of two days a month and once a week during the summer months, to continue providing much-needed care to an underserved and at-risk population which includes those with a diabetes diagnosis as well. The Advantage Dental expanded practice dental hygienist is able to help patients in need of further dental services get connected with their primary dental care home and Advantage Dental case management services as needed.

Starting in January 2019 Advanced Health created gap list for Advantage Dental with members with diabetes who needed to be seen by their dental providers. Advanced Health sent this monthly gap lists to Advantage Dental from January 2019 through June of 2019. Starting in November of 2019 Advanced Health began resending the diabetic member monthly gap list to Advantage Dental with the agreement to continue to do so indefinitely. The gap in list distribution was due to staff transitions. During this time Advantage Dental developed a proactive workflow where they used the gap list to schedule diabetic members as soon as possible and tracked the members appointments to ensure they were kept or rescheduled if needed.

In September 2019 Advanced Health, added an oral health indicator to the primary care provider member-level diabetic A1C gap lists. This indicator identified if the member had received an oral health exam in the calendar year. This indicator was identified as high value as a point of care outreach and referral guide by the Interagency Quality Committee.

The COVID-19 pandemic negatively impacted progress on this oral health integration TQS project in 2020. Advantage Dental had a significant decrease in access to and utilization of oral health care for CCO members in Coos and Curry County. Primary care providers directed resources to the frontlines of patient care with providing emergent and telehealth services. Work and progress on the Oral Health transformation strategy was re-prioritized to 2021.

E. **Brief narrative description**:

Advanced Health will continue to work with Advantage Dental, the primary care provider network, and behavioral health providers to create pathways for better information sharing, care coordination and integration for shared patients with diabetes. This means that both PCP clinics and Advantage Dental will receive reports and gaps lists of diabetic members in need of dental appointments. PCP clinics will work directly with Advantage Dental Care Coordinators, who can be reached by calling a single number, to schedule patients in real time during their PCP visits. With the more complete dental visit information available to PCP offices, they will be able to more effectively coordinate appointments such as diabetic oral health exams, annual checkups and cleanings, urgent dental needs, and sealants for pediatric patients. The Interagency Quality Committee will work together to develop both a process for scheduling members identified as needing appointments with their dental providers and clinic specific processes for working the gap lists.

The original plan prior to COVID-19 was for Advanced Health to be responsible for sending member gap lists out monthly starting in mid-March 2020 once initial 2020 claims data becomes available. The initial goal was to have new processes in place by April 2020 and for all participating clinics to be able to meet the upcoming new Patient Centered Primary

Care Home Oral Health Services Standards 3.F.1 and 3.F.2 before the end of 2020. This project timeline has been moved to 2021 to decrease the burden on the provider network which is still managing the COVID-19 pandemic response.

In addition, Advanced Health will also continue to work with Advantage Dental and local dental providers to offer education to local primary care providers on the benefits of regular oral health evaluations to patients with chronic diseases, especially diabetes. We will also continue to explore additional opportunities to integrate care, especially for vulnerable populations such as those with serious and persistent mental illness. Advanced Health will continue to analyze available data and monitor throughout the course of the performance improvement projects for potential health disparities which need to be addressed through additional or modified interventions.

F. **Activities and monitoring for performance improvement**:

Activity 1 description (continue repeating until all activities included): Create, validate and disseminate reports and educational materials as requested by the Interagency Quality Committee

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Create, validate and disseminate reports and educational materials as requested by the Interagency Quality Committee. Monitor performance on the Oral Evaluations for Adults with Diabetes quality measure with a goal of returning to 2019 performance in CY 2021.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Oral Evaluation status provided to PCPs for members also meeting denominator criteria for A1c Poor Control quality measure	Provide Oral Evaluation status to PCPs for all members meeting the denominator criteria of the Oral Health Evaluations quality measure	04/2021		
No or little patient education materials related to oral health available in PCP settings.	Standardized, targeted patient education materials related to oral health available in PCP settings	08/2021		
22.7% of adults with diabetes receiving an oral evaluation (2019 performance)	24.7%	CY 2020 (final report available 6/2021) Not met due to pandemic-related drop in utilization and availability of services in 2020	22.7%	CY 2021 performance (reported in 06/2022)

A. **Project short title**: Project 6: Community Collaborative – Initiation and Engagement in Alcohol or Other Drug Treatment

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project or program

If continued, insert unique project ID from OHA: 44

B. **Components addressed**

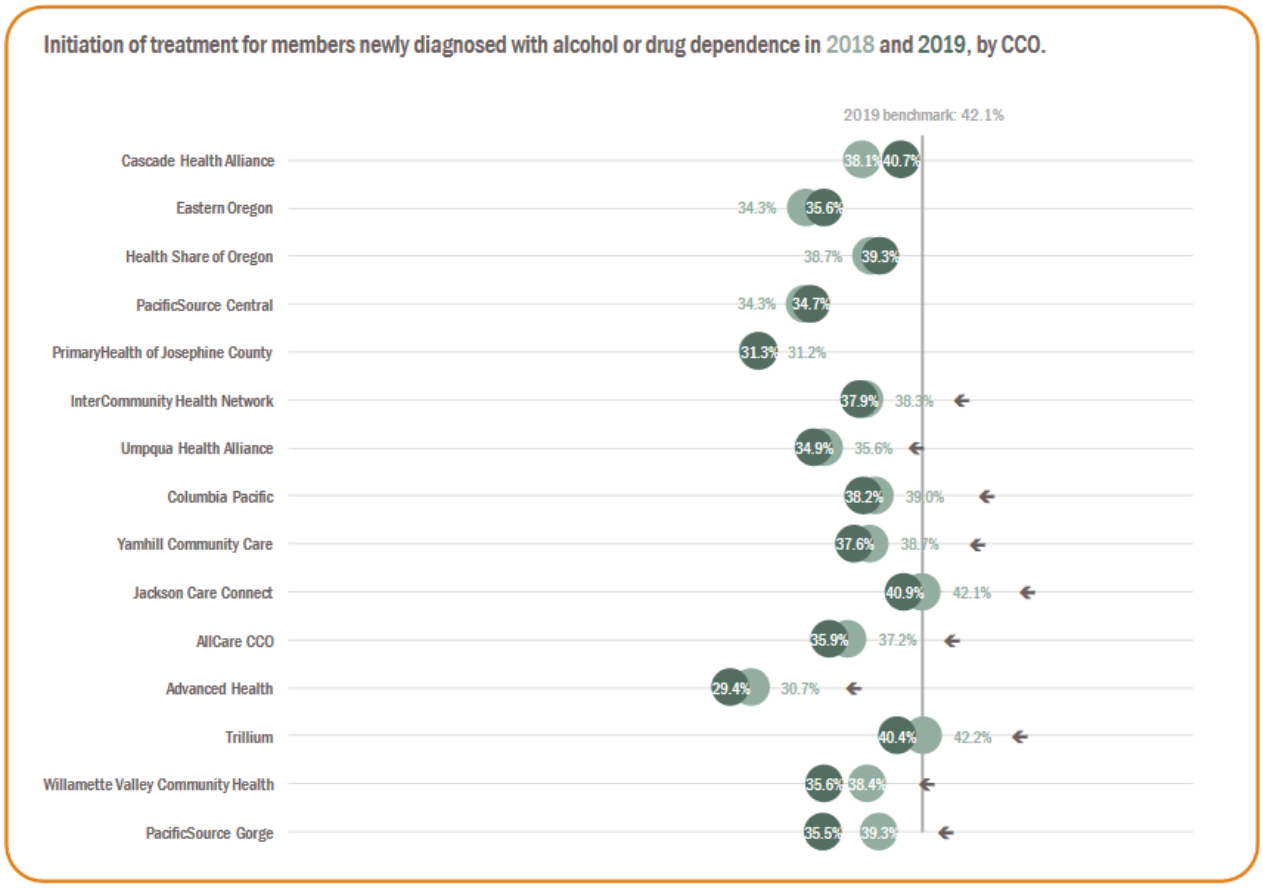
i. Component 1: Access: Timely
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☐ No
v. If this project addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

Initiation and Engagement of Alcohol or Other Drug Treatment was a new Coordinated Care Organization Quality Incentive Measure in 2020 that is comprised of two components ensuring access to care for initiating and engaging in treatment. Historically, Advanced Health has had a low performance rate compared to statewide performance:

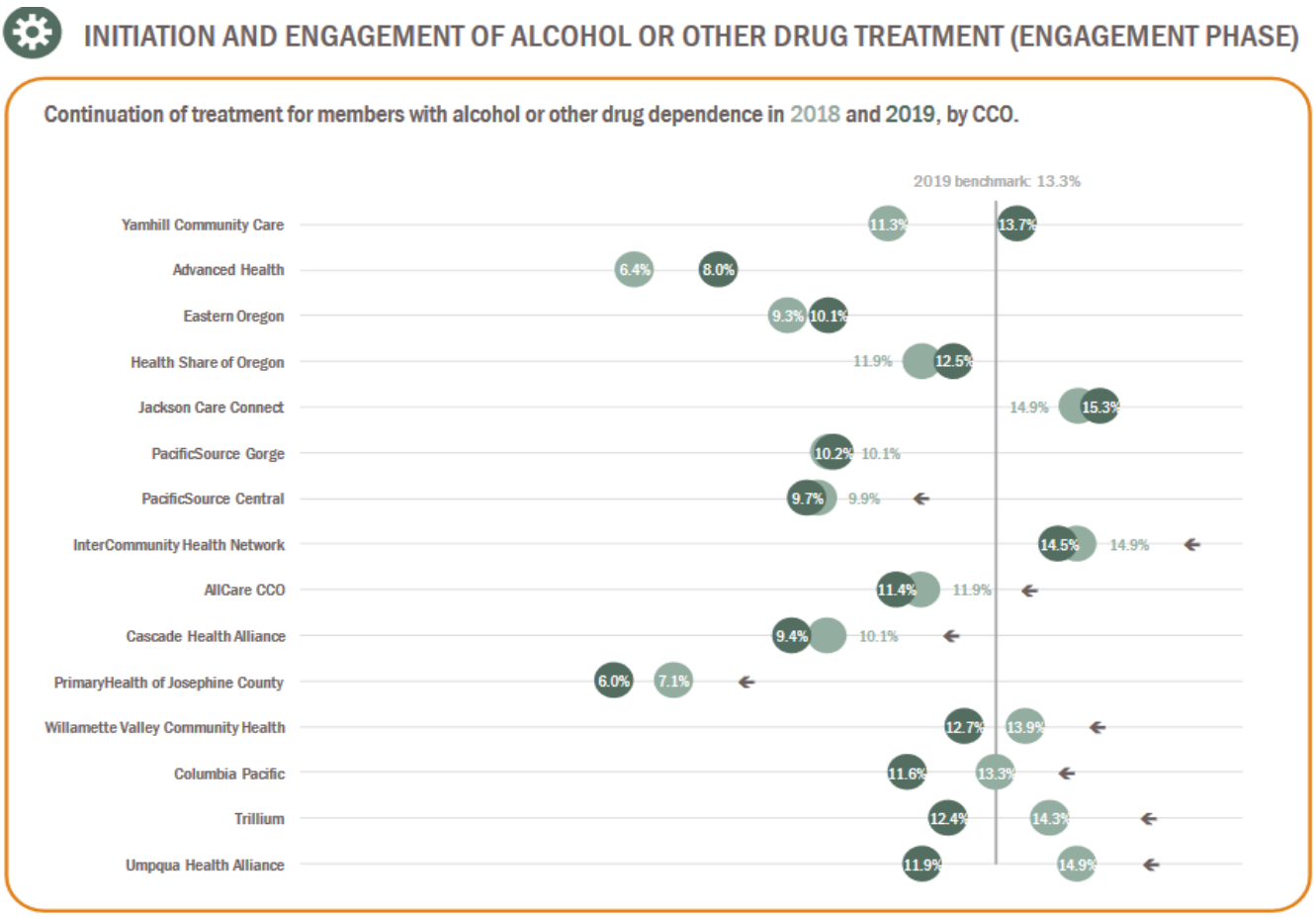
Initiation: The statewide benchmark for initiation in 2018 was 40.7% with a state average performance at 37.8%. In 2019 the statewide benchmark for Initiation increased to 42.1% and Advanced Health's performance decreased to 29.4% from 30.7% in 2018. The results from the 2019 CCO Quality Measures report is included below.

INITIATION AND ENGAGEMENT OF ALCOHOL OR OTHER DRUG TREATMENT (INITIATION PHASE)



In 2020, the benchmark for initiation of SUD treatment was 46.8%. Advanced Health's 2020 improvement target was 31.1%. Preliminary data from the OHA 12 Month Rolling Dashboard report for the period from November 2019 through October 2020 shows an improvement to 35.8% in Advanced Health's rate of initiation of SUD treatment from 29.4% in 2019. Considering the decrease in utilization of all types of services in 2020 due to the COVID-19 pandemic response and protective orders, this increase in performance is a welcome change from negative performance changes observed on so many other access and utilization of services quality measures across the health care system.

Engagement: The statewide benchmark for engagement in 2018 was 12.4% with a statewide average performance at 13.1%. In 2019 the statewide benchmark for engagement increased to 13.3% and Advanced Health's performance improved to 8.0% from 6.4% in 2018. The results from the 2019 CCO Quality Measures report is included below.



In 2020, the benchmark for engagement in SUD treatment was 18.5%. Advanced Health's 2020 improvement target was 9.0%. Preliminary data from the OHA 12 Month Rolling Dashboard report for the period from November 2019 through October 2020 shows a decrease to 6.8% in Advanced Health's rate of initiation of SUD treatment from 8.0% in 2019. The Advanced Health network and health care systems across the state and the nation have experienced a decrease in utilization of all types of services in 2020 due to the COVID-19 pandemic response and protective orders.

The 2020 performance improvement for initiation of SUD treatment indicates an improvement in timeliness of care received by Members newly diagnosed with a substance use disorder. However, the decrease in the rate of engagement is a concern. Although the decrease may be part of the wider decrease in utilization and access to services that we observed as a result of the public health measures taken to respond to the COVID-19 pandemic, Advanced Health and the Interagency Quality Committee are committed to increasing performance in 2021.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

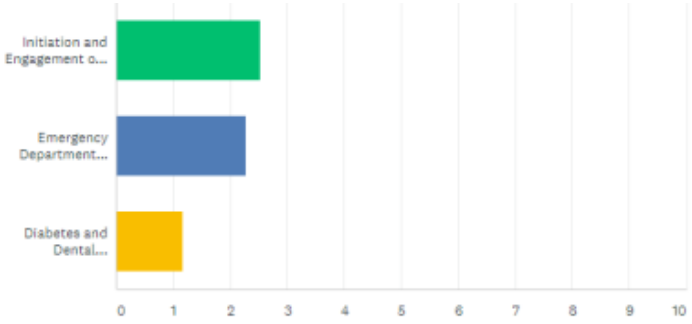
Advanced Health's low performance rate for the Initiation and Engagement in Alcohol and Other Drug Treatment quality measure has been an ongoing concern for the Advanced Health Interagency Quality Committee. The Interagency Quality Committee includes representatives from Behavioral Health, Non-Emergent Medical Transportation, Oral Health, Physical Health (Adult and Pediatric), and Substance Use Treatment. All the physical health members also represent Patient Center Primary Care Homes (PCPCH).

The point of concern identified by the Interagency Quality Committee around timeliness regarding Initiation and Engagement in Alcohol and Drug Treatment (IET) was due to low performance despite all the work that had been done

in the community around community-wide opioid prescribing, SBIRT screenings implemented in primary care homes in 2015, and Adapt (and Advanced Health contracted SUD treatment provider) opening the doors to their new "Fresh Start" day treatment and supportive housing facility in March of 2017. According to Adapt's 2018 Annual Report, 424 patients were treated within their MAT Opioid Treatment Program alone in 2018.

While discussing Initiation and Engagement to Alcohol and Drug Treatment metric requirements for 2020, the Interagency Quality Committee highlighted barriers among the provider network system to include incentive quality metric specification complexity, workflow training complexity to providers and staff, lack of structured referral pathway system, gaps in care due to referral loop closure pathways and lack of understanding around the additional documentation required for privacy requirements related to substance use treatment (42 CFR requirements). Another barrier identified is the inability for the CCO to provide proactive data to support work being done at point of care due to the reactive process of relying on claims data to identify the triggering events. By the time the claim passes into the system for reporting, the opportunity for taking timely action has already passed. The Interagency Quality Committee recognized that due to the complexity of the metric, Advanced Health was unlikely to achieve improvement targets if work remained isolated within individual provider organizations.

Advanced Health offered to sponsor a lean training Kaizen event and asked the Interagency Quality Committee to direct the focus of the training. After multiple meetings with discussion around workplan focus, the Interagency Quality Committee identified three potential areas of collaborative work: 1) ED Utilization/ ED Navigator/ Community Education, 2) Diabetic Oral Health- a community workflow, or 3) Initiation and Engagement of Alcohol or Other Drug Treatment – a community workflow. The Interagency Quality Committee then voted anonymously via Survey Monkey and ranked their preference for the lean training event project focus.



	1	2	3	TOTAL	SCORE
Initiation and Engagement of alcohol or other drug treatment-Community Workflow	58.82% 10	35.29% 6	5.88% 1	17	2.53
Emergency Department Navigator and Community Education around ED Utilization	35.29% 6	58.82% 10	5.88% 1	17	2.29
Diabetes and Dental Care-Community Workflow	5.88% 1	5.88% 1	88.24% 15	17	1.18

The Interagency Quality Committee voted to concentrate group efforts towards a LEAN training/Kaizen event focused on the 2020 quality incentive measure, Initiation and Engagement of Alcohol and Other Drug Treatment. The committee

deemed the work to be aligned with Patient Centered Primary Care Home (PCPCH) 5 Star designation requirements related to coordination of care and cooperation with community service providers.

Alongside Patient Centered Care Homes, this work also aligns with the priorities identified in the Advanced Health Community Health Improvement Plan, approved by the Community Advisory Council, by supporting individual prevention services and improving access to integrated services and delivery of addiction services as priority areas.

This project aims to improve timely access to alcohol and substance use treatment for all members with special health care needs by meeting the incentive metric specification timeliness requirements as follows:

- Ensure members receive an initial visit within 14 days of their initial diagnosis (index episode) of an alcohol or substance use disorder
- Ensuring members also receive at least two engagement episodes of care within 34 days of the initial visit.

Project work also aligns with the Patient Centered Primary Care Home Model (PCPCH) to support the quality of care being provided to the member and support the providers in achieving and/or maintaining the advanced PCPCH 5 Star designation requirements with the following guidelines:

- 3.C.2 Referral Process or Colocation with Mental Health, Substance Abuse or Developmental Providers (PCPCH has a cooperative referral process with specialty mental health, substance abuse, and developmental providers including a mechanism for co-management as needed or is co-located with specialty mental health, substance abuse, and developmental providers)
- 5.C.2 Coordination of Care (PCPCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs, as well as coordinated care efforts)
- 5.E.3 Cooperation with Community Service Providers (PCPCH tracks referrals and cooperates with community service providers outside the PCPCH, such as dental, educational, social service, foster care, public health, non-traditional health workers and pharmacy services)

The Interagency Quality Committee's vote supported a project that would create a Coos and Curry County provider infrastructure to mitigate gaps in care in a proactive manner and improve the coordination of care within the health system by engaging the leaders driving the workflow process. The committee sought a collaborative approach and identified a 4-day Kaizen event as the ideal method. A Kaizen Event is defined as a focused improvement activity in which a cross -functional team designs and fully implements improvements to the defined process or project focus, in turn generating rapid results and a learned behavior. The training was intended to be facilitated in the spring of 2020, but due to the COVID-19 pandemic was put on a temporary reschedule hold for the fall of 2020. The fall training was also postponed to the fall of 2021 due to key stakeholders undergoing a community-based Electronic Health Record implementation and continued safety precautions and travel restrictions as a result of the COVID-19 pandemic. The training will focus on improving the Initiation and Engagement in Alcohol or Other Drug Treatment quality measure by bringing 20 community stakeholders together in order to learn Lean process improvement tools, a common language around process improvement, and build a standardized community workplan. By taking an upstream approach at the provider system level, the community stakeholders will ensure that members with special health care needs related to alcohol and substance use disorder will receive appropriate, timely, coordinated and integrated services for the care they require.

E. **Brief narrative description**:

The lean training Kaizen event to kick off this project was scheduled for April 2020. Due to the negative impact of the COVID-19 pandemic and restrictions around in-person training, the project was put on hold. Advanced Health

Interagency Quality Committee decided against a virtual training event, preferring to wait until the group could gather again in person. The current plan is to reschedule the Kaizen training event in the fall of 2021. At that time Advanced Health and the Interagency Quality Committee will develop an integrated action plan to improve timely access to and integration of substance use disorder treatment. The action plan will be developed by a cross-functional team and will integrate improvements across multiple sectors of the community health care delivery network, including substance use treatment, integrated behavioral health, primary care, intensive care coordination, primary care case management, outpatient SUD treatment and peer support, and transitional housing.

A reporting stratification process will be developed to monitor the index episodes, episodes of initiation, episodes of engagement at the patient level, per vendor and per provider. This information will be reviewed and monitored by the Interagency Quality Committee, as well as the Advanced Health's Quality Department and distributed among CCO contracted partners who play a critical role in the community collaborative.

F. **Activities and monitoring for performance improvement**:

Activity 1 description (continue repeating until all activities included): Facilitate community Kaizen training event with 20 participants from provider network organizations including representatives from substance use treatment, integrate behavioral health, primary care, intensive care coordination, primary care case management, outpatient SUD treatment, peer support, and transitional housing.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Community Kaizen training event

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Training event not complete	20 participants trained	11/2021		

Activity 2 description: Develop integrated community workplan to improve the referral pathway to alcohol and substance use treatment, including primary care integrated behavioral health involvement to improve the rate of referral completion.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: Develop, test, and implement integrated community work plan, including setting performance improvement targets.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No workplan for structured referral system in place	Community workplan developed	11/2021	Structured community referral system developed and ready for testing.	01/2022
No standardized community referral system in place	Referral system pilot	02/2022	Adoption/implementation of referral system across community provider network	12/2022

No baseline for rate of referrals completed	Establish baseline rate of referrals completed	02/2022	Set improvement targets for rate of referral completion	4/2022

Activity 3 description: Develop data monitoring dashboard from CCO claims data that can be shared with community partners during the developmental, test, and implementation phases of the workplan

☐ Short term or ☒ Long term

Monitoring activity 3 for improvement: Development of claims-based data dashboard to be used for ongoing monitoring of the Initiation and Engagement for Alcohol or Substance Use Treatment performance rate.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No dashboard developed	Develop dashboard for performance monitoring	11/2021.	Dashboard monitored and distributed monthly	01/2022
29.4% Initiation rate 8% Engagement rate Baseline is based on CY 2019 final data reported in 06/2020	2021 improvement target: Component 1, Initiation 31.1% Component 2, Engagement 9.0%	12/2021 Report available 6/2022	2022 Target TBD	6/2022
Data not monitored monthly by Quality Committee	Review dashboard data at Quality Committee	01/2022	Monitor dashboard monthly at Quality Committee for testing period (6 months)	7/2022

A. **Project short title:** Project 7: Improve Language Services Access

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project or program

If continued, insert unique project ID from OHA: 45

B. **Components addressed**

i. Component 1: CLAS standards
ii. Component 2 (if applicable): Access: Cultural considerations
iii. Component 3 (if applicable): Health equity: Cultural responsiveness
iv. Does this include aspects of health information technology? ☐ Yes ☐ No
v. If this project addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

vi. If this project addresses CLAS standards, which standard does it primarily address? 7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided

C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

In 2020, Advanced Health's Board of Directors adopted the following definition of Health Equity, developed by the Health Equity Committee of OHA's Office of Equity and Inclusion, and adopted by the Oregon Health Policy Board and the OHA:

> *Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances.*
>
> *Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments to address:*
>
> - *The equitable distribution or redistribution of resources and power; and*
> - *Recognizing, reconciling and rectifying historical and contemporary injustices.*

The board of directors adopted this definition to make clear Advanced Health's commitment to health equity and its intent to take action to promote health equity for Advanced Health Members and all community members in Coos and Curry Counties. The board of directors has charged Advanced Health to use this definition as a cornerstone for developing and operationalizing this organization-wide Health Equity Plan.

The adopted definition of Health Equity was distributed to committees and staff, including the Community Advisory Council (CAC) and the Health Equity Steering Committee. Both committees had in depth conversations about their interpretations of the definition and how the adoption of this definition by Advanced Health's board of directors would empower the work throughout Advanced Health staff and committees of advancing health equity. The Health Equity definition was shared on the internal electronic bulletin board for all staff to access and it has also been shared with staff during internal staff assessments. This definition has been presented to Advanced Health's other advisory committees to the board, the Clinical Advisory Panel and Interagency Quality Committee for review, discussion, and integration into their work.

Spanish is the prevalent non-English language spoken by Advanced Health Members, with 1.2%, or about 280 Members, indicating that their primary language is Spanish. While some language data is unavailable (marked as "undetermined," "other," or "declined to answer") it is not nearly as big a gap in the data as the race and ethnicity data. At least 43 more Advanced Health Members primarily speak a language other than Spanish or English. Advanced Health employs two Spanish language OHA Qualified Health Care Interpreters.

Advanced Health's provider network consists of virtually all local providers. As of July 2020, and as reported in the Advanced Health Delivery System Network Narrative Report, we monitor and report on providers' languages. Within Advanced Health's PCP network, there are multiple bilingual providers: Spanish (6); Hindi (2); Taiwanese (2); Mandarin (1); and Nepali (1). Within the mental health and addiction treatment system, there providers who speak the following non-English languages: Spanish (3), Russian (3), Lakota (2), Japanese (1), Hindi (1), Romanian (1), French (1), and Arabic (1). There is also a mental health provider who is fluent in American Sign Language. Within the oral health provider network, there are four providers who speak Spanish and one provider fluent in American Sign Language. One of the oral health providers who speaks Spanish and the provider fluent in ASL are both available to attend appointments in

multiple Advantage Dental clinic locations within the Advanced Health service area. This information is collected at the time of provider credentialing and recredentialing and is available to Members through the Advanced Health provider directory on our website or available in print, at no cost, upon request.

The Interagency Quality Committee took up the review and monitoring of the quarterly language interpreter services report in 2020. The Interagency Quality Committee includes representatives from organizations representing physical health, behavioral health, oral health, and non-emergency medical transportation services. This group reviewed data collection processes as well as clinic workflows and processes for identifying and offering services to patients with limited English proficiency. The committee identified gaps in how interpreter services are provided to members across the network. Every primary care organization follows Patient-Centered-Primary-Care Home standards regarding language access by providing access to language interpreter services unique to each organization. The Hospital provider and Substance Use provider also used language access lines as well as iPads with video translation. Many of the providers placed responsibility for requesting the language services on the Member. Although there were a few organizations which had bilingual providers that automatically scheduled Members identified with language needs with those providers, the majority of the providers had manual and ineffective methods of identifying Members with language access needs. It was not well-known within the community that Advanced Health had two OHA Qualified Medical Interpreters. Each organization relied on their language line or internally employed bilingual staff and providers to be available at the time of the service.

In addition to the assessment and direction from the Interagency Quality Committee, staff feedback from the organizational health equity self-assessment conducted in 2020 also indicated that while having two Qualified Health Care Interpreters on staff and available to provide in-person interpretation services for Members is a strength of the organization, access to and utilization of language interpretation services is still a concern.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

One of the ways Advanced Health is working to operationalize the health equity definition is in the review and improvement of language services offered to and used by Advanced Health members with limited English proficiency. Improving the quality and utilization of language services will empower members with limited English proficiency to fully access the health care services available to them to improve and maintain their health.

In late 2019, Advanced Health participated in a pilot of the proposed Health Equity quality measure with OHA Analytics and the Office of Equity and Inclusion, along with a number of other CCOs. The purpose of the pilot was to test the specifications of the proposed language services access quality measure and assess CCOs' capability to report the data elements required for the measure and the quarterly reporting required in the 2020 contract. Advanced Health, like most other participating CCOs struggled to combine the disparate and fragmented data sources that were available and identified other gaps where data was not available at all. Ultimately, Advanced Health was unsatisfied with the report generated during the pilot and has determined that action is needed to improve both access to and utilization of interpreter services as well as data collection and reporting capabilities.

In 2020, Advanced Health planned to form a cross-functional Language Services Action Team, including staff from quality improvement, compliance, member services, analytics, certified health care interpreters, and executive leadership to develop and guide an improvement work plan. The group met in February 2020 for a kickoff meeting to review the results of Advanced Health's 2020 Language Services Self-Assessment and the results of the 2019 language access services quality measure pilot. With the onset of the COVID-19 pandemic and the resulting public health emergency response, staff time and resources were redirected. Resources focused on maintaining core operations and services as staff quickly shifted to working remotely. Customer service staff and the qualified health care interpreters shifted their

priorities to assisting with the pandemic response by providing information to members and the community about the rapidly changing situation, including how to access health care services for routine, urgent, and emergency care as well as COVID-19 testing and safety precautions. The qualified health care interpreters on Advanced Health's staff were key members of the local pandemic response, staffing the Spanish language COVID-19 information line and offering interpretation services for telehealth visits. The Language Services Action Team did not meet again in 2020 in its original form.

The Interagency Quality Committee took up the review and monitoring of the quarterly language interpreter services report in 2020. The Interagency Quality Committee includes representatives from organizations representing physical health, behavioral health, oral health, and non-emergency medical transportation services. This group reviewed data collection processes as well as clinic workflows and processes for identifying and offering services to patients with limited English proficiency. Advanced Health quality and analytics staff worked to implement several recommendations to improve data collection, reporting, and patient identification. A Tableau dashboard was implemented in 2020 to improve identification of members requiring interpreter services. The dashboard is used by Advanced Health quality staff to give feedback and reports to provider organizations on the need for interpreter services and where members with limited English proficiency are accessing health care services.

In 2020, as part of the process of routine provider network auditing, Advanced Health added elements to its survey and attestation tools to assess compliance with CLAS standards. The following elements were added to assess provider network implementation of CLAS standards 5-8:

- Patient forms are available for persons with limited English proficiency and in preferred alternate formats. (Example: sixth grade reading level, large print, preferred reading language or available staff to assist with completing forms).
- Patients are informed of available language assistance services in their preferred language, verbally and in writing, and are provided at no cost.
- Certified language interpreters are used.

Preliminary results of the survey, as well as data available from the 2020 quarterly language access reports indicates that not all providers are using OHA qualified or certified health care interpreters. Advanced Health plans to focus on improving access to health care services for members with limited English proficiency by increasing availability of high-quality in-person certified health care interpreter services.

Advanced Health provides a language line service to members and the provider network. This language line service is currently under review (by an internal team and IT) to ensure the offered services are being fully utilized and that appropriate staff are trained on how to use the telephonic and video services. To be HIPAA compliant, Language Line doesn't collect any identifiable information during the calls, so we get very little data collection when using the Language Line services. It makes sense that this is the process, but of course, is presents a challenge when we are trying to report on language access service utilization.

E. **Brief narrative description**:

In 2021 Advanced Health will develop a comprehensive language access work plan to incorporate recommendations for improvement from the Interagency Quality Committee, the Clinical Advisory Panel, the Coos and Curry Community Advisory Councils, especially consumer CAC members, and other community partners. Some of those planned activities are outlined below. The workplan will include both short-term and long-term activities and will align requirements and goals from this Transformation and Quality Strategy, the Health Equity Plan, and the new health equity CCO quality incentive measure.

A key goal from Advanced Health's 2020 Health Equity plan is to increase access to health care interpreters by increasing the number of OHA qualified and certified interpreters available locally for in-person, telephonic, and virtual language assistance. This goal is informed by recommendations from staff, the Interagency Quality Committee, and the Clinical Advisory Panel. It is also aligned with CLAS Enhanced National Standard number seven, "Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided." When training opportunities are identified, Advanced Health will offer scholarships to local individuals interested in becoming an OHA qualified or certified health care interpreter and offering services to Advanced Health members and the community. In 2021, Advanced Health staff will also explore the feasibility of developing a local health care interpreter training program in partnership with local community-based organizations, local workforce development initiatives, and under the guidance of OHA.

Advanced Health's newly formed Member Information Committee will work to improve culturally and linguistically appropriate communication and information available to members. One area of improvement slated for 2021 is the addition of a member-facing page on the website to inform members about the language access services available to them at no cost, how to access those services, and of best practices for high quality language services, including use of qualified or certified interpreters.

A provider-facing web page will also be deployed in 2021 with information about regulatory and contractual compliance related to language services, as well as Advanced Health's policies and procedures for language access and interpreter services, and best practices to ensure high quality services are delivered to patients with limited English proficiency. The member and provider webpages will also include informational videos in addition to the written information.

Advanced Health's quality staff will continue to work with the Interagency Quality Committee and the analytics team to improve data collection and reporting processes for the quarterly language interpreter services reports. The results of the quarterly reports will be monitored by the Quality Committee and will be presented to the Community Advisory Councils.

F. **Activities and monitoring for performance improvement**:

Activity 1 description: Review progress from 2020 language access services self-assessment to 2021 assessment and develop work plan to address gaps in services. The work plan will incorporate goals and priorities based on the recommendations and input from stakeholders as described above.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Develop comprehensive language access services work plan.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Workplan not complete	Draft prepared for review by stakeholders	4/2021	Workplan complete, incorporating feedback and recommendations from stakeholders	7/2021

Monitoring activity 1 for improvement: Monitor progress toward meeting improving utilization of high-quality language access services and toward meeting the requirements of the CCO quality incentive measure.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
TBD % of LEP Members receiving interpreter services at health care encounters. (Aggregate 2020 Q1-Q4 data from quarterly interpreter services reports. Report available by 3/31/2021.)	10% improvement from baseline	12/2021 (Aggregate 2021 Q1-Q4 data from quarterly interpreter services reports. Report available by 3/2022)	10% improvement from 2021 rate	12/2022

Activity 2 description: Advanced Health staff will also explore the feasibility of developing a local health care interpreter training program in partnership with local community-based organizations, local workforce development initiatives, and under the guidance of OHA. Further actions for program development will hinge on the feasibility evaluation.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Reach out to community partners and OHA to gather information on program requirements and assess interest and capacity of community partners. Work collaboratively with community partners to evaluate options for program development.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No decision	Reach out to OHA and community partners to begin discussion of program requirements and feasibility.	3/2021	Work collaboratively with community partners to evaluate options and decide whether to go forward with developing a local health care interpreter training program.	6/2021

Activity 3 description: Member Information Committee and Provider Services staff will gather existing materials and develop new materials where needed to communicate to both members and providers about language access services. Information will include written materials, and potentially videos as well, and will be posted on the Advanced Health website. Provider Services staff will train providers and their staff on how to access the resources and best practices.

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement: Develop and launch a member-facing resource webpage with information about the language access services available to them at no cost, how to access those services, and of best practices for high quality language services, including use of qualified or certified interpreters.

No member resource webpage for language services	Develop member webpage and present to CAC and Interagency Quality Committee to review content and make recommendations for improvement.	7/2021	Revise member resource webpage based on CAC member and Quality Committee feedback.	9/2021

Monitoring activity 3 for improvement: Develop and launch a provider-facing resource webpage with information about the language access services available to members at no cost to them, regulatory and contractual compliance related to language services, as well as Advanced Health's policies and procedures for language access and interpreter services, and best practices to ensure high quality services are delivered to patients with limited English proficiency.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No provider resource webpage for language services	Develop provider webpage and present to CAP and Interagency Quality Committee to review content and make recommendations for improvement	7/2021	Revise provider resource webpage based on CAP and Quality Committee feedback	9/2021

A. **Project short title**: Project 8: Roadmap to Improved Behavioral Health Access and Integration

Continued or slightly modified from prior TQS? ☒Yes ☐No, this is a new project or program

If continued, insert unique project ID from OHA: 46

B. **Components addressed**

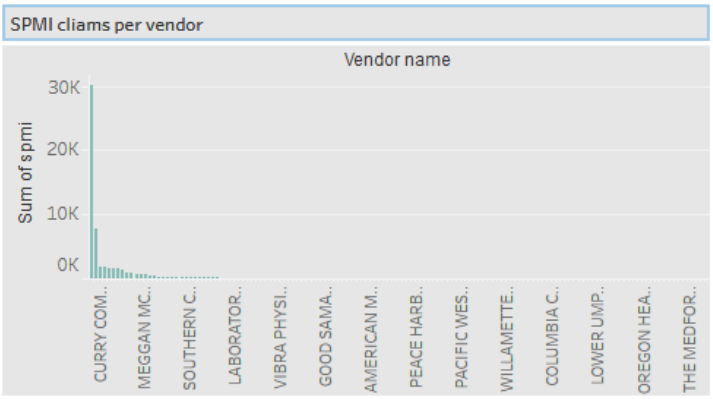
i. Component 1: Serious and persistent mental illness
ii. Component 2 (if applicable): Access: Quality and adequacy of services
iii. Component 3 (if applicable): Behavioral health integration
iv. Does this include aspects of health information technology? ☐ Yes ☐ No
v. If this project addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

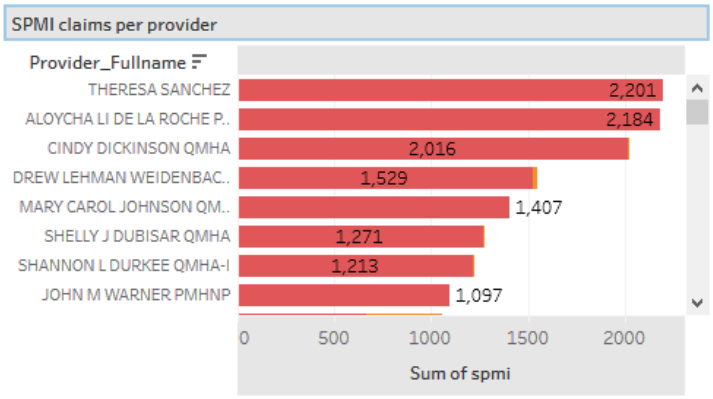
C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

Advanced Health currently contracts with 110 individual behavioral health providers and 62 substance abuse providers. Advanced Health continues to accept applications to enter the network from providers meeting the qualifications with plans to expand by 10% with the addition of youth resources. Integrated behavioral health has been contracted in 5

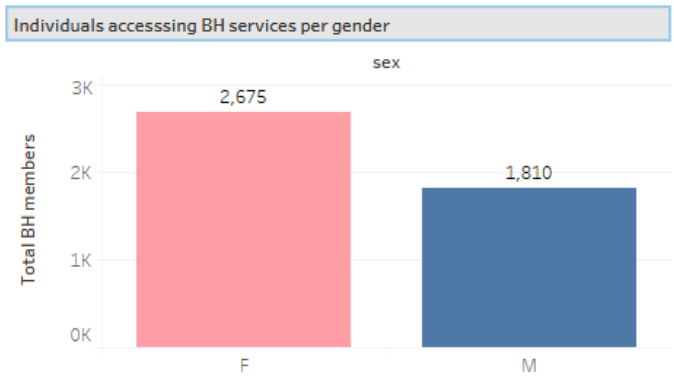
clinics, allowing members and PCP's quick access to mental health consults. In 2020, Advanced Health members had been seen by an integrated behavioral specialist 10,800 times. Integrated behavioral specialists are trained in referrals to specialty programs once a member has been identified as needing additional behavioral health or substance abuse services. Expansion into Applied Behavioral Analysis has already begun through partnership with our FQHC, Waterfall Clinic, with a start date of May 1, 2021. Advanced Health contracted with Coos Health and Wellness for Intensive In-Home Behavioral Health (IIBHT) services set to start taking their first clients April 1, 2021.

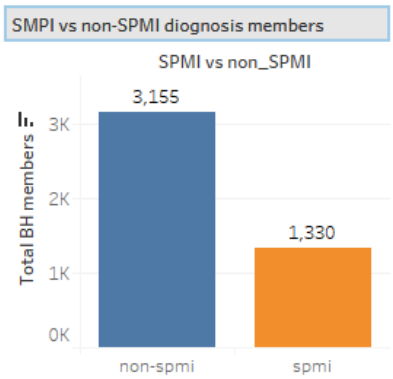
Advanced Health began directly managing the claims for behavioral health in 2020. Advanced Health can access data to identify Serious and Persistent Mental Illness (SPMI) diagnoses coming through claims and pair the data with services being accessed. Through this reporting, a global picture is created depicting access to behavioral health services for members with SPMI. Claims can be filtered by types of services accessed including care coordination, therapy, and medication management to ensure equitable access for Advanced Health Members with an SPMI diagnosis.

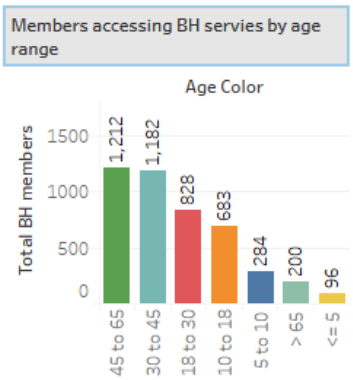


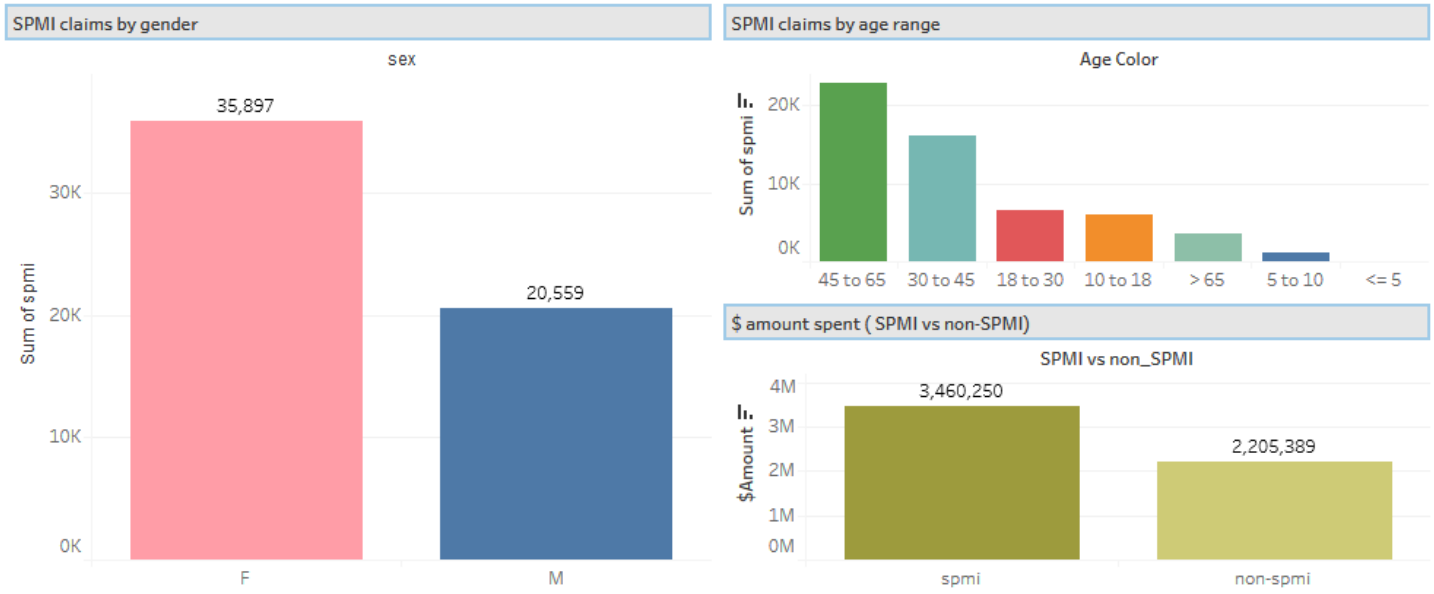


Health Assessment Screening tools were also used as a secondary method to identify SPMI needs through self-reporting. Health Risk Assessment (HRA) screenings are delivered to the member when then enter the plan and annually thereafter. Members not responding to the surveys were contacted by phone by customer service to ensure that all members needing additional services were identified. Members could also be referred for care coordination through providers, community partners, and self-requests. The total breakdown for members with an identified SPMI diagnosis are listed below. Advanced Health will continue to track these data points to determine network adequacy and to ensure that members are receiving the appropriate care. The dashboard also allows Advanced Health to identify issues of health equity, ensuring all members have equal access to care.









The dashboard also allows Advanced Health to identify specific members with an SPMI diagnosis and determine what services they are accessing to evaluate the need for additional services including ACT, EASA, or IIBHT. Individual cases are staffed by the ICC director with the ICC teams to evaluate high needs members for care coordination and possible linkages to other special needs services with the goal of preventing crisis and relapse by providing a robust treatment plan and working with the members to meet their health care goals.

The provider team at Advanced Health also participates in several community collaboration meetings monthly, including the mental health/law enforcement meeting which collaborates with local law enforcement and provider representatives such as the homeless resource center, the County Mental Health Provider (CMHP), and the hospital psychiatric liaison. The CMHP hosts a monthly meeting of agencies that are involved in direct patient care as well as supported employment and peer support services representatives to share new initiatives and engage in meaningful dialog aimed at cross collaboration between agencies.

BH member's overvier

membid	Member_name	proccode	Qty of Service	Provider_Fullname	Vendor name	SP
[redacted]	[redacted]	90832	1	GEORGIA ENGLAND QMHP-C	CURRY COMMUNITY HEALTH	sp
		90834	1	GEORGIA ENGLAND QMHP-C	CURRY COMMUNITY HEALTH	sp
				KEQING SUN QMHP	CURRY COMMUNITY HEALTH	sp
		90837	1	ERIN KATHLEEN PORTER QMHP MSW	CURRY COMMUNITY HEALTH	sp
		H0032	1	ERIN KATHLEEN PORTER QMHP MSW	CURRY COMMUNITY HEALTH	sp
		Q3014	1	GEORGIA ENGLAND QMHP-C	CURRY COMMUNITY HEALTH	sp
		T1016	1	GINA M MCDONALD TWH-CHW	CURRY COMMUNITY HEALTH	sp
			2	GINA M MCDONALD TWH-CHW	CURRY COMMUNITY HEALTH	sp
			3	ERIN KATHLEEN PORTER QMHP MSW	CURRY COMMUNITY HEALTH	sp
				GINA M MCDONALD TWH-CHW	CURRY COMMUNITY HEALTH	sp
			4	ERIN KATHLEEN PORTER QMHP MSW	CURRY COMMUNITY HEALTH	sp
[redacted]	[redacted]	96127	1	CAROL SUE FRANK MD	BAY CLINIC LLP	sp
		99214	1	CAROL SUE FRANK MD	BAY CLINIC LLP	sp
		G8431	1	CAROL SUE FRANK MD	BAY CLINIC LLP	sp

Behavioral services have been integrated in all school districts in Coos and Curry County. Advanced Health has also partnered with the FQHC's to include school-based clinics to allow for medical appointments in addition to school-based

therapists. To increase the exchanged of information and allow for the coordination of services, Advanced Health has put forth funds to allow greater access to a new EHR, Epic, that will be used in the largest hospital, Bay Area Hospital, and the 2 largest clinics, North Bend Medical Center and Bay Clinic. The expected go live date for the Epic EHR conversion is later in 2021. Coos Health and Wellness will also be transitioning to Epic in 2022. For those clinics and community service agencies, Advanced Health has purchased and application, Activate Care, to share information including treatment plans and provider information for members in the ICC program.

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

Prior to 2020, Advanced Health CCO partnered with the local County Mental Health Program (CMHP) for primary management and service delivery of all mental health related services. Members were required to be an "open client" with the CMHP with a full behavioral health assessment and treatment plan prior to being eligible for mental health services. Advanced Health underwent a major transformation in Behavioral Health services in 2020, which carved the way for services to be contracted with multiple providers rather than delegating all services to the County Mental Health Provider (CMHP). Advanced Health continues to contract with the local CMHPs while expanding network access to several community partners including individual behavioral health providers and integrated behavioral health providers co-located in primary care and specialty clinics. This shift provided expanded and increased access to Behavioral Health services for those with serious and persistent mental illness (SPMI).
The service expansion created foundational changes to services to include:

- New contracts with local mental health providers allowing a broader network for Members to choose from.
- Greater accountability for mental health programs including more fee-for-service encounters, incentivizing agencies to increase services to Members.
- Integrated services for mental health services within medical clinics.
- Care coordination for high-risk members with Serious and Persistent Mental Illness.

With multiple new providers, the need for new accountability to identify the SPMI population arose. Advanced Health has not historically identified the SPMI population for targeted services. Creating a new system with the capabilities to identify the needs was the first task in the 2020 TQS project. The roadmap to improving behavioral health access and integration begins with creating a data-driven approach to identify the high risk and vulnerable population of members with SPMI and then to extend that data to the behavioral health provider network.

Advanced Health's Behavioral Health Director began by putting in place guidelines to ensure members with SPMI are not only connected with an appropriate Integrated Behavioral Health care team but also enrolled in Intensive Care Coordination Services (ICC), or Assertive Community Treatment (ACT), when needed, and offered Skills Coaching and Supported Employment. These care standards when utilized together provide a comprehensive treatment model to support members with SPMI in an empowering recovery-based model.
The guidelines for the expansion of services are focusing on addressing the following needs:

- SPMI: Early intervention involves connecting SPMI members with the appropriate levels of supportive services and decreases the need for higher levels of care. Ongoing monitoring and identification for this vulnerable group will be key in improving outcomes.
- Cultural Considerations: Interventions must be targeted and culturally appropriate to be useful to members literacy and language needs.
- Access: Quality and adequacy of services
- Health equity: Implementation of identification and tracking mechanisms to better serve the SPMI population through identification, referral, and ongoing tracking.

E. **Brief narrative description**:

The next steps in the TQS project include collaborating with providers to provide access and education for a provider facing dashboard that will allow for ongoing initiatives aimed at identifying gaps in services and seeking provider feedback on areas for growth opportunity in serving our most vulnerable population. Because of the complicating factors related to Covid-19, Advanced Health elected to postpone the provider rollout to allow providers to focus on shifting their practices to telemedicine.

Ongoing areas of improvement include collaboration with providers which will begin in the next few months. We look forward to working with the community of providers in this effort. Advanced Health is also working on identifying more areas of potential health inequities in the dashboard with the goal of breaking down services accessed by race and language.

Advanced Health continues to accept applications to enter the network from providers meeting the qualifications.

F. **Activities and monitoring for performance improvement**:

Activity 1 description: Identify additional Licensed Behavioral Health Providers and expand contracted network to increase access to Behavioral Health services.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: Identify Behavioral Health providers not contracted with Advanced Health within Coos and Curry County and work to contract with them to bring them into the Advanced Health provider network.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
172 contracted providers in 2020	Continue to expand network with qualified providers	12/2021	Continue to expand network with qualified providers	12/2022

Activity 2 description: Refine the Tableau data dashboards developed in 2020 to monitor encounter data from the expanded Behavioral Health network. Analyze dashboard results for opportunities to improve Member access and utilization of services, especially for members with an SPMI diagnosis.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Review 2020 Tableau data dashboards for potential revisions or additional data sources prior to rolling out dashboard results to providers.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
2020 encounter data collected	2020 encounter data processed after adequate time for claims runout	3/2021	Continue to feed data and analyze for process improvement	06/30/2021
Identified data sources for claims and encounter data	Ongoing meetings with analytics to review additional	07/2021	Complete revisions to data dashboard, if deemed necessary	8/2021

as well as member demographic data to be include in dashboards	and best sources of data			

Activity 3 description: Rollout Tableau dashboards to community providers.

☒ Short term or ☐ Long term

Monitoring activity 3 for improvement: Train and implement Tableau Dashboard for community providers. Monitor percentage of providers actively using software and number of Members actively enrolled in behavioral health services. Due to Covid restrictions, these targets and benchmarks are still in the development phase. Advanced Health will continue to engage with providers to educate on access and provide community-based solutions.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No documented procedure	Develop and document internal procedure to monitor dashboards and reach out to providers	5/2021	Roll out dashboards to community providers	6/2021
No improvement targets set	Set target for percentage of providers actively engaging with data	5/2021	Set targets for number of Members enrolled in behavioral health services, including integrated behavioral health	7/2021

A. **Project short title**: Project 9: Patient-Centered Primary Care Home Advancement and Enrollment

Continued or slightly modified from prior TQS? ☐Yes ☒No, this is a new project or program

If continued, insert unique project ID from OHA: Add text here

B. **Components addressed**

i. Component 1: PCPCH: Member enrollment
ii. Component 2 (if applicable): PCPCH: Tier advancement
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☐ No
v. If this project addresses social determinants of health & equity, which domain(s) does it address?

☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health

vi. If this project addresses CLAS standards, which standard does it primarily address? Choose an item

C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

In 2017, the Patient-Centered Primary Care Home (PCPCH) standards were revised and moved from a 3 tier recognition system to a 5 tier recognition system. OHA monitors CCO Member enrollment with a PCPCH through the Patient-Centered Primary Care Home (PCPCH) Enrollment quality measure which uses a weighted formula to give a higher rating when more members are empaneled with higher-tier PCPCH recognized clinics. The PCPCH measure was part of the CCO incentive measure set through 2019. In 2020, the measure is no longer incentivized through the CCO quality program. However, in the 2020 CCO contract there are provisions requiring CCOs to financially support PCPCH recognized practices in their network.

In 2018 Advanced Health achieved a 68.8% rate for the PCPCH Enrollment measure, surpassing the OHA benchmark for that year.

In 2019 Advanced Health's rating improved to 76.8% with the addition of a newly recognized tier 4 clinic and another clinic moving from tier 4 to 5 star.

Advanced Health is awaiting OHA's final calculation of the PCPCH Enrollment quality measure for 2020, however our rate will increase again because, despite the challenges presented by the COVID-19 pandemic and protective orders, a large clinic in the Advanced Health network successfully moved from Tier 4 to be recognized as a 5 Star clinic. At the end of 2020 the two largest primary care clinics in Advanced Health's network are now 5 Star PCPCH recognized clinics. More detail on Advanced Health's 2020 PCPCH member assignment at all tier levels is given below.

PCPCH Recognition Level	Number of Members Assigned	% of Total Advanced Health Members
5 Star	13,234	56%
Tier 4	5,171	22%
Tier 3	2,657	11%
Tier 2	773	3%
Tier 1	0	0%
Not recognized	1,965	8%

D. **Project context:** For new projects, include justification for choosing the project. For continued projects, provide progress to date since project inception.

One focus area of the 2015-2018 Coos County Community Health Improvement Plan was to increase access to care providers. This priority was identified from the Coos County Community Health Assessment, reviewed and approved by the Coos County Community Advisory Council. The subcommittee/workgroup tasked with increasing access to care chose as one of their strategies to form a PCPCH learning collaborative to support local clinics and providers in attaining PCPCH recognition and reaching their target recognition levels. This strategy also aligns with OHA's PCPCH Enrollment quality performance metric for CCOs, the PCPCH area of focus in the Transformation Plan, and with several requirements for clinics participating in the CPC+ program.

Advanced Health had conducted a performance improvement project around PCPCH enrollment in 2014 and 2015 with a core strategy of providing technical assistance to clinics to attain PCPCH recognition. By 2016, 88.6% of Advanced Health members were receiving primary care services at a Tier 3 PCPCH recognized clinic.

In 2017 the recognition standards for PCPCH were revised and the tier structure was expanded from three levels to five. The change to the tier structure precipitated a change to the OHA PCPCH Enrollment measure calculation. With the threshold for the PCPCH measure remaining at 60% and the new calculation methodology, it became impossible for a CCO to meet the measure if the clinics in their provider network remained at Tier 3.

In 2017 the Access to Care Community Health Improvement Plan Subcommittee formed the PCPCH Learning Collaborative and worked to engage representatives from interested clinics in both Coos and Curry counties, including Bay Clinic, North Bend Medical Center, Waterfall Community Health Center, Coast Community Health Center, Curry Community Health, and Curry Health Network. At the beginning of 2017, all these clinics were recognized as Tier 3 PCPCH clinics. The PCPCH Learning Collaborative, led by Advanced Health's Quality Improvement Specialist and the Community Engagement Team, developed and shared tools to assist fellow collaborative members to achieve higher levels of PCPCH recognition.

By the end of 2017, Bay Clinic, North Bend Medical Center's Coos Bay clinic, Coast Community Health Center, Curry Health Network, and Curry Medical Center of Curry Health Network had all attained Tier 4 PCPCH recognition. The North Bend Medical Center offices in Myrtle Point, Coquille, Bandon, and Gold Beach, and Waterfall Community Health Center had all maintained Tier 3 PCPCH recognition.

In 2018, the PCPCH Learning Collaborative met quarterly and included discussion topics such as, supply and demand, empanelment, and care team models. Some clinics planning to attest to a higher tier in early 2019 held focused work sessions with the Advanced Health Quality Improvement Specialist to review relevant standards, processes, and documentation requirements. Also in 2018, Advanced Health added another Tier 4 PCPCH recognized clinic to the contracted provider network in Curry County, expanding access for Advanced Health members living in the area.

For the 2019 measurement year, the OHA Metrics and Scoring Committee raised the threshold for the PCPCH quality incentive measure to 68.0%. Advanced Health's 2019 final PCPCH quality measure rate was 76.8%. While this is above the threshold set for 2019 performance, Advanced Health remains committed to improving the members' experience of care through ensuring timely access to culturally appropriate and responsive care, and the PCPCH model is one vehicle to promote these values. PCPCH clinics in Coos and Curry county are working to offer more integrated services, including behavioral health and oral health. Clinics are focusing on enhancing processes for patient outreach and engagement. Bay Clinic became a 5-Star PCPCH site in 2019.

Despite the barriers of COVID-19, North Bend Medical Center's Coos Bay location became a 5-Star PCPCH site in 2020.

E. **Brief narrative description**:

Advanced Health is currently contracted with all primary care providers in Coos and Curry county, so contracting with providers not currently in the network is not a viable strategy to increase PCPCH enrollment. Instead, Advanced Health will continue to keep in close communication with all primary care organizations in the network regarding their plans for PCPCH recognition tier advancement and will provide targeted technical assistance as needed to support provider organizations in meeting those goals. Advanced Health's Quality Improvement Specialist has experience with PCPCH standard implementation and routinely checks in with the quality staff at PCPCH recognized clinics.

In 2020 Advanced Health developed PMPM payment mechanisms in contracts with PCPCH recognized clinics. The payments increase with the number of members assigned to the clinic for primary care, offer higher payments for higher tier recognition, and increase year-over-year. These PMPM payments meet the CCO contractual requirements and also provide a financial incentive for unrecognized clinics to become recognized, for clinics to advance to higher tiers of recognition, and for recognized clinics to accept higher numbers of Advanced Health members for primary care.

Advanced Health's quality and analytics teams will work to support clinics' PCPCH programs by revising some quality measure reports to align with the PCPCH quality measures and include all the information (numerator, denominator, rate) the clinics need to meet their PCPCH standard requirements.

As of December 31, 2020, 92% of Advanced Health members had a source of primary care with a PCPCH recognized clinic. Of the remaining clinics in the network (and in the service area), two may have the administrative capacity to consider PCPCH recognition in the future. Another organization operates three clinics, only one of which has PCPCH recognition. Advanced Health quality staff will continue to build professional relationships with the quality staff of these clinics and work to encourage them to consider PCPCH attestation with Advanced Health's support and technical assistance.

F. **Activities and monitoring for performance improvement**:

Activity 1 description: Support in-network FQHC in obtaining 5 Star PCPCH recognition, providing quality measure reports and technical assistance as requested. This clinic is re-attesting to Tier 4 in early 2021. They had planned to attest to 5 Star, but due realities of COVID-19 response and subsequent staffing and resource constraints, they are planning to attest for 5 Star recognition in the next reporting period.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: PCPCH recognition level.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Tier 4 PCPCH	Maintain Tier 4 recognition.	5/2021	5 Star PCPCH recognition	5/2022

Activity 2 description: Revise quality measure reporting to be responsive to the needs of contracted PCPCH clinics. Ensure quality reports support their PCPCH programs.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: Prioritize quality measure report revisions and implement changes.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Quality measure progress reports don't fully align with PCPCH clinic needs.	Prioritize changes needed to support network clinics' PCPCH program reporting	5/2021	Implement changes and begin delivering revised quality measure progress reports	8/2021

Activity 3 description: Monitor both the PCPCH tier levels of primary care providers in the Advanced Health network and the proportion of Advanced Health's membership assigned to PCPCH recognized clinics.

☐ Short term or ☒ Long term

Monitoring activity 3 for improvement: Monitor progress quarterly as part of the DSN Capacity reporting process.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
92% of Advanced Health members receive primary care from a PCPCH recognized provider (12/2020)	93% of Advanced Health members receive primary care from a PCPCH recognized provider	12/2022	94% of Advanced Health members receive primary care from a PCPCH recognized provider	12/2023
76.8% PCPCH Enrollment Quality Measure (CY 2019)	80% PCPCH Enrollment Quality Measure	12/2020 (reported by OHA in 6/2021)	84% PCPCH Enrollment Quality Measure	12/2022 (reported by OHA in 6/2024)

Section 2: Discontinued Project(s) Closeout

Advanced Health has not discontinued reporting on any projects in 2021.

Section 3: Required Transformation and Quality Program Attachments

A. REQUIRED: Attach your CCO's Quality Improvement Committee documentation (for example, strategic plan, policies and procedures as outlined in TQS guidance).

Attachments:

1. Quality Assurance and Performance Improvement Policies and Procedures
2. Interagency Quality Committee Charter
3. Member Rights and Protections Policies and Procedures
4. Member Grievance System Policies and Procedures
5. Clinical Practice Guidelines Policies and Procedures
6. Clinical Advisory Panel Charter

Quality Assurance and Performance Improvement (QAPI) Policy and Procedures

Company: Advanced Health CCO	Approved by: Anna Warner Title: Executive Program Director Current Revision Date: March 15, 2021
Department: Quality	

Contents:

1. PURPOSE

1.1. Advanced Health members are best served by a Quality Assurance Program designed to provide robust methods for process measurement and analysis to assure early detection of discrepancies and continual performance improvement.

2. SCOPE

2.1. Advanced Health is a Coordinated Care Organization, contracted with the Oregon Health Authority to administer the benefit for Oregon Health Plan members in Coos and Curry Counties. Advanced Health maintains a network of providers and contractors for primary physical health, behavioral health, dental health, specialty services, hospital services, chemical dependency services, and transportation services.

3. ACRONYMS AND DEFINITIONS

3.1.

4. POLICIES

4.1. Management provides evidence of its commitment to the development, implementation, and continual improvement of the Quality Assurance Program by:

- Communicating to the organization the importance of meeting member needs for effective, equitable, understandable, and respectful services, as well as statutory and regulatory requirements;
- Ensuring that member needs and expectations are determined and fulfilled in a manner that is responsive to cultural beliefs, preferred languages, health literacy, and other communication needs with the aim of improving member satisfaction;
- Planning the processes and activities needed for the Quality Assurance Program;
- Conducting an annual Quality Program Evaluation;
- Establishing an annual Transformation and Quality Strategy and Work Plan;
- Ensuring availability of resources;
- Defining organizational roles, responsibilities, and authorities; and,
- Planning actions to address risks and opportunities.

5. PROCEDURES

5.1. ***Performance Evaluation and Improvement***

Advanced Health has planned and implemented the following monitoring, measurement, and analysis activities in order to demonstrate that services provided to members conform to requirements and that the Quality Assurance Program, including the Transformation and Quality Strategy and Work Plan, performs as expected. The results of the monitoring, measurement, and analysis activities are used to improve the effectiveness of the Quality Assurance Program.

5.2. ***Participation as a Member of the OHA Quality and Health Outcomes Committee (QHOC)***

Advanced Health is committed to participation and attendance at the monthly Quality and Health Outcomes Committee. Advanced Health's Executive Program Director and Quality Manager regularly attend the meetings held in Salem. Other CCO employees, contractors, and providers may participate, either in-person or by phone, depending on the topic of the meeting or the learning collaborative session.

5.3. ***External Quality Review and Corrective Action***

Advanced Health participates in annual External Quality Reviews (EQRs) conducted by an External Quality Review Organization, as required by the Oregon Health Authority. Any findings from the EQR generate corrective action or improvement plans to eliminate the cause or causes of the problem and prevent recurrence. The corrective action or improvement plan includes a determination of the root cause, actions to address the root cause, and verification that the actions taken were effective.

5.4. ***Utilization Review***

A robust program of Utilization Review is in place to ensure that high quality, Medically Appropriate services are delivered to all members, including those with special health care needs. A number of mechanisms are in place to monitor for both under- and over-utilization of services.

5.4.1. *Medical Management Department Activities*

The Medical Management Department includes Utilization Review functions. This team reviews prior authorizations to ensure that treatments follow the clinical practice guidelines, the Prioritized List of Health Services and the associated guidelines to assure that services are medically appropriate and evidence-based. The list of services requiring prior authorization is reviewed at least annually for opportunities to reduce administrative burden on providers while still ensuring that care is delivered locally when possible, in a cost-effective manner, and consistent with medical evidence. The authorization process ensures that members have access to second opinions when desired, and all members (including those with special healthcare needs) may have direct access to a specialist when medically appropriate.

The Medical Services Department monitors performance to ensure that requests are handled in a timely and consistent manner. A data dashboard is in place to allow monitoring of number of authorization requests received, average and individual time to completion, percent approved or denied, and the types of requests seen. This data is used to inform staffing decisions and prior authorization requirements. Attention is focused on high risk, high dollar interventions.

5.5. *Grievance and Appeal System*

Advanced Health maintains a comprehensive Member Grievance System policy and procedure, including robust processes addressing Grievances, Notice of Adverse Benefit Determination, Appeals, Contested Case Hearings, requests for expedited Appeals or Expedited Contested Case Hearings, continuation of benefits, documentation requirements, and quality improvement review. Advanced Health reviews the policy and procedure annually, revising as needed to ensure the document accurately reflects the implemented process and meets all federal, state, and contract requirements. The Advanced Health policy and procedure are submitted annually to OHA for review and feedback. The Grievance and Appeal System is also part of the regular External Quality Review cycle and is reviewed at least every three years through that process.

Advanced Health works closely with organizations to which portions of the Grievance and Appeal System are delegated to ensure the processes of the delegated entities meet the requirements of the Advanced Health policy and procedure. Delegate Grievance System policies and procedures are reviewed at least annually for compliance with federal, state, CCO contract, and Advanced Health requirements. Grievance System records and data collected from delegated entities are reviewed at the time of collection and all information from delegates is incorporated into the quarterly Grievance System report submitted to OHA. The data and trends noted in the quarterly Grievance System report are also reviewed by the Interagency Quality and Accountability Committee for opportunities for system-level quality improvements.

5.6. *Program Evaluation & Improvement Strategy and Work Plan*

The entire Quality Assurance and Performance Improvement Program is reviewed and evaluated at least once per year to ensure its continuing suitability, adequacy, and effectiveness in satisfying the requirements of the Oregon Health Authority and Advanced Health's goals and objectives. This evaluation includes assessing opportunities for improvement and the need for changes to the Quality Assurance Program. The Quality Program Evaluation is prepared by the Executive Program Director and Quality Manager in collaboration with key subject matter experts and reviewed by the Interagency Quality and Accountability Committee, the Clinical Advisory Panel, and the CCO Board of Directors.

Input to the Quality Program Evaluation includes, but is not limited to, the following information:

- Results of External Quality Review
- Member complaints and the grievance system
- Status of current improvement efforts and suggestions for new improvement efforts
- Status of CCO quality incentive measures and other CCO performance measures

- Quality and appropriateness of care for members, especially those with special health care needs
- Improvement in an area of poor performance in care coordination for members with SPMI
- Monitoring and enforcement of consumer rights and protections
- Compliance of the fraud, waste, and abuse prevention program
- Utilization data
- Network contractor and provider monitoring results and findings

Output of the Quality Program Evaluation informs the Transformation and Quality Strategy and Work Plan for the coming year and includes decisions and actions related to:

- Improvement of the effectiveness of the Quality Assurance Program and its processes
- Improvement of member services related to requirements
- Resource needs

5.7. *Performance Improvement Process*

Advanced Health continually improves the effectiveness of the Quality Assurance Program through review by the Interagency Quality and Accountability Committee and other committees, participation in OHA Quality and Health Outcomes Committee meetings, participation in OHA Transformation Center technical assistance and learning collaborative opportunities, analysis of data, external quality review, and internal quality program evaluation.

OHA determines and/or approves contractual requirements for all CCOs related to Performance Improvement Projects (PIPs), Transformation and Quality Strategy components, Quality Incentive Measures, and other performance measures. Advanced Health conforms to these requirements and incorporates these improvement projects as well as other projects into its annual Transformation and Quality Strategy and Work Plan.

In managing the Transformation and Quality Strategy and Work Plan, Advanced Health employs a variety of process improvement tools, including PDSA, DMAIC, impact analysis, project management, and other lean tools. The process improvement method(s) used depend on the needs of the specific project and the capabilities of the team planning and implementing the improvements.

Process improvement priorities are determined with consideration to a variety of sources, including but not limited to:

- OHA Requirements: Performance Improvement Project focus areas, Transformation and Quality Strategy components, Quality Incentive Measures, other performance measures, and other contractual requirements
- Advanced Health's strategic plan and direction from the Board of Directors
- Community Priorities: input from the Community Advisory Councils, findings from the Community Health Assessments, and priorities identified in the Community Health Improvement Plans
- External Quality Review results
- Member complaints and grievance reports
- Cultural and linguistic needs of Advanced Health members
- Delegate and provider compliance
- Delegate, provider, and community partner feedback
- Annual Quality Program Evaluation
- Other statutory and regulatory requirements

5.8. *Committees*

Advanced Health's Quality Assurance and Performance Improvement processes rely on a series of collaborative, yet distinct and well-defined standing committees. Each committee is characterized by a charter that defines the committee's purpose, goals, schedule of meetings, scopes of authority, membership composition, and member responsibilities. The standing committees that participate in Quality Assurance and Performance Improvement processes are described below.

5.8.1. *Interagency Quality and Accountability Committee*

This committee is chaired by the Advanced Health Director of Quality and attended by representatives of delegate organizations, as well as community partners and providers. The Interagency Committee meets monthly. The purpose of this committee is to provide a platform for collaboration and coordination between Advanced Health's leadership, contractors, network provider organizations, and community partners purposed at achieving the Triple Aim. This committee supports data-driven decision making and development of a culture of quality through the review of data reports that support OHA contract compliance, achievement of Advanced Health's strategic plan, advances in individual and population health, enhancement of the member's experience of care, and cost efficacy. The Interagency Quality and Accountability Committee reports to the Advanced Health Board of Directors.

5.8.2. *Clinical Advisory Panel*

The Clinical Advisory Panel is chaired by Advanced Health's Chief Medical Officer and membership includes providers representative of behavioral health, physical health, dental health, and substance use treatment. The CAP usually meets twice per month. The CAP provides input on clinical programs and policies with the goal of achieving the Triple Aim: improved outcomes in individual and population health; enhancement of the patient's experience of care; and, cost efficacy. The Clinical Advisory Committee provides perspective of practicing clinicians to Advanced Health. The Clinical Advisory Panel reports to the Advanced Health Board of Directors.

5.8.3. *Pharmacy and Therapeutics Committee*

The Pharmacy and Therapeutics Committee meets at least quarterly. Committee membership includes Advanced Health providers representing various specialties (e.g. family practice, internal medicine, OB/GYN, pediatrics, mental health etc.) and may also include community partners (e.g. Bay Area Hospital) and pharmacists. The Pharmacy and Therapeutics Committee is responsible for maintaining a formulary providing the most cost-effective drug therapies to Advanced Health members and ensuring compliance with DMAP rules and regulations. The Pharmacy and Therapeutics Committee reports to the Advanced Health Clinical Advisory Panel.

5.8.4. *Community Advisory Councils*

Advanced Health has established two Community Advisory Councils, one in Coos County and one in Curry County. Both councils hold monthly meetings. Membership includes a broad spectrum of representatives, including Advanced Health members and their families, health providers, non-clinical partner organizations, and other key community representation. Over 50% of the councils are consumer representatives. The purpose of these councils is to provide the voice of the consumer to advise Advanced Health and its governing body in its efforts to meet the Triple Aim of better health, better care, and lower costs. The Consumer Advisory Councils report to the Advanced Health Board of Directors.

5.8.5. *Community Health Improvement Plan Committees*

The Consumer Advisory Council (CAC) provided input and recommendations on priorities of the Community Health Improvement Plan (CHIP). The Coos and Curry CHIP Steering Committees are responsible to set up appropriate supports and structures to monitor and move the work of the CHIP forward. Each CHIP subcommittee is responsible to develop an implementation plan for achieving the goals and objectives outlined by the CHIP. Progress reports are presented for approval to the respective CAC and then to the Advanced Health Board of Directors.

5.9. *Transformation and Quality Strategy (TQS) Development Process*

Much of the process for the TQS analysis, development, and planning is described in the above sections regarding the Program Evaluation & Improvement Strategy and Work Plan and the Performance Improvement Process. The Executive Program Director and Quality Manager worked with the key personnel and committees described above beginning in the third quarter of the calendar through January of the reporting year to select the list of projects and programs to be included in the TQS to highlight the work of Advanced Health and that best address the required TQS components. These projects and programs include priorities that align with the Community Health Improvement Plan, CCO quality measures, PCPCH standards, CPC+ program metrics, contract requirements, current and future Performance Improvement Projects, as well as other statutory and regulatory requirements.

The TQS projects and programs are presented for discussion and feedback, beginning in the fourth quarter of the year prior to the reporting year, to the Interagency Quality and Accountability Committee and the Clinical Advisory Panel. The Consumer Advisory Councils work on the Community Health Improvement Plan throughout the year, and that information is incorporated in the presentations to the other committees. The information is presented to the Advanced Health Board of Directors for review and approval prior to the March submission to OHA.

In February and March of the reporting year, additional details, data, activities, and targets are collected from the project or program leaders. Final versions of sections are reviewed by relevant executive leadership and other personnel involved as needed, including those functions discussed below in the Organizational Roles and Responsibilities section.

6. REFERENCE SOURCES

6.1. §438.330 Quality assessment and performance improvement program

6.2. Exhibit B – Statement of Work: Part 10 Transformation Reporting, Performance Measures and External Quality Review

7. RESPONSIBILITES (Compliance, Monitoring, Review)

7.1. *Executive Program Director*

The Executive Program Director has the authority and responsibility to make appropriate changes to the Quality Assurance Program and to communicate the requirements to personnel. Every level of management shares the responsibility to ensure proper maintenance and performance of the Quality Assurance Program. A brief overview of key titles and their responsibilities related to the quality assurance program is provided below.

7.2. *Board of Directors*

- Representative of equity partners, community partners, community stakeholders, and the Community Advisory Councils

- Guides, controls, and directs the organization through the adoption and review of annual strategic plans, the annual budgeting process, and written policies
- Oversees the performance of the organization
- Reviews and authorizes the annual Transformation and Quality Strategy
- Ultimately responsible for the quality of clinical services provided to members

7.3. ***Chief Executive Officer***

- Facilitates business planning and develops appropriate strategies to attain annual strategic objectives
- Reviews activity reports and financial statements to determine progress and status in attaining quality, performance, and compliance objectives
- Ensures adequate resource availability
- Ensures the promotion and awareness of member needs and contract requirements throughout the organization
- Reports directly to the Board of Directors

7.4. ***Chief Compliance Officer***

- Ensures contractual obligations as well as statutory and regulatory requirements are met
- Oversees the development, review, and revision of the compliance plan
- Implements the compliance plan
- Audits and monitors contractors and providers
- Opens and performs preliminary investigations regarding Waste, Fraud, and Abuse and makes referrals to OPAR or MFCU as required

7.5. ***Chief Medical Officer***

- Ensures services are medically appropriate, high quality, cost-effective, and in accordance with Oregon Health Authority (OHA) Coordinated Care Organization (CCO) contract and related Oregon Administrative Rules (OAR) and the Code of Federal Regulations (CFR)
- Reviews member Appeal and Contested Case Hearings requests
- Ensures assigned staff adhere to medical policy and member benefits

7.6. ***Executive Program Director***

- Directs development, implementation, and improvement of the Quality Assurance and Performance Improvement Program and annual Transformation and Quality Strategy
- Develops, implements, and communicates quality improvement strategies throughout the organization as well as to delegate and provider network, community partners, and other stakeholders
- Assists with the annual External Quality Review process
- Oversees Member Grievance System
- Health Equity Administrator

7.7. ***Directors and Managers***

- Oversee successful operation of assigned area of responsibility to ensure production efficiency, quality of service, and cost-effective management of resources
- Coordinate business practices and procedures to optimize operations
- Ensure training of new and existing employees
- Support efforts to improve the effectiveness of the Quality Assurance Program
- Provide direction to staff
- Assist with annual EQR process in areas of assigned responsibility

8. RELATED DOCUMENTS

8.1. Interagency Quality Committee Charter

8.2. Clinical Advisory Panel Charter

8.3. Pharmacy and Therapeutics Committee Charter

8.4. Coos and Curry Community Advisory Council Charters
8.5. Coos and Curry Community Health Improvement Plans
8.6. Coos and Curry Community Health Assessment
8.7. Annual Transformation and Quality Strategy

9. ATTACHMENTS

9.1. None

10. APPROVALS

10.1. Document Owner

10.1.1. __Anna Warner, Executive Program Director_____

10.2. Collaborators

10.2.1. __Amarissa Wooden, Quality Manager_____

10.3. Approvals

10.3.1. Committees

10.3.1.1. _N/A_____

10.3.2. Signers

10.3.2.1. __Anna Warner, Executive Program Director_____

10.4. Original Effective Date

10.4.1. __July 29, 2015_____

10.5. Revision Date

10.5.1. __March 12, 2020_____

10.6. Review Date

10.6.1. _____

Inter-Agency Quality and Accountability Subcommittee Charter

Title:	**Interagency Quality and Accountability Subcommittee**
Date Chartered:	September 2014
Time Line:	Standing Committee
Purpose:	The Interagency Quality Committee exists to provide a platform for collaboration and coordination between Advanced Health's leadership, provider network, and community partners purposed at achieving the Triple Aim: improved outcomes in individual and population health; enhancement of the patient's experience of care; and, cost efficacy.
Goals:	1. Work collaboratively to build relationships and systems that support Advanced Health members and providers by designing, measuring, evaluating, and improving the effectiveness of quality management systems; 2. Work collaboratively to achieve CCO performance metrics; 3. Identify opportunities for practice/agency level health system transformation and improvement; 4. Identify barriers and gaps to achieving transformation and improvement; 5. Identify and implement actions to promote improved processes within the service delivery system; 6. Participate in the development and implementation of Advanced Health's annual Quality Improvement Strategy and Work Plan and the Transformation and Quality Strategy; 7. Recommend standards and strategies for quality review of the following services: • Mental Health Services • Physical Health Services • Addictions Services • Oral Health • Non-Emergency Medical Transportation Services 8. Advise, evaluate, and support Advanced Health's strategic initiatives and goals related to quality, access, and process improvement. Evaluation may include, but is not limited to monitoring of the following: • Clinical record keeping/documentation review • Utilization review including under- and over-utilization, in and out of network utilization, and emergency services • Referrals • Comorbid conditions • Prior authorizations and medication review • Encounter data management • CCO-initiated member disenrollment • Access to care and services 9. Conduct a quarterly review and analysis of all complaints and appeals received including a focused review of any persistent and significant member complaints and appeals. 10. Monitor Non-Medical/Flexible Fund expenditures for compliance

	with established policy and procedure and recommend changes as needed; 11. Make recommendations regarding corrective actions to address issues identified through this committee's review process; monitor progress, results, and effectiveness of corrective actions recommended at previous meetings.
Committee Chair:	The committee will be chaired by Advanced Health's Director of Quality
Committee Membership	Advanced Health's Medical Director, Director of Behavioral Health, Director of Quality, Quality Improvement Specialist, Coos Health and Wellness, Curry Community Health, ADAPT, Advantage Dental, Bay Area Hospital, Waterfall Community Health Center, Coast Community Health Center, North Bend Medical Center, Bay Clinic, Coquille Valley Hospital, Southern Coos Hospital, Curry Health Network/Curry General Hospital, Community Advisory Council representatives, when invited, and other community providers as invited or interested. Additional members will be added as needed.
Committee Members' Responsibilities	• Actively participate both in and out of meetings to achieve the committee's goals • Work effectively with other committee members • Act as role models to inspire their organization's engagement • Participate in External Quality Review processes when requested
Meeting Frequency:	Full committee will meet monthly for 1 hour or more often if necessary to accomplish the purpose of the committee Time framed work groups may be convened to focus on a particular objective or project
Term	Ongoing
Review Charter:	Annually
Date(s) Revised:	March 2016, May 2017, February 2018, November 2019

Member Rights, Protections and Responsibilities Policies and Procedures

Company: Advanced Health	Approved by: M. Hale Title: CCO Drafted by: M. Hale Title: CCO
Department: Compliance	
Member Rights, Protections and Responsibilities	Approved Date: March 16, 2020
	Revision Dates:

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1.0 Purpose

1.1 The purpose of these Member Rights, Protections and Responsibilities Policies and Procedures is to delineate how Advanced Health will ensure compliance with applicable rules and regulations relating to such rights, protections and responsibilities.

2.0 Scope

2.1 These Policies and Procedures apply to Advanced Health, and by extension to Privileged Providers, other Network Providers and other contracted entities that interact with Members on behalf of Advanced Health.

3.0 Acronyms and Definitions

3.1 "Contract" means the CCO 2.0 Contract.

3.2 Capitalized terms not otherwise defined in this Policy and Procedure shall have the meaning as defined in the Contract.

3.3 "Member" has the same meaning as defined in the CCO 2.0 Contract and includes potential members.

3.4 "Member Rights, Protections and Responsibilities", "Member Rights" and "Member Rights and Responsibilities" have the same meaning as those rights, protections and responsibilities set forth in 42 CFR §438.100, OAR 410-141-3590 and the Contract, and each of these terms.

3.4.1 More specifically, these guaranteed rights and protections include the right to:

3.4.1.1. Be treated with dignity and respect;

3.4.1.2. Be treated by participating providers the same as other people seeking health care benefits to which they are entitled and to be encouraged to work with the Member's care team, including Providers and community resources appropriate to the Member's needs;

3.4.1.3. Choose a Primary Care Provider (PCP) or service site and to change those choices as permitted in Advanced Health's administrative policies;

3.4.1.4. Refer oneself directly to Behavioral Health or family planning services without getting a referral from a PCP or other Participating Provider;

3.4.1.5. Have a friend, family member, member representative, or advocate present during appointments and other times as needed within clinical guidelines;

3.4.1.6. Be actively involved in the development of their Treatment Plan;

3.4.1.7. Be given information about their condition and Covered and Non-Covered services to allow an informed decision about proposed treatments;

3.4.1.8. Consent to treatment or refuse services and be told the consequences of that decision, except for court ordered services;

3.4.1.9. Receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency;

3.4.1.10. Have written materials explained in a manner that is understandable to the Member and be educated about the coordinated care approach being

used in the community and how to navigate the coordinated health care system;

3.4.1.11. Receive culturally and linguistically appropriate services and supports in locations as geographically close to where Members reside or seek services as possible and choice of providers within the delivery system network that are, if available, offered in non-traditional settings that are accessible to families, diverse communities, and underserved populations;

3.4.1.12. Receive oversight, care coordination and transition and planning management from Advanced Health within the targeted population to ensure culturally and linguistically appropriate community-based care is provided in a way that serves them in as natural and integrated an environment as possible and that minimizes the use of institutional care;

3.4.1.13. Receive necessary and reasonable services to diagnose the presenting condition;

3.4.1.14. Receive integrated person-centered care and services designed to provide choice, independence and dignity and that meet generally accepted standards of practice and are medically appropriate;

3.4.1.15. Have a consistent and stable relationship with a care team that is responsible for comprehensive care management;

3.4.1.16. Receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources including but not limited to the use of certified or qualified health care interpreters, certified traditional health workers including community health workers, peer wellness specialists, peer support specialists, doulas, and personal health navigators who are part of the Member's care team to provide cultural and linguistic assistance appropriate to the Member's need to access appropriate services and participate in processes affecting the Member's care and services;

3.4.1.17. Obtain Covered Preventive Services;

3.4.1.18. Have access to urgent and emergency services 24 hours a day, seven days a week without prior authorization;

3.4.1.19. Receive a referral to specialty providers for medically appropriate covered coordinated care services in the manner provided in Advanced Health's referral policy;

3.4.1.20. Have a clinical record maintained that documents conditions, services received, and referrals made;

3.4.1.21. Have access to one's own clinical record, unless restricted by statute;

3.4.1.22. Transfer of a copy of the clinical record to another provider;

3.4.1.23. Execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, or behavioral health treatment and the right to execute directives and powers of attorney for health care established under ORS 127;

3.4.1.24. Receive written notices before a denial of, or change in, a benefit or service level is made, unless a notice is not required by federal or State regulations;

3.4.1.25. Be able to make a complaint or appeal with Advanced Health and receive a response;

3.4.1.26. Request a contested case hearing;

3.4.1.27. Receive a notice of an appointment cancellation in a timely manner; and

3.4.1.28. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion.

3.4.2 Additional rights guaranteed under Contract, and federal and State law include the right to:

3.4.2.1.A second opinion from a Health Care Professional within the Provider Network or outside the Provider Network, at no cost to the Members;

3.4.2.2.Exercise their civil rights under Title VI of the Civil Rights Act and ORS Chapter 659A and to report a complaint of discrimination by contacting the Contractor, OHA, the Bureau of Labor and Industries or the Office of Civil Rights;

3.4.2.3.Receive written notice of Advanced Health's nondiscrimination policy and process to report a complaint of discrimination on the basis of race, color, national origin, religion, sex, sexual orientation, marital status, age, or disability in accordance with all Applicable Laws including Title VI of the Civil Rights Act and ORS Chapter 659A;

3.4.2.4.Equal access for both males and females under 18 years of age to appropriate facilities, services and treatment under this Contract, consistent with OHA obligations under ORS 417.270;

3.4.2.5.OHA certified or qualified health care interpreter services available free of charge to each Potential Member and Member. This applies to all non-English languages and sign language, not just those that OHA identifies as prevalent;

3.4.2.6.Have in place a mechanism to help Members and Potential Members understand the requirements and benefits of Advanced Health's plan and develop and provide written information materials and educational

programs consistent with the requirements of OAR 410-141-3280124F1 and 410-141-3300;

3.4.2.7. Receive information on available treatment options and alternatives presented in a manner appropriate to the Member's condition, preferred language, and ability to understand;

3.4.2.8. To request and receive a copy of their own Health Record, (unless access is restricted in accordance with ORS 179.505 or other Applicable Law) and to request that the records be amended or corrected as specified in 45 CFR Part 164;

3.4.2.9. Be furnished by Advanced Health the information specified in 42 CFR §438.10(f)(2)-(3), and 42 CFR §438.10(g), if applicable, as specified in the CFR within thirty (30) days after Advanced Health receives notice of the Member's Enrollment from OHA within the time period required by Medicare. Advanced Health shall notify all Members of their right to request and obtain the information described in this section at least once a year;

3.4.2.10. Access Covered Services which at least equals access available to other persons served by Advanced Health;

3.4.2.11. Exercise Member's rights, and that the exercise of those rights will not adversely affect the way Advanced Health, its staff, Subcontractors, Participating Providers, or OHA, treat the Member. Advanced Health shall not discriminate in any way against Members when those Members exercise their rights under the OHP;

3.4.2.12. Any cost sharing authorized under the Contract for Members is in accordance with 42 CFR §447.50 through 42 CFR §447.90 and the applicable Oregon Administrative Rules;

3.4.2.13. Be notified of Member's responsibility for paying a Co-Payment for some services, as specified in OAR 410-120-1230;

3.4.2.14. If available and upon request by Member, utilize electronic methods to communicate with and provide Member information;

3.4.2.15. Be furnished health care services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR §438.206 through 42 CFR §438.210);

3.4.2.16. Be provided information to help understand the requirements and the benefits of the Plan; and

[1] New OAR 410-141-3580

3.4.2.17. Exercise his or her rights and the exercise of those rights will not adversely affect the way Advanced Health, its Network Providers, or the State Medicaid agency treats the Member.

3.4.3 Advanced Health Members shall have the following responsibilities:

3.4.3.1. Choose or help with assignment to a PCP or service site;

3.4.3.2. Treat Advanced Health, Providers, and clinic staff members with respect;

3.4.3.3. Be on time for appointments made with Providers and to call in advance to cancel if unable to keep the appointment or if expected to be late;

3.4.3.4. Seek periodic health exams and preventive services from the PCP or clinic;

3.4.3.5. Use the PCP or clinic for diagnostic and other care except in an emergency;

3.4.3.6. Obtain a referral to a specialist from the PCP or clinic before seeking care from a specialist unless self-referral to the specialist is allowed;

3.4.3.7. Use urgent and emergency services appropriately and notify the Member's PCP or clinic within 72 hours of using emergency services in the manner provided in the Advanced Health's referral policy;

3.4.3.8. Give accurate information for inclusion in the clinical record;

3.4.3.9. Help the Provider or clinic obtain clinical records from other providers that may include signing an authorization for release of information;

3.4.3.10. Ask questions about conditions, treatments, and other issues related to care that is not understood;

3.4.3.11. Use information provided by Advanced Health Providers or care teams to make informed decisions about treatment before it is given;

3.4.3.12. Help in the creation of a Treatment Plan with the provider;

3.4.3.13. Follow prescribed agreed upon treatment plans and actively engage in their health care;

3.4.3.14. Tell the Provider that the Member's health care is covered under the OHP before services are received and, if requested, show the Provider the Division Medical Care Identification form;

3.4.3.15. Tell the Department or Authority worker of a change of address or phone number;

3.4.3.16. Tell the Department or Authority worker if the Member becomes pregnant and notify the worker of the birth of the member's child;

3.4.3.17. Tell the Department or Authority worker if any family members move in or out of the household;

3.4.3.18. Tell the Department or Authority worker if there is any other insurance available;

3.4.3.19. Pay for Non-Covered Services under the provisions described in OAR 410-120-1200 and 410-120-1280;

3.4.3.20. Pay the monthly OHP premium on time if so required;

3.4.3.21. Assist Advanced Health in pursuing any third-party resources available and reimburse Advanced Health the amount of benefits it paid for an injury from any recovery received from that injury; and

3.4.3.22. Bring issues or complaints or grievances to the attention of Advanced Health.

4.0 Policies

4.1 Advanced Health shall remain steadfast in its commitment towards ensuring its Members maintain access and receive treatment in a manner consistent with 42 CFR 438.100, OAR 410-141-3590 and Exhibit B Part 3 of the CCO 2.0 Contract, and will comply with all other federal and State laws that pertain to Member Rights, Protections and Responsibilities including Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR Part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR Part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education activities); Titles II and III of the Americans with Disabilities Act; and, Section 1557 of the Patient Protection and Affordable Care Act.

4.2 Advanced Health will ensure communication of Member Rights, Protections and Responsibilities to its Members, Subcontractors, including Network Providers, and employees.

4.3 Advanced Health shall monitor compliance with this Member Rights, Protections and Responsibilities Policy and Procedure.

4.4 Advanced Health shall follow its policies and procedures for the implementation and enforcement of any corrective action plans or disciplinary actions.

5.0 Procedures

5.1 Advanced Health meets its commitment to comply with all requirements outlined in Policy 5.1 by having a system with dedicated staff charged with the review and oversight of Member Rights, Protections and Responsibilities. While all staff are responsible for ensuring that our Members are treated in a manner consistent with their rights, the staff with primary responsibility for review and oversight of Member Rights, Protections and Responsibilities are:

5.1.1 The Chief Executive Officer—Primary responsibility for enforcement of any zero tolerance, or related action resulting in the termination of a contract or employee.

5.1.2 The Chief Compliance Officer—Primarily responsibility for auditing and monitoring of Advanced Health and its Subcontractors, including its Provider Network, and implementing appropriate corrective action as necessary up to, and including, termination of contractual agreements.

5.1.3 The Chief Medical Officer— Shared or primary responsibility for monitoring and overseeing any disciplinary action process of a Network Provider.

5.1.4 The Chief Operating Officer— Shared or primary responsibility for monitoring and overseeing any disciplinary action process of a Network Provider.

5.1.5 HR Generalist—Primary responsibility for monitoring employees, and overseeing any corrective or disciplinary action of employee(s)

5.1.6 Executive Program Director—Oversight and primary responsibility for all Grievance and Appeals monitoring and reporting processes. Primary responsibility for overseeing matters elevated through customer service monitoring activities.

5.1.7 Regulatory Compliance Committee—Primary body charged with oversight of all governance activities, including oversight of any corrective action process and monitoring to ensure corrective actions plans are closed timely.

5.2 Member Rights and Responsibilities will be communicated in, at a minimum, the following ways:

5.2.1 Communication to Members. The Director of Member Services is primarily responsible for communicating Member Rights, Protections and Responsibilities by ensuring that:

5.2.1.1. Members receive the Member Handbook, which includes Member Rights, Protections and Responsibilities within thirty (30) days after notification from OHA of the Member's Enrollment and at least annually thereafter;

5.2.1.2. Advanced Health's Member Handbook is maintained and prominently displayed at Advanced Health's front desk, or within the Member waiting area;

5.2.1.3. Paper and electronic copies of the Member Handbook are available upon request to Members;

5.2.1.4. An electronic copy of the Member Handbook is prominently displayed on Advanced Health's website; and

5.2.1.5. Customer service staff are well-versed in Member Rights, Protections and Responsibilities and assist Members over the phone who may have questions regarding their rights and responsibilities.

5.2.2 Communication to Subcontractors. The Chief Compliance Officer is primarily responsible for communicating Member Rights, Protections and Responsibilities

to its Network Providers, Privileged Providers and other Subcontractors who interact with our Members by ensuring that:

5.2.2.1. Contractual agreements include Member Rights, Protections and Responsibilities and the responsibilities of the Subcontractors to promote and honor those rights during their interactions with the Members;

5.2.2.2. Advanced Health's Provider Handbook, which includes Member Rights, Protections and Responsibilities, is given to each new Provider, either electronically or paper form, is electronically available on Advanced Health's website, and available upon request; and

5.2.2.3. Questions that Subcontractors may have regarding Member Rights, Protections and Responsibilities are promptly answered.

5.2.3 Communication to Employees. The Human Resource Generalist is primarily responsible for communicating Member Rights, Protections and Responsibilities to Advanced Health employees by ensuring that:

5.2.3.1. Training on Member Rights, Protections and Responsibilities is completed upon hire and at least annually thereafter for employees of Advanced Health;

5.2.3.2. A log is maintained documenting the completion of such training; and

5.2.3.3. Additional training is completed as needed as part of employee coaching or corrective action.

5.2.4 Communication to Provider Network. The Chief Medical Officer is primarily responsible for promoting Member Rights, Protections and Responsibilities within the Provider Network by ensuring that:

5.2.4.1. He or she promotes Member Rights, Protections and Responsibilities within the Provider Network, and educates fellow Providers by reinforcing our responsibilities and expectations during interactions with other Providers; and

5.2.4.2. Additional training and counseling, as applicable, is provided to those Providers who may not demonstrate a comprehensive understanding of Member Rights, Protections and Responsibilities.

5.3 Compliance with this Member Rights, Protections and Responsibilities Policy and Procedure will be monitored through at least the following mechanisms:

5.3.1 Quality Monitoring. Advanced Health's Quality Department, under the direction of the Executive Program Director, monitors and responds to Member Grievances, in accordance with Advanced Health's Grievance and Appeals Policies and Procedures, and reports Grievances and Appeals to OHA in accordance with OHA requirements.

5.3.1.1. Grievances involving potential violations of Member Rights are reported to the Chief Compliance Officer for further investigation and response, as needed.

5.3.2 Contracts Monitoring. Annual review of Subcontractor performance includes a review of Member Rights processes.

5.3.3 Customer Services. Potential violations of Member Rights, Protections and Responsibilities are generally identified through Member Complaints, and are investigated and acted upon in accordance with Advanced Health's Grievance and Appeals Policies and Procedures.

5.3.4 Claims Post-Payment Integrity and Member Survey Letters. As part of its Post-Payment Integrity Review processes, Advanced Health monitors its Member survey letters for indications of potential, suspected or likely Member Rights, Protections and Responsibilities violations.

5.4 Corrective action plans and disciplinary actions will be in accordance with the:

5.4.1 Employee Handbook, Supervisor Manual and applicable Human Resource Policies and Procedures;

5.4.2 The Compliance Manual and related Fraud, Waste and Abuse Policies and Procedures;

5.4.3 The Contracting Manual Policies and Procedures; and

5.4.4 Terms of applicable Subcontract agreements.

6.0 Reference Sources

6.1 42 CFR §438.100 and *et. seq*.

6.2 42 CFR §§447.50 through 447.90

6.3 42 CFR Part 80 (Title VI of the Civil Rights Act of 1964)

6.4 45 CFR Part 91 (Age Discrimination Act of 1975)

6.5 The Rehabilitation Act of 1973

6.6 Title IX of the Education Amendments of 1972

6.7 Titles II and III of the Americans with Disabilities Act

6.8 Section 1557 of the Patient Protection and Affordable Care Act

6.9 ORS § 417.270

6.10 ORS § 127.505 through 127.660.

6.11 OAR 410-141-3590.

6.12 CCO 2.0 Contract, Exhibit B, Part 3.

7.0 Related Documents

7.1 Employee Handbook.

7.2 Supervisor Manual

7.3 Provider Handbook.

7.4 Compliance Plan.

7.5 Fraud, Waste and Abuse Policies and Procedures.

7.6 Grievance and Appeals Policies and Procedures.

7.7 Advance Directives Policies and Procedures.

7.8 Behavioral Health Policies and Procedures.

7.9 Care Coordination/Intensive Care Coordination Policies and Procedures.

8.0 Attachments

8.1 None

9.0 Approvals

Document Owner:	Michael Hale Name
Approved:	***Michael C. Hale*** Signature Title: Chief Compliance Officer Date: March 16, 2020
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Member Grievance System Policies and Procedures

Company: Advanced Health CCO	Approved by: Anna Warner Title: Executive Program Director
Department: Grievance and Appeals	
Process: Member Grievance System	Revision Date: March 3, 2021
	Original Effective Date: September 2, 2014

Contents

1.0 Purpose

The purpose of this Member Grievance System policy and procedure manual is to ensure that Advanced Health shall have a Grievance System, supported by written policies and procedures, for Members that includes a Grievance process, Appeal process, and access to Contested Case Hearings.

2.0 Scope

This policy and procedure manual applies to all Advanced Health employees, health services providers, and Advanced Health plan Members.

3.0 Policy

It is the policy of Advanced Health to establish, maintain, enforce, and evaluate a robust and responsive Member Grievance System that supports quality management and improvement, while also providing a respectful and understandable process for Advanced health Members to give voice to concerns regarding their care, including a process

for the Appeal of any Adverse Benefit Determinations, directly, or through their provider, if there is written consent of the member, and the opportunity, if requested by the Member, for a review of decisions through the State's Fair Hearing process.

The Grievance System shall meet the requirements of CCO Contract Exhibit I, OAR 410-141-3875 through 410-141-3915 and 42 CFR § 438.400 through 42 CFR § 438.424. This system will also include Grievances and Appeals related to requests for accommodation in communication or provision of services for Members with a disability or limited English proficiency.

Information gathered through the Grievance and Appeal system shall be used by Advanced Health and the provider network for the purpose of quality improvement and to ensure Members' access to clinically appropriate covered services (including physical, behavioral, and oral health services) and coordinated care that meets Members' needs and respects their dignity.

4.0 Procedure

4.1 Grievance and Appeal System Requirements

This Procedure describes Advanced Health's Grievance and Appeal System and how the Grievance and Appeal System complies with the requirements of the CCO Contract, OAR 410-141-3875 through 410-141-3915 and 42 CFR § 438.400 through 42 CFR § 438.424 (collectively, the "Requirements").

a) Advanced Health provides all Members with written, oral or posted materials explaining: (i) how Advanced Health accepts, processes, and responds to Grievances, Appeals, and Requests; (ii) Member rights and responsibilities; and (iii) how to file for a hearing through the State's eligibility hearings unit. Advanced Health provides Members assurance of confidentiality in all written, oral, and posted material relating to the Grievance and Appeal System. As examples, Advanced Health provides materials to its Members by means of the following mechanisms.

   i. Members are provided information about the Grievance and Appeal System, including information in written materials describing this Procedure and how to file a Grievance, Appeal, or Hearing Request. This information includes toll free numbers at which Grievances and Appeals may be filed and information about the availability of assistance in the filing process.

   ii. Members are provided educational materials regarding Advanced Health policies and procedures, including a copy of this Procedure, information in the Advanced Health Member Handbook that is sent to all newly enrolled Members, given to all Members at meetings with Advanced Health, made available on Advanced Health's website, and provided upon a Member's request.

   iii. Advanced Health also provides Members a copy of the Authorization for Use and Disclosure of Information form (MSC 2099), Advanced Health Complaint form and Information Packet and the Appeal and Hearing Request form (OHP 3302).

b) All communications and materials provided to Members are drafted to be easily understood and to address health literacy issues, including by preparing documents at a low-literacy reading level. For example, Grievances are referred to as "Complaints" in communications and materials provided to Members, consistently with the Oregon Health Plan Complaint form (OHP 3001).

c) Advanced Health documents and maintains records of each Grievance and Appeal in a log as further provided in Section 4.8 below. As further provided in Advanced Health's Transformation and Quality Strategy, Advanced Health, including Advanced Health's Grievance and Appeals Committee, analyzes the information that it receives regarding Grievances and Appeals in order to develop specific initiatives to

improve the access, quality, and appropriateness of the services that are provided to Members.

d) A Grievance or Appeal may be filed either orally (in person or by telephone) or in writing. Advanced Health's customer service staff processes each Grievance and Appeal that Advanced Health receives and, if the customer service staff does not have authority to act on the Grievance or Appeal, sends the Grievance or Appeal to Advanced Health's Grievance System Coordinator.

e) Advanced Health's staff ensures that each Grievance and Appeal is accepted, processed, and responded to according to this Procedure, including as follows.

   i. Advanced Health acknowledges receipt of the Grievance or Appeal to the Member or, as applicable, the Member's representative, within five business days of the date on which a Grievance or Appeal is filed.

   ii. The staff and consulting experts who make decisions on each Grievance or Appeal, whether employed directly or through a subcontractual agreement, are individuals who: (1) were not involved in any previous level of review or decision making nor a subordinate of any such individual; (2) in certain circumstances, as further provided in Sections 4.2 and 4.4, must be health care professionals with appropriate clinical experience; (3) take into account all comments, documents, records, or other information submitted by the Member or Provider, as applicable, without regard to whether the information was submitted or considered in an initial Adverse Benefit Determination or resolution of a Grievance; and (4) must not receive incentivized compensation for utilization management activities or otherwise be subject to utilization management activities that are structured so as to provide incentives for the staff or consulting experts to deny, limit, or discontinue medically necessary services to any Member.

f) Advanced Health keeps all healthcare information concerning a Grievance, Appeal, or Hearing Request confidential, consistent with appropriate use or disclosure requirements.

g) Advanced Health and any Provider whose authorizations, treatments, services, items, quality of care, or request for payment are involved in a Grievance, Appeal, or Contested Case Hearing may use the Member's information, without obtaining a release of information from the Member, for purposes of: (i) resolving the Grievance, Appeal, or Contested Case Hearing; and (ii) maintaining the log as further provided in Section 4.8 below. If, in order to respond to the Grievance, Appeal, or Contested Case Hearing, Advanced Health needs to communicate with someone other than a Provider described in the preceding sentence, then Advanced Health will obtain an Authorization for Release of Information from the Member to allow Advanced Health to obtain further documentation on an as needed basis and in a confidential manner. Advanced Health maintains any Authorization for Release of Information in the Member's record.

h) Advanced Health provides all Members reasonable assistance in completing forms and taking other procedural steps related to filing Grievances, Appeals, or Hearing Requests. The assistance that Advanced Health provides includes, but is not limited to: (1) Assistance from qualified community health workers, qualified peer wellness specialists, or personal health navigators to participate in processes affecting the Member's care and services; (2) Free interpreter services or other services to meet language access requirements as required in 42 CFR § 438.10, which is provided in the attached Schedule 2; (3) Providing auxiliary aids and services upon request including but not limited to toll-free phone numbers that have adequate teletypewriter / telecommunications device for the deaf and interpreter capabilities; and (4) Reasonable accommodation or policy and procedure modifications as required by any disability of the Member.

i) Advanced Health does not, and requires its Subcontractors and Network Providers not to:

   i. discourage a Member from using any aspect of the Grievance and Appeal System or take punitive action against a Provider who requests an expedited resolution or supports a Member's Grievance or Appeal;

   ii. encourage the withdrawal of a Grievance, Appeal, or Request that has been filed; or

   iii. use the filing or resolution of a Grievance, Appeal, or Request as a reason to retaliate against a Member or to request Member disenrollment.

j) In all of Advanced Health's administrative offices and in those other offices to which Advanced Health has assigned responsibilities for Appeal, Request, or Grievance involvement, Advanced Health makes available a supply of blank: (1) OHP Complaint Forms (OHP 3001); (2) Advanced Health Appeal forms; (3) Administrative Hearing Request forms (MSC 443); (4) Notice of Hearing Rights (OHP 3030); and (5) Health Systems Division Service Denial Appeal and Hearing Request forms (OHP 3302). Advanced Health makes some of these forms available on its website.

k) Advanced Health provides information about the Grievance and Appeal System, including a copy of this Procedure, to all Network Providers and Subcontractors at the time they enter into a contract with Advanced Health and through periodic meetings and trainings. Advanced Health includes this information, including a copy of this Procedure, in its Provider Handbook and on its Provider website and also provides updates to all Network Providers and Subcontractors within five business days of OHA approving any update to this Procedure. The information that Advanced Health provides to Network Providers and Subcontractors includes the information that Advanced Health provides to Members regarding:

   i. The right to file Grievances and Appeals;

   ii. The requirements and timeframes for filing a Grievance or Appeal;

   iii. The availability of assistance in the process of filing a Grievance or Appeal;

   iv. The right to request a Contested Case Hearing; and

   v. The fact that benefits may continue while an Appeal or Contested Case Hearing is pending, and that the Member may be required to pay the cost of services provided while the Appeal or Contested Case Hearing is pending if the final decision is adverse to the Member.

l) Advanced Health does not delegate or subcontract adjudication of Appeals. If Advanced Health delegates any aspect of the Appeal process to a Subcontractor, then Advanced Health remains responsible for making the final decision resolving each Appeal.

m) Advanced Health promptly cooperates, and causes its Subcontractors and Network Providers to promptly cooperate, in all investigations or requests from the Department of Human Services Governor's Advocacy Office, DHS's Client Services Unit ("CSU"), OHA's Ombudsman, or Contested Case Hearing representatives, including by providing all requested written materials in a timely manner, as expeditiously as the Member's health condition requires, and no longer than the timeframes established in the CCO Contract.

n) If, at the Member's request, Advanced Health continues or reinstates the Member's benefits while an Appeal or Contested Case Hearing is pending, then the benefits will continue as provided in Section 4.7 below.

o) With respect to each Subcontractor or Network Provider to whom Advanced Health delegates any of Advanced Health's responsibilities relating to Grievances under the Grievance and Appeal System, Advanced Health:

i. Requires and validates that the Subcontractor complies with the Requirements;

ii. Monitors the Subcontractor's performance on an ongoing basis, including by requiring the Subcontractor to participate in periodic meetings, which may include reviewing Grievances and recommending quality improvements;

iii. Performs a formal compliance review with respect to the Subcontractor annually to assess performance, deficiencies, or areas for improvement;

iv. Causes the Subcontractor to take Corrective Action for any identified areas of deficiencies that need improvement; and

v. Requires Subcontractors to maintain and provide to Advanced Health records of all Grievances and Appeals that are filed with the Subcontractor, which records Advanced Health reviews, analyzes, and logs in accordance with Section 4.8.

4.2 Grievance Procedure

a) A Member may file a Grievance at any time, orally or in writing, to Advanced Health or OHA. Advanced Health accepts, acknowledges receipt of, processes, documents, and logs Grievances as provided in Section 4.1 above and in this Section 4.2.

i. Advanced Health resolves each Grievance in writing and provides notice of the disposition as expeditiously as the Member's health condition requires but no later than 30 calendar days from the date that the Grievance was filed (the "Grievance Filing Date").

ii. If Advanced Health is able to resolve a Grievance within five business days from the Grievance Filing Date, then Advanced Health will provide the Member with notice of resolution within that five-day period. If Advanced Health is unable to resolve a Grievance within five business days from the Grievance Filing Date, then, within that five-day period, Advanced Health will notify the Member in writing: (1) that a delay in Advanced Health's decision, of up to 30 calendar days from the Grievance Filing Date, is necessary to resolve the Grievance; and (2) all reasons why the additional time is necessary.

iii. On receipt, Advanced Health assigns the Grievance to staff and consulting experts as provided in this Section. If a Member files a Grievance orally, Advanced Health's customer service staff asks the Member whether the Member would like Advanced Health to send the Member a copy of the Oregon Health Plan Complaint Form (OHP 3001) to use in filing a written Grievance.

A. The staff and consulting experts to whom resolution of a Grievance is assigned satisfy the requirements provided in Section 4.1(e)(ii) above.

B. If the Member who is filing a Grievance agrees, Advanced Health's customer service staff may, with respect to some types of Grievances, facilitate resolution of the Grievance in a single phone call. As examples, Advanced Health's customer service staff is authorized to change a Member's primary care provider assignment if requested, refer to Advanced Health case management or Intensive Care Coordination services, and offer Member education. If the nature of the Grievance cannot be resolved by these means, if it requires

clinical review, or if the Member requests that the Grievance be assigned to someone other than Advanced Health's customer services staff, then Advanced Health's customer service staff escalates the Grievance for review and resolution.

C. Escalated Grievances are given to the Grievance System Coordinator and, as needed, Advanced Health's executive level staff, for review and resolution. The Grievance System Coordinator may also engage Advanced Health's Clinical Advisory Panel to review and resolve Grievances involving clinical or other issues, as appropriate.

D. If a Grievance involves a denial of expedited resolution of an Appeal, clinical issues, or a denial based on Medical Appropriateness or medical necessity, then the Grievance is assigned to health care professionals with appropriate clinical expertise in treating the Member's conditions or disease, and only a person with that expertise may resolve the Grievance.

E. Details and resolutions of Grievances are reviewed each week by the Grievance System Coordinator to monitor for appropriate resolution and categorization of Grievances, emerging trends, and opportunities for improvement.

iv. If Advanced Health is notified of a Grievance that a Member chose to resolve outside of Advanced Health's Grievance and Appeal System, then Advanced Health notes the Grievance in its Grievance log as further provided in Section 4.8 below.

b) The notices of resolution that Advanced Health provides in response to Grievances are as provided in this section.

i. Advanced Health provides the Member a written notice of resolution in response to all Grievances, regardless of whether Advanced Health received the Grievance in writing or orally. In addition to the written notice of resolution, Advanced Health may also respond to the Grievance orally.

ii. The notice of resolution addresses each aspect of the Member's Grievance specifically and explains the reasons for Advanced Health's decision.

iii. Each notice of resolution notifies the Member that, if the Member is dissatisfied with Advanced Health's disposition of the Grievance, the Member may present the Grievance to the CSU toll free at 800-273-0557 or OHA's Ombudsman at 503-947-2346 or toll free at 877-642-0450.

iv. Each notice of resolution complies with OHA's formatting and readability standards in OAR 410-141-3300, which is attached to this Procedure as Schedule 3, and the standards described in 42 CFR § 438.410, which is attached to this Procedure as Schedule 2. Each notice is written in language sufficiently clear that a layperson can understand the disposition of the Grievance and the process for Members who are dissatisfied to present the Grievance to CSU or OHA's Ombudsman.

c) In compliance with Title VI of the Civil Rights Act and ORS Chapter 659A, Advanced Health reviews and reports to OHA Grievances that raise issues related to racial or ethnic background, gender identity, sexual orientation, socioeconomic status, culturally or linguistically appropriate service requests, disability status, and other identity factors for consideration in improving services for health equity.

d) When Advanced Health receives a Grievance related to a Member's entitlement of continuing benefits in the same manner and same amount during the transition of transferring from Advanced Health to

another CCO, it logs the Grievance and works with the receiving CCO to ensure continuity of care during the transition.

4.3 Notice of Adverse Benefit Determination (NOABD)

a) When Advanced Health takes or intends to take any Adverse Benefit Determination, Advanced Health notifies the requesting Provider, if any, and mails a written Notice of Adverse Benefit Determination to the Member as provided in this Section 4.3. Advanced Health requires each Subcontractor and Network Provider to follow this Procedure when the Subcontractor or Network Provider takes or intends to take any Adverse Benefit Determination.

b) Each written NOABD:

i. Uses Advanced Health's NOABD template, which NOABD template Advanced Health provided to OHA's Contract Administrator for review and approval prior to use;

ii. Meets the formatting and readability standards provided in the attached Schedule 2 and the attached Schedule 3;

iii. Is written in language sufficiently clear that a layperson could understand the NOABD and make an informed decision about appealing the Adverse Benefit Determination and following the process for requesting an Appeal;

iv. Is translated in writing for Members who speak prevalent non-English languages; and

v. Includes an explanation that auxiliary aids and an oral interpretation of the NOABD are available and how the Member may access the auxiliary aids and oral interpretation.

c) Each NOABD includes:

i. Relevant information including, but not limited to the following:

A. The Adverse Benefit Determination that Advanced Health has made or intends to make, including whether Advanced Health is denying, terminating, suspending, or reducing a service, or denying payment;

B. Date of the NOABD;

C. Advanced Health's name, address, and phone number;

D. Name of the Member's Primary Care Practitioner ("PCP"), Primary Care Dentist ("PCD"), or behavioral health professional, as applicable;

E. Member's name, address, and ID number;

F. Service requested or previously provided;

G. Date on which the service or item was either requested or provided;

H. The name of the person who requested or provided the item or service;

I. Effective date of the Adverse Benefit Determination, if different from the date of the NOABD; and

J. Whether Advanced Health considered other conditions, such as co-morbidity factors, if the service was below the funding line on the OHP Prioritized List of Health Services.

ii. A clear and thorough explanation of the specific reasons for the Adverse Benefit Determination, including, but not limited to any of the following reasons:

A. The item requires Prior Authorization, and it was not prior authorized;

B. The service or treatment requested is not medically necessary or Medically Appropriate;

C. Service or treatment is not a Covered Service or does not meet requirements based on the Prioritized List of Health Services;

D. The service or item was received in an emergency care setting and does not qualify as an Emergency Service;

E. The person was not a Member at the time of the service or is not a Member at the time of a requested service;

F. The Provider is not on Advanced Health's panel and prior approval was not obtained (if such prior authorization would be required under the Requirements); or

G. Advanced Health denies Member's disenrollment request and finds that there is not good cause for the request.

iii. A reference to the specific sections, to the highest level of specificity, of the statutes and administrative rules involved for each reason identified in the NOABD.

iv. An explanation of the Member's right to be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Adverse Benefit Determination, including medical necessity criteria and any processes, strategies, or evidentiary standards used by Advanced Health in setting coverage limits or making the Adverse Benefit Determination.

v. An explanation of the Member's right to file an Appeal, including information relating to the filing and resolving of Appeals as provided in Section 4.4 below and that a Provider, or authorized representative, may file on behalf the Member with the Member's written consent, including:

A. The procedures to exercise the right to an Appeal, including the toll- free number that the Member can use to file the Appeal by phone and procedures for contacting Advanced Health to obtain assistance in preparing and filing the Appeal;

B. That the Appeal may be filed orally or in writing; and

C. That, unless the Member or Provider is requesting expedited resolution, the Member or Provider must file the Appeal in writing within the 60-day Appeal timeframe or the Appeal will expire.

vi. An explanation of the Member's right to request a Contested Case Hearing following resolution of the Appeal or if Advanced Health fails to meet the Timing Requirements, and the procedures to exercise the right to request a Contested Case Hearing.

vii. An explanation of the expedited Appeal and Contested Case Hearing process and the circumstances under and mechanisms by which a Member may request an expedited Appeal or Contested Case Hearing.

viii. An explanation of the Member's right to request that the benefits that are being denied continue pending resolution of the Appeal; how to request the services that are being denied; and the circumstances under which the Member may be required to pay the costs for the services if the outcome of the Appeal (including any contested case hearing) upholds the Adverse Benefit Determination.

ix. The telephone number to contact Advanced Health for additional information.

d) Along with the NOABD, Advanced Health provides the Member with the Appeal and Hearing Request form (OHP 3302) to request to review a health care decision.

e) Advanced Health mails the NOABD within the following time frames:

i. For termination, suspension, or reduction of previously authorized Covered Services, the following time frames apply:

A. Advanced Health mails the NOABD at least 10 calendar days before the date that the Adverse Benefit Determination takes effect (the "ABD Effective Date"), except as permitted under subsections (B) or (C) of this section.

B. Advanced Health may mail the NOABD less than 10 calendar days before the ABD Effective Date, but not later than the ABD Effective Date, if:

1) Advanced Health has factual information confirming the death of the Member;

2) Advanced Health receives a clear written statement signed by the Member stating that the Member no longer wishes services or gives information that requires termination or reduction of services and indicates that the Member understands that this must be the result of supplying the information;

3) Advanced Health can verify that the Member has been admitted to an institution where the Member is ineligible for Covered Services from Advanced Health;

4) Advanced Health is unaware of the Member's whereabouts, the post office returns Advanced Health's mail directed to the Member indicating no forwarding address, and OHA and the Department of Human Services has no other address for the Member;

5) Advanced Health verifies that another state, territory, or commonwealth has accepted the Member for Medicaid services;

6) The Member's PCP, PCD, or behavioral health professional prescribed a change in the level of medical or dental care;

7) There is adverse determination made with regards to the preadmission screening requirements for Long-Term Psychiatric Care admissions; or

8) The safety or health of individuals in a facility would be endangered, the

Member's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the Member's urgent medical needs, or the Member has not resided in the Long-Term Psychiatric Care facility for 30 days (applies only to Adverse Benefit Determinations for Long-Term Psychiatric Care facility transfers).

C. Advanced Health may mail the NOABD less than 10 calendar days before the ABD Effective Date, but not later 5 calendar days before the ABD Effective Date, if Advanced Health has facts indicating that an Adverse Benefit Determination should be taken because of probable Fraud by the Member, and Advanced Health has, whenever possible, verified those facts through secondary sources.

ii. For denial of payment, Advanced Health mails the NOABD at the time the Adverse Benefit Determination affects the claim.

iii. For standard authorization requests for services not previously authorized, Advanced Health provides an NOABD as expeditiously as the Member's health condition requires and no later than 14 calendar days following receipt of the request for service, except as provided below:

A. Advanced Health may have an extension of up to 14 additional calendar days if: (a) the Member or the Provider requests the extension; or (b) Advanced Health justifies to OHA upon request a need for additional information and how the extension is in the Member's interest.

B. If Advanced Health extends the timeframe, in accordance with subsection (A) above, then it gives the Member written notice within two calendar days, and makes reasonable effort to give the Member oral notice, of the reason for the decision to extend the timeframe and inform the Member of the right to file a Grievance if he or she disagrees with that decision.

iv. If a Provider indicates, or Advanced Health determines, that following the standard timeframe for an authorization decision could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function, then Advanced Health will make an expedited authorization decision and provide the NOABD as expeditiously as the Member's health condition requires and no later than 72 hours after receipt of the request for service, except as provided below:

A. Advanced Health may extend the 72-hour period up to 14 calendar days if: (a) the Member requests the extension; or (b) Advanced Health justifies to OHA upon request a need for additional information and how the extension is in the Member's interest.

B. If Advanced Health extends the timeframe, in accordance with subsection (A) above, then it gives the Member written notice, and makes reasonable effort to give the Member oral notice, of the reason for the decision to extend the timeframe and inform the Member of the right to file a Grievance if he or she disagrees with that decision.

v. Any Prior Authorization decision not reached within the timeframes provided in this Section 3(e) constitutes a deemed exhaustion of the Advanced Health Appeals process. The NOABD for any such decision will be mailed on the date that the service authorization decision timeframe expires. The Member will have the right to initiate a Contested Case.

4.4 Appeal Procedures

a) A Member may file an Appeal with Advanced Health orally (in person or via telephone call) or in writing, as further provided in this Section 4.4. Additionally, Advanced Health treats as Appeals all Requests and other notices that are filed with OHA and that OHA transmits to Advanced Health for resolution as an Appeal. Advanced Health accepts, acknowledges receipt of, processes, documents, and logs Appeals as provided in Section 4.1 above and in this Section 4.4. Advanced Health has only one level of Appeal.

b) Advanced Health treats all oral Appeals as Appeals to establish the earliest possible filing date. However, unless the Member requests an expedited resolution of the Appeal as provided in Section 4.6 below, the Member must file a written and signed Appeal after orally filing an Appeal.

c) The Member must file the Appeal with Advanced Health no later than 60 days from the date of the NOABD that is the subject of the Appeal.

d) Responsibility for initially reviewing each Appeal is given to an appropriate Advanced Health staff member, who generally will be the Grievance System Coordinator or the Lead Customer Service Representative, who then provides information to the Chief Medical Officer, the Medical Director, or another designated reviewer for resolution of the Appeal. The Appeal may also be reviewed by the Clinical Advisory Panel if necessary. If the party filing the Appeal (the "Appellant") requests expedited resolution of the Appeal or the Appeal involves clinical issues or a denial that is based on lack of Medically Appropriate services, then the Appeal is assigned to health care professionals with appropriate clinical expertise in treating the Member's conditions or disease, and only a person with that expertise may review and resolve the Appeal. Advanced Health maintains internal documentation that provides who makes and is accountable for each decision resolving an Appeal.

e) Consistent with applicable confidentiality requirements, on receipt of an Appeal, Advanced Health's staff begins obtaining documentation of all relevant facts concerning the Appeal. Advanced Health's staff takes into account all comments, documents, records, and other information submitted by the Appellant, without regard to whether the information was submitted or considered in an initial Adverse Benefit Determination or resolution of a Grievance.

f) Advanced Health gives the Appellant a reasonable opportunity, in person as well as in writing, to present evidence and testimony and make legal and factual arguments. Advanced Health's staff:

   i. Works with the Appellant to arrange for a reasonable time at which the Appellant may present information at Advanced Health's administrative office to Advanced Health's designated staff member in customer service staff, the Grievance System Coordinator, or another designated staff member;

   ii. Promptly informs the Appellant of the limited time available for the Appellant to present information and make arguments sufficiently in advance of the resolution timeframe for standard Appeals and in the case that an Appellant requests an expedited resolution; and

   iii. At the Member’s request, and sufficiently in advance of the resolution timeframe, provides the Member, at no cost to the Member, a copy of the Member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied on, or generated by Advanced Health or at Advanced Health's direction in connection with the Appeal. When requested, Advanced Health strives to provide the Member with the copy of the Member's case file along with written acknowledgment of Appeal and provide additional documents and records as they are obtained.

g) Advanced Health includes as parties to the Appeal: (i) the Member or Member Representative, if any; (ii) any Provider or Subcontractor directly adversely affected by the Adverse Benefit Determination and filing the Appeal or otherwise acting on behalf of the Member as provided in this Procedure; (iii) Advanced Health; and (iv) the legal representative of a deceased Member's estate, if any.

h) Advanced Health resolves each Appeal and provides the notice of the Appeal resolution described in subsection (h) of this section 4.4 (the "Notice of Appeal Resolution"), as expeditiously as the Member's health condition requires and within the time frames in this section:

i. For the standard resolution of Appeals, Advanced Health resolves the Appeal and provides a Notice of Appeal Resolution to the Member no later than 16 days from the day Advanced Health received the Appeal. This timeframe may be extended pursuant to subsection (iv) of this section.

ii. For resolution of an Appeal filed by a Provider or Subcontractor about an action affecting the Provider or Subcontractor, Advanced Health resolves the Appeal and provides a Notice of Appeal Resolution to the Appellant no later than 30 days from the day Advanced Health received the Appeal.

iii. For an expedited Appeal, Advanced Health provides the Member and, as applicable, the Provider a Notice of Appeal Resolution no later than 72 hours after Advanced Health received the Appeal. This timeframe may be extended pursuant to subsection (iv) of this section.

iv. Advanced Health may extend the timeframes from subsections (i) and (iii) of this section by up to 14 days if:

A. The Member requests the extension; or

B. Advanced Health shows to the satisfaction of OHA, upon its request, that there is need for additional information and how the delay is in the Member's interest.

v. If Advanced Health extends the timeframes, then, for any extension not requested by the Member, it: (1) makes reasonable efforts to give the Member prompt oral notice of the delay; and (2) within two calendar days, gives the Member written notice of the reason for the decision to extend the timeframe and informs the Member of the right to file a Grievance if the Member disagrees with that decision. Advanced Health also alerts the member of their right to request a contested case hearing if Advanced Health fails to adhere to required time frames.

i) For notice on an expedited resolution, Advanced Health makes reasonable efforts to provide oral notice in addition to the written Notice of Appeal Resolution. For all Appeals, the written Notice of Appeal Resolution:

i. Uses Advanced Health's Notice of Appeal Resolution template;

ii. Meets the formatting and readability standards provided in the attached Schedule 2 and the attached Schedule 3;

iii. Is written in language sufficiently clear that a layperson could understand the Notice of Appeal Resolution and make an informed decision about requesting a Contested Case Hearing;

iv. Is translated in writing for Members who speak prevalent non-English languages; and

v. Includes an explanation that auxiliary aids and an oral interpretation of the Notice of Appeal

Resolution are available and how the Member may access the auxiliary aids and oral interpretation.

j) Additionally, each Notice of Appeal Resolution includes the following:

i. The results of the resolution process and the date Advanced Health completed the resolution; and

ii. For Appeals not resolved wholly in favor of the Member, the Notice of Appeal Resolution also includes the following information:

A. Reasons for the resolution and reference to the particular sections of the statutes and administrative rules involved for each reason;

B. An explanation of the right of the Member to file, within 120 days from the date of the Notice of Appeal Resolution, a Hearing Request or request an expedited Contested Case Hearing with OHA and how to do so, which includes the Appeal and Hearing Request (OHP 3302);

C. An explanation of the right to request to continue receiving benefits while the Contested Case Hearing is pending and how to do so;

D. An explanation of the Member's right to be represented in a Contested Case Hearing by an attorney or Member Representative and the availability of free legal help through Legal Aid Services and Oregon Law Center, including the telephone number of the Public Benefits Hotline, 1-800-520-5292, TTY 711;

E. An explanation that the Member may be held liable for the cost of continued benefits if the Contested Case Hearing decision upholds Advanced Health's Adverse Benefit Determination; and

k) If Advanced Health delegates any part of the Appeal process to a Subcontractor, then Advanced Health requires the Subcontractor to (i) notify Advanced Health of any Appeal no later than two days after it is filed with the Subcontractor, and (ii) cooperate in providing Advanced Health with all information that Advanced Health requires to resolve the Appeal. Advanced Health's Grievance System Coordinator coordinates with the Subcontractor to ensure that the Appeal is processed in accordance with this Procedure and that Advanced Health makes the final decision resolving the Appeal.

4.5 OHA Contested Case Hearings

a) A Member may request a Contested Case Hearing by filing the Appeal and Hearing Request Form 3302 with OHA or Advanced Health no later than 120 days from the date of Advanced Health's Notice of Appeal Resolution. A Member may also request a Contested Case Hearing if Advanced Health fails to satisfy any of the Timing Requirements. A Provider or Subcontractor filing a Hearing Request with respect to an Appeal that directly adversely affected the Provider or Subcontractor must file the Request no later than 30 days after the Notice of Appeal Resolution.

b) Within two business days of OHA's request, Advanced Health's Grievance System Coordinator or designated customer service staff creates and provides to OHA's Hearings Unit a hearing file containing the following documentation (the "Required Documentation"):

i. Advanced Health's log of all Appeals containing any of the following information:

A. The Member's name and Medicaid ID number;

B. Date of the original NOABD;

C. The Notice of Appeal Resolution;

D. Date and nature of the Appeal;

E. Whether continuing benefits were requested and provided; and

F. Advanced Health's resolution and the resolution date of the Appeal and

ii. A complete record for each Appeal included in the log for no less than 300 days, to include:

A. Records of each review or investigation; and

B. Resolution, including all written decisions and copies of correspondence with the Member and all evidence, testimony, or additional documentation provided by the Member, the Member Representative, or the Member's Provider as part of the Appeal process.

iii. Advanced Health's Grievance System Coordinator or designated customer service staff gathers and verifies that each item included in the Required Documentation file is related to the Contested Case Hearing and does not contain any documents not related to the Member or the Member's Appeal.

c) If the Member files a Hearing Request with Advanced Health and the Request either relates to an Appeal that Advanced Health has completed or Advanced Health's failure to comply with a Timing Requirement, then Advanced Health:

i. Date-stamps the Hearing Request with the date of receipt;

ii. Immediately transmits to OHA a copy of each of the Hearing Request, the NOABD, and the Notice of Appeal Resolution; and

iii. Within two business days, transmits to OHA all documents and records that Advanced Health relied upon, including those used as the basis for the Adverse Benefit Determination or the Notice of Appeal Resolution, if applicable, and all other Required Documentation.

d) If the Member files a Hearing Request with Advanced Health and the Appeal is not complete, Advanced Health notifies the OHA Administrative Hearing unit of the request. The notification includes a copy of the hearing request, a copy of the Notice of Adverse Benefit Determination, and the appeal start date.

e) A Hearing Request may be expedited by selecting yes, for a fast hearing, on the Appeal and Hearing request form 3302, to indicate that the Request meets the requirements for an expedited Contested Case Hearing.

f) A Member may be represented in a Contested Case Hearing by an attorney or any of the individuals identified in ORS 183.458.

g) OHA will resolve the case ordinarily within 90 calendar days from the date that Advanced Health receives the Appeal, not counting the number of days that the Member took to subsequently file the Request.

4.6 <u>Request for Expedited Appeal or Expedited Contested Case Hearings</u>

a) Advanced Health has established and maintains a process for an expedited review of Appeals and for

ensuring that Members have access to expedited Contested Case Hearings. Expedited Appeals are available when the Member or the Provider indicates, or Advanced Health determines, that taking the time for a standard resolution could seriously jeopardize the Member's life, health, or ability to attain, maintain or regain maximum function. Advanced Health trains its customer service staff to identify when a Member or Provider is requesting expedited review and to take action as soon as possible to begin the Appeal process when such a review is requested or when the staff is uncertain about whether expedited review may be necessary.

b) Advanced Health ensures that punitive action is not taken against a Provider who requests an expedited resolution or supports a Member's Appeal.

c) Advanced Health completes the review of an expedited Appeal within the timeframes provided in Section 4.4(h)(iii) above. Advanced Health informs the Member or Provider who files the expedited Appeal of the limited time available for Advanced Health to receive materials or documentation for review in resolving the Appeal.

d) If Advanced Health provides an expedited Appeal but denies the services or items requested in the expedited Appeal, then Advanced Health informs the Member of the right to request an expedited Contested Care Hearing and sends the Member the Appeal and Hearing Request Form 3302. Advanced Health also submits all relevant documentation to OHA within two business days of the date of Advanced Health's Notice of Appeal Disposition.

e) Advanced Health makes reasonable efforts to provide oral notice of each expedited resolution. If Advanced Health denies a request for expedited resolution of an Appeal, Advanced Health:

   i. Transfers the Appeal to the time frame for standard resolution provided in Section 4.4(h)(i) above; and

   ii. Follows-up within two calendar days of resolution and any oral notice with a written notice. The written notice states the right of a Member to file a Grievance with Advanced Health if the Member disagrees with Advanced Health's decision to deny the request for expedited resolution.

4.7 <u>Continuation of Benefits</u>

a) As used in this Section 4.7, "timely" means filing on or before the later of the following:

   i. Within 10 calendar days of Advanced Health sending the NOABD or Notice of Appeal Resolution; or

   ii. In the case, of a request for continuing benefits during an Appeal, the intended effective date of Advanced Health's proposed Adverse Benefit Determination;

b) Advanced Health continues a Member's benefits in the same manner and same amount while an Appeal or Contested Case Hearing is pending if:

   i. The Member timely files the Appeal or Request;

   ii. The Appeal or Contested Case Hearing involves the termination, suspension, or reduction of previously authorized services;

   iii. The services were ordered by an authorized Provider;

   iv. Neither the time period nor service limits covered by the relevant authorization have expired; and

v. The Member timely files the extension of benefits.

c) Advanced Health will continue to provide benefits:

i. While an Appeal is pending until:

A. The Member withdraws the Appeal;

B. 10 days following the date that Advanced Health mails the Notice of Appeal Resolution resolving the Appeal adversely to the Member, unless the Member timely requests a Contested Case Hearing and continuing benefits, in which case Advanced Health will continue the benefits; or

C. The time period or service limits covered by the relevant authorization is met.

ii. While a Contested Case Hearing is pending until:

A. The Member withdraws the Hearing Request;

B. A final order resolves the Contested Case Hearing adversely to the Member; or

C. The time period or service limits covered by the relevant authorization is met.

d) If the final resolution of the Appeal or Contested Case Hearing is adverse to the Member, Advanced Health may, consistent with the CCO Contract and 42 CFR § 431.230(b), recover from the Member the cost of the services provided to the Member while the Appeal or Contested Case Hearing was pending, to the extent that they were provided solely because of the requirements of this Section 4.7.

e) For reversed Appeal and Contested Case Hearing resolution:

i. Services not provided while the Appeal or Contested Case Hearing is pending: If Advanced Health or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not provided while the Appeal or Contested Case Hearing was pending, then Advanced Health will authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires, but no later than 72 hours from the date it receives notice reversing the Adverse Benefit Determination.

ii. Services provided while the Appeal or Contested Case hearing is pending: If Advanced Health or the Administrative Law Judge reverses a decision to deny authorization of services, and the Member received the disputed services while the Appeal or Contested Case Hearing was pending, then Advanced Health will pay for those services in accordance with OHA policy and regulations.

4.8 Documentation and Quality Improvement Review of the Grievance and Appeal System

a) Advanced Health documents and maintains records of each Grievance and Appeal that it receives and that its Subcontractors receive. Advanced Health fully and timely complies with all record requests. Advanced Health fully and promptly complies with OHA monitoring and oversight. As further provided in Advanced Health's Transformation and Quality Strategy, Advanced Health analyzes the information in those records to develop specific initiatives for monitoring, evaluating, and improving the access, quality, and appropriateness of services provided to Members.

b) Advanced Health maintains yearly logs of all Grievances and Appeals for 10 years, which logs satisfy the following requirements:

i. The logs contain the following information pertaining to each Member's Grievance or Appeal:

A. The Member's name, ID number, the date that the Grievance or Appeal was filed, and whether the Grievance or Appeal was filed in writing or orally;

B. A copy of the applicable NOABD and, if the Appeal or Grievance was filed in writing, a copy of the Grievance or Appeal;

C. Documentation of Advanced Health's review, resolution, or disposition of the matter at each level, including at any Hearing, which documentation includes the reason for the decision and the dates of the review, any review meetings, and resolution or disposition;

D. Notations of oral communications with the Member and copies of all written communications with the Member and all other parties to the Grievance, Appeal, or Hearing, including all written decisions;

E. All evidence, testimony, or additional documentation provided by the Member, the Member Representative, or the Member's Provider as part of the Appeal process;

F. If Advanced Health learns that the Member resolved any Grievance or Appeal outside of Advanced Health's Grievance and Appeal System, notations containing the information that Advanced Health obtained regarding the resolution; and

G. A general description of the reason for the Grievance or Appeal.

ii. The logs contain the following aggregate information for each year:

A. The number of Adverse Benefit Determinations; and

B. A categorization of the reasons for and resolutions or dispositions of Grievances and Appeals.

c) Each month, Advanced Health's designated customer service staff and the Grievance System Coordinator review the log, including all data collected from Advanced Health's Subcontractors, for completeness and accuracy. The monthly review includes but is not limited to, a review of the timeliness of all documentation and compliance with this Procedure.

d) Within 45 days following the end of each calendar quarter, Advanced Health provides to OHA's Contract Administrator, via Administrative Notice, a Grievance and Appeal Log (the "Log") and Grievance System Narrative Report (the "Report"), each of which are prepared using a template prepared by OHA. In preparing and submitting the Log and Report, Advanced Health follows the Oregon Health Authority reporting templates and instructions posted on the CCO Contract Forms website, and compiles and submits all documentation that it and its Subcontractors hold and maintains and data collected from its and its Subcontractor's monitoring of the Grievance and Appeal System. Along with the Log and Report, Advanced Health submits: (i) samples of NOABD that it provided in the preceding quarter and corresponding prior authorization records, which include the date of the request for the service, the diagnosis submitted, the CPT or HCPC (treatment) codes being requested, and any comorbid diagnosis that the provider may list on the prior authorization request; (ii) all NOABD for Applied Behavioral Analysis services, (iii) all prior authorization requests for Hepatitis C treatment and the resulting approval notice or NOABD; and (iv) any other related documentation requested by OHA. Advanced Health submits records corresponding to the samples that OHA selects to OHA in the manner directed by OHA no later than 14 days following Advanced Health receiving a request from OHA.

e) Advanced Health analyzes the records in the logs, and all information that it has related to the Grievance and Appeal System, including all information that it obtains from its Subcontractors, as part of its ongoing monitoring procedures and quality improvement strategy, as well as for updates and revisions to the state quality strategy and in alignment with the requirements of the CCO Contract.

   i. Advanced Health's Grievance and Appeals Committee periodically reviews data relating to Grievances and Appeals and develops proposals for making quality improvements.

   ii. Advanced Health keeps a copy of each Grievance regarding a Provider or the quality of care a Provider renders on file in the Provider's credentialing file. Grievances against Providers are reviewed as part of the re-credentialing process.

   iii. The Grievance System Coordinator reviews details and resolutions of Grievances on a weekly basis to monitor for appropriate resolution and categorization of Grievances, emerging trends, and opportunities for improvement.

   iv. The Grievance System Coordinator periodically deliver reports to Providers, with a goal of delivering reports at least quarterly, which reports detail the number and category of Grievances that Advanced Health has received relating to the Providers. The Grievance System Coordinator works to schedule meetings with Providers that have higher than average numbers of Grievances in order to provide coaching, guidance, and work on developing a plan for improving Member experience with the Provider.

f) Advanced Health forwards the Report to its Quality Improvement committee to comply with the Quality Improvement standards as follows:

   i. Review of completeness, accuracy, and timeliness of documentation;

   ii. Compliance with written procedures for receipt, disposition, and documentation; and

   iii. Compliance with applicable OHP rules.

g) Advanced Health maintains the logs, each Log, and each Report in a central location that is accessible to OHA and CMS on request. Advanced Health promptly complies, and requires its Subcontractors to promptly comply, with all Grievance and Appeal records requests from OHA, CMS, EQRO, or other external auditors. Advanced Health submits records, in accordance with such requests, to the OHA Contract Administrator via Administrative Notice no later than 14 days following Advanced Health's receipt of a request for records, except that, if the request is related to a Contested Case Hearing, Advanced Health submits the Required Documentation within 24 hours for an expedited Contested Case Hearing and 2 days for a standard Contested Case Hearing.

h) Advanced Health maintains records evidencing its compliance with Section 4.1(o) of this Procedure, the provisions in the CCO Contract governing the relationship between Advanced Health and its Subcontractors, OAR 410-141-3875 through 410-141-3915, 42 CFR 438.230, and 42 CFR 438.400 through 438.424. Those records include records relating to any Corrective Actions that Advanced Health initiates as a result of Subcontractor monitoring, up to and including termination of the Subcontractor. Advanced Health submits those records to the OHA Contract Administrator, via Administrative Notice, and federal, state, and OHA contracted auditors no later than 14 calendar days after receiving a request for the records, unless the requesting party establishes a different timeframe.

i) Advanced Health will revise this Procedure and the Policy, as applicable, within 30 days of notification by OHA, CMS, or EQRO that this Procedure or the Policy does not comply with grievance and appeal system

requirements under Federal or State law or the CCO Contract. Advanced Health will cause its Subcontractors to which Advanced Health has delegated any of Advanced Health's responsibilities under the Grievance and Appeal System to revise the Subcontractor's grievance and appeal system policies and procedures within 30 days of notification by OHA, CMS, or EQRO that the Subcontractor's policies or procedures do not comply with grievance and appeal system requirements under Federal or State law or the CCO Contract. Advanced Health submits to OHA's Contract Administrator, via Administrative Notice, all revised materials for review and approval.

j) Advanced Health provides to OHA's Contract Administrator, via Administrative Notice, this Procedure, the Policy, all Member notice templates (including Advanced Health's notice of resolution for Grievances, NOABD, and Notice of Appeal Resolution (collectively, "Member Notice Templates")), and all other documents that Advanced Health provides to Members relating to the Grievance and Appeal System. Advanced Health also provides any of those documents to OHA for compliance review and approval as OHA may request. If Advanced Health makes any changes to any documents that OHA has approved, then Advanced Health provides to OHA's Contract Administrator, via Administrative Notice, the revised documents and a description with particularity of the proposed changes. Regardless of whether Advanced Health proposes to make any changes to this policy and procedure manual, Advanced Health provides this policy and procedure manual to OHA's Contract Administrator, via Administrative Notice, for review and approval each year by the date specified in the CCO Contract.

   i. Advanced Health does not adopt, implement, nor distribute to Network Providers, this Procedure or the Policy until OHA notifies Advanced Health that they are approved.

   ii. Advanced Health does not distribute to Members or Network Providers any notices using a Member Notice Template until OHA notifies Advanced Health that the Member Notice Template is approved.

k) Advanced Health annually reviews, and if necessary, updates this Procedure and the Policy.

l) Advanced Health will revise, and as applicable will cause its Subcontractors to revise, any Member Notice Template within 30 days of notification by OHA, CMS, or EQRO that the Member Notice Template does not comply with grievance and appeal system requirements under Federal or State law or the CCO Contract.

5.0 Reference Sources

ORS: 192.553-to-192.581

OAR: 410-141-3875 -to- 410-141-3915

42 CFR: 438.400 –to- 42 CFR 438.424; 438 CFR 483.10

CCO Contract, Exhibit I

6.0 Responsibilities

6.1 Executive Program Director

6.1.1 Oversees Member Grievance System processes, including any processes delegated or subcontracted to other organizations or providers.

6.1.2 Ensures timely and accurate reports and logs are delivered to OHA.

6.2 Grievance System Coordinator

6.2.1 Manage and coordinate activities necessary for the timely acceptance, processing, documentation, resolution, and reporting of Member Grievances, Appeals, and Contested Case Hearings.

6.2.2 Accept, process, and document Member Grievances, Appeals, and Requests for Contested Case Hearings.

6.2.3 Maintain records related to the Grievance and Appeal System and review for accuracy and completeness.

6.2.4 Correspond with Members, Providers, and Subcontractors regarding Grievances and Appeals.

6.2.5 Coordinate with the OHA Hearings Unit for Contested Case Hearing Requests and the OHA Ombudsperson for Grievances filed directly with OHA.

6.2.6 Review all Grievances and escalate individual Grievances to appropriate executive-level staff for review and resolution when appropriate.

6.2.7 Identify and escalate trends for review.

6.2.8 Prepare Grievance and Appeal data for the quarterly Log and Report to OHA, using the instructions and templates provided by OHA.

6.2.9 Present data analysis and trends to Grievance and Appeals Committee, Quality Improvement Committee, Clinical Advisory Panel, individual providers, or others as appropriate and as requested

6.2.10 Coordinate review of Appeal Requests by Medical Director or other appropriate clinical staff.

6.3 Medical Director

6.3.1 Review Appeal Requests when appropriate or ensure appropriate clinical staff to perform secondary review.

6.3.2 Review requests for expedited Appeals or ensure appropriate clinical staff perform the review of the expedited request and make a determination within the timeframe.

6.3.3 Review Grievance and Appeal data trends.

6.3.4 Provide peer-to-peer provider coaching or intervention when necessary.

6.4 Customer Service Representative

6.4.1 Accept, process, and document Member Grievances.

6.4.2 Resolve Grievances as authorized and within the scope of the Customer Service training, such as changing a Member's PCP assignment if requested, referring Member to case management or Intensive Care Coordination services, or offering Member education.

6.4.3 Escalate all other Grievances to Grievance System Coordinator or appropriate Advanced Health staff.

6.4.4 Categorize Grievances following the conventions established by OHA in the template Log and Report.

6.4.3 Accept Appeal Requests and escalate to the Grievance System Coordinator for acknowledgement and processing.

7.0 Related Documents

OHA Documents

- OHA Grievance and Appeal Log Instructions
- Oregon Health Plan Complaint Form (OHP 3001)
- Notice of Adverse Benefit Determination form (OHP 2405)
- Request to Review a Health Care Decision Appeal and Hearing Request form (OHP 3302)
- Authorization for Use and Disclosure of Information (MSC 2099)

Advanced Health Documents

- Member Handbook
- Provider Handbook
- Transformation and Quality Strategy
- Credentialing Policy and Procedure

Advanced Health Member Notice Templates

- Complaint Form and Information (Complaint Packet)
- Complaint Resolution
- Complaint Extension
- Notice of Adverse Benefit Determination (NOABD)
- Prior Authorization Decision Extension
- Appeal Request Form
- Appeal Acknowledgement
- Notice of Appeal Resolution – Overturn
- Notice of Appeal Resolution – Uphold
- Appeal Extension
- Appeal Acknowledgement and Expedited Request Denied

8.0 Acronyms and Definitions

Capitalized terms used in this procedure (this "Procedure") that are not defined in this Procedure have the meaning provided in the CCO Contract, as that term is defined below.

Adverse Benefit Determination: The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to make a service authorization decision within the timeframe required by the CCO Contract; failure to satisfy any of the Timing Requirements; the denial of a Member's request to exercise his or her right under 42 C.F.R. § 438.52(b)(2)(ii) to obtain services outside the network; or the denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

Appeal: a review by Advanced Health of an Adverse Benefit Determination or Advanced Health's failure to satisfy any of the Timing Requirements.

CCO Contract: The Oregon Health Plan Amended and Restated Health Plan Services Contract Coordinate Care Organization Contract between Advanced Health and OHA, as it may be amended from time to time.

Contested Case Hearing: A proceeding before OHA under the Administrative Procedures Act relating to an Adverse Benefit Determination or Advanced Health's failure to adhere to the Timing Requirements.

Grievance: A Member's expression of dissatisfaction to Advanced Health or OHA about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, any of the following, regardless of whether remedial action is requested: (a) the quality of care or services provided; (b) aspects of interpersonal relationships such as rudeness of a Provider or employee; (c) failure to respect a Member's rights; (d) a Member's right to dispute an extension of time proposed by Advanced Health to make an authorization decision or for adjudication of an appeal; and (e) communication issues or access to Covered Services or facilities for Members who have disabilities, difficulty communicating due to a disability, or limited English proficiency or diverse cultural and ethnic backgrounds.

Grievance and Appeal System: Advanced Health's processes for accepting, processing, and responding to Grievances, Appeals, and Requests and collecting and tracking information about Grievances, Appeals, and Contested Case Hearings.

Member: A person who is enrolled in Advanced Health, including enrolled dependents, and is entitled to receive Covered Services. For purposes of this Procedure, references to a Member means the Member, a Member Representative, and the representative of a deceased Member's estate. References to a Member may also, in appropriate circumstances, mean a Provider who is acting on behalf of a Member and with the Member's written consent.

Notice of Adverse Benefit Determination or NOABD: A written notification to a Member advising the Member that Advanced Health is making or intends to make an Adverse Benefit Determination.

OHA: Oregon Health Authority.

Policy: The Member Grievance System Policy.

Request: A request for a Contested Case Hearing.

Timing Requirements. The timeframes provided in 42 CFR § 438.408(b)(1) and (2) regarding the standard resolution of Grievances and Appeals, which are incorporated in this Procedure in Sections 2(a)(i) and 4(h). 42 CFR § 438.408 is attached as Schedule 1 and incorporated by this reference.

9.0 Attachments

Schedule 1

Timing Requirements – 42 CFR § 438.408

(a) Basic rule. Each MCO, PIHP, or PAHP must resolve each grievance and appeal, and provide notice, as expeditiously as the enrollee's health condition requires, within State- established timeframes that may not exceed the timeframes specified in this section.

(b) Specific timeframes—

(1) Standard resolution of grievances. For standard resolution of a grievance and notice to the affected parties, the timeframe is established by the State but may not exceed 90 calendar days from the day the MCO, PIHP, or PAHP receives the grievance.

(2) Standard resolution of appeals. For standard resolution of an appeal and notice to the affected parties, the State must establish a timeframe that is no longer than 30 calendar days from the day the MCO, PIHP, or PAHP receives the appeal. This timeframe may be extended under paragraph (c) of this section.

(3) Expedited resolution of appeals. For expedited resolution of an appeal and notice to affected parties, the State must establish a timeframe that is no longer than 72 hours after the MCO, PIHP, or PAHP receives the appeal. This timeframe may be extended under paragraph (c) of this section.

(c) Extension of timeframes.

(1) The MCO, PIHP, or PAHP may extend the timeframes from paragraph (b) of this section by up to 14 calendar days if—

(i) The enrollee requests the extension; or

(ii) The MCO, PIHP, or PAHP shows (to the satisfaction of the State agency, upon its request) that there is need for additional information and how the delay is in the enrollee's interest.

(2) Requirements following extension. If the MCO, PIHP, or PAHP extends the timeframes not at the request of the enrollee, it must complete all of the following:

(i) Make reasonable efforts to give the enrollee prompt oral notice of the delay.

(ii) Within 2 calendar days give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision.

(iii) Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

(3) Deemed exhaustion of appeals processes. In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.

(d) Format of notice—

(1) Grievances. The State must establish the method that an MCO, PIHP, and PAHP will use to notify an enrollee of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described at § 438.10.

(2) Appeals.

(i) For all appeals, the MCO, PIHP, or PAHP must provide written notice of resolution in a format and language that, at a minimum, meet the standards described at § 438.10.

(ii) For notice of an expedited resolution, the MCO, PIHP, or PAHP must also make reasonable efforts to provide oral notice.

(e) Content of notice of appeal resolution. The written notice of the resolution must include the following:

(1) The results of the resolution process and the date it was completed.

(2) For appeals not resolved wholly in favor of the enrollees—

(i) The right to request a State fair hearing, and how to do so.

(ii) The right to request and receive benefits while the hearing is pending, and how to make the request.

(iii) That the enrollee may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the MCO's, PIHP's, or PAHP's adverse benefit determination.

(f) Requirements for State fair hearings—

(1) Availability. An enrollee may request a State fair hearing only after receiving notice that the MCO, PIHP, or PAHP is upholding the adverse benefit determination.

(i) Deemed exhaustion of appeals processes. In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in § 438.408, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.

(ii) External medical review. The State may offer and arrange for an external medical review if the following conditions are met.

(A) The review must be at the enrollee's option and must not be required before or used as a deterrent to proceeding to the State fair hearing.

(B) The review must be independent of both the State and MCO, PIHP, or PAHP.

(C) The review must be offered without any cost to the enrollee.

(D) The review must not extend any of the timeframes specified in § 438.408 and must not disrupt the continuation of benefits in § 438.420.

(2) State fair hearing. The enrollee must request a State fair hearing no later than 120 calendar days from the date of the MCO's, PIHP's, or PAHP's notice of resolution.

(3) Parties. The parties to the State fair hearing include the MCO, PIHP, or PAHP, as well as the enrollee and his or her representative or the representative of a deceased enrollee's estate.

Schedule 2

Information Requirements - 42 CFR § 438.410

(a) Definitions. As used in this section, the following terms have the indicated meanings:

Limited English proficient (LEP) means potential enrollees and enrollees who do not speak English as their primary language and who have a limited ability to read, write, speak, or understand English may be LEP and may be eligible to receive language assistance for a particular type of service, benefit, or encounter.

Prevalent means a non–English language determined to be spoken by a significant number or percentage of potential enrollees and enrollees that are limited English proficient.

Readily accessible means electronic information and services which comply with modern accessibility standards such as section 508 guidelines, section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines (WCAG) 2.0 AA and successor versions.

(b) Applicability. The provisions of this section apply to all managed care programs which operate under any authority in the Act.

(c) Basic rules.

(1) Each State, enrollment broker, MCO, PIHP, PAHP, PCCM, and PCCM entity must provide all required information in this section to enrollees and potential enrollees in a manner and format that may be easily understood and is readily accessible by such enrollees and potential enrollees.

(2) The State must utilize its beneficiary support system required in § 438.71.

(3) The State must operate a Web site that provides the content, either directly or by linking to individual MCO, PIHP, PAHP, or PCCM entity Web sites, specified in paragraphs (g), (h), and (i) of this section.

(4) For consistency in the information provided to enrollees, the State must develop and require each MCO, PIHP, PAHP and PCCM entity to use:

(i) Definitions for managed care terminology, including appeal, co-payment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home health care, hospice services, hospitalization, hospital outpatient care, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care; and

(ii) Model enrollee handbooks and enrollee notices.

(5) The State must ensure, through its contracts, that each MCO, PIHP, PAHP and PCCM entity provides the required information in this section to each enrollee.

(6) Enrollee information required in this section may not be provided electronically by the State, MCO, PIHP, PAHP, PCCM, or PCCM entity unless all of the following are met:

(i) The format is readily accessible;

(ii) The information is placed in a location on the State, MCO's, PIHP's, PAHP's, or PCCM's, or PCCM entity's Web site that is prominent and readily accessible;

(iii) The information is provided in an electronic form which can be electronically retained and printed;

(iv) The information is consistent with the content and language requirements of this section; and

(v) The enrollee is informed that the information is available in paper form without charge upon request and provides it upon request within 5 business days.

(7) Each MCO, PIHP, PAHP, and PCCM entity must have in place mechanisms to help enrollees and potential enrollees understand the requirements and benefits of the plan.

(d) Language and format. The State must:

(1) Establish a methodology for identifying the prevalent non–English languages spoken by enrollees and potential enrollees throughout the State, and in each MCO, PIHP, PAHP, or PCCM entity service area.

(2) Make oral interpretation available in all languages and written translation available in each prevalent non–English language. All written materials for potential enrollees must include taglines in the prevalent non–English languages in the State, as well as large print, explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free telephone number of the entity providing choice counseling services as required by § 438.71(a). Large print means printed in a font size no smaller than 18 point.

(3) Require each MCO, PIHP, PAHP, and PCCM entity to make its written materials that are critical to obtaining services, including, at a minimum, provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non–English languages in its particular service area. Written materials must also be made available in alternative formats upon request of the potential enrollee or enrollee at no cost. Auxiliary aids and services must also be made available upon request of the potential enrollee or enrollee at no cost. Written materials must include taglines in the prevalent non–English languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number of the MCO's, PIHP's, PAHP's or PCCM entity's member/customer service unit. Large print means printed in a font size no smaller than 18 point.

(4) Make interpretation services available to each potential enrollee and require each MCO, PIHP, PAHP, and PCCM entity to make those services available free of charge to each enrollee. This includes oral interpretation and the use of auxiliary aids such as TTY/TDY and American Sign Language. Oral interpretation requirements apply to all non–English languages, not just those that the State identifies as prevalent.

(5) Notify potential enrollees, and require each MCO, PIHP, PAHP, and PCCM entity to notify its enrollees—

(i) That oral interpretation is available for any language and written translation is available in prevalent languages;

(ii) That auxiliary aids and services are available upon request and at no cost for enrollees with disabilities; and

(iii) How to access the services in paragraphs (d)(5)(i) and (ii) of this section.

(6) Provide, and require MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities to provide, all written materials for potential enrollees and enrollees consistent with the following:

(i) Use easily understood language and format.

(ii) Use a font size no smaller than 12 point.

(iii) Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of enrollees or potential enrollees with disabilities or limited English proficiency.

(iv) Include a large print tagline and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats. Large print means printed in a font size no smaller than 18 point.

(e) Information for potential enrollees.

(1) The State or its contracted representative must provide the information specified in paragraph (e)(2) of this section to each potential enrollee, either in paper or electronic form as follows:

(i) At the time the potential enrollee first becomes eligible to enroll in a voluntary managed care program, or is first required to enroll in a mandatory managed care program; and

(ii) Within a timeframe that enables the potential enrollee to use the information in choosing among available MCOs, PIHPs, PAHPs, PCCMs, or PCCM entities.

(2) The information for potential enrollees must include, at a minimum, all of the following:

(i) Information about the potential enrollee's right to disenroll consistent with the requirements of § 438.56 and which explains clearly the process for exercising this disenrollment right, as well as the alternatives available to the potential enrollee based on their specific circumstance;

(ii) The basic features of managed care;

(iii) Which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program. For mandatory and voluntary populations, the length of the enrollment period and all disenrollment opportunities available to the enrollee must also be specified;

(iv) The service area covered by each MCO, PIHP, PAHP, PCCM, or PCCM entity;

(v) Covered benefits including:

(A) Which benefits are provided by the MCO, PIHP, or PAHP; and

(B) Which, if any, benefits are provided directly by the State.

(C) For a counseling or referral service that the MCO, PIHP, or PAHP does not cover because of moral or religious objections, the State must provide information about where and how to obtain the service;

(vi) The provider directory and formulary information required in paragraphs (h) and (i) of this section;

(vii) Any cost-sharing that will be imposed by the MCO, PIHP, PAHP, PCCM, or PCCM entity consistent with those set forth in the State plan;

(viii) The requirements for each MCO, PIHP or PAHP to provide adequate access to covered services, including the network adequacy standards established in § 438.68;

(ix) The MCO, PIHP, PAHP, PCCM and PCCM entity's responsibilities for coordination of enrollee care; and

(x) To the extent available, quality and performance indicators for each MCO, PIHP, PAHP and PCCM entity, including enrollee satisfaction.

(f) Information for all enrollees of MCOs, PIHPs, PAHPs, and PCCM entities: General requirements.

(1) The MCO, PIHP, PAHP and, when appropriate, the PCCM entity, must make a good faith effort to give written notice of termination of a contracted provider, within 15 calendar days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

(2) The State must notify all enrollees of their right to disenroll consistent with the requirements of § 438.56 at least annually. Such notification must clearly explain the process for exercising this disenrollment right, as well as the alternatives available to the enrollee based on their specific circumstance. For States that choose to restrict disenrollment for periods of 90 days or more, States must send the notice no less than 60 calendar days before the start of each enrollment period.

(3) The MCO, PIHP, PAHP and, when appropriate, the PCCM entity must make available, upon request, any physician incentive plans in place as set forth in § 438.3(i).

(g) Information for enrollees of MCOs, PIHPs, PAHPs and PCCM entities—Enrollee handbook.

(1) Each MCO, PIHP, PAHP and PCCM entity must provide each enrollee an enrollee handbook, within a reasonable time after receiving notice of the beneficiary's enrollment, which serves a similar function as the summary of benefits and coverage described in 45 CFR 147.200(a).

(2) The content of the enrollee handbook must include information that enables the enrollee to understand how to effectively use the managed care program. This information must include at a minimum:

(i) Benefits provided by the MCO, PIHP, PAHP or PCCM entity.

(ii) How and where to access any benefits provided by the State, including any cost sharing, and how transportation is provided.
  (A) In the case of a counseling or referral service that the MCO, PIHP, PAHP, or PCCM entity does not cover because of moral or religious objections, the MCO, PIHP, PAHP, or PCCM entity must inform enrollees that the service is not covered by the MCO, PIHP, PAHP, or PCCM entity.
  (B) The MCO, PIHP, PAHP, or PCCM entity must inform enrollees how they can obtain information from the State about how to access the services described in paragraph (g)(2)(i)(A) of this section.

(iii) The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.

(iv) Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not provided by the enrollee's primary care provider.

(v) The extent to which, and how, after-hours and emergency coverage are provided, including:
  (A) What constitutes an emergency medical condition and emergency services.
  (B) The fact that prior authorization is not required for emergency services.

(C) The fact that, subject to the provisions of this section, the enrollee has a right to use any hospital or other setting for emergency care.

(vi) Any restrictions on the enrollee's freedom of choice among network providers.

(vii) The extent to which, and how, enrollees may obtain benefits, including

(viii) family planning services and supplies from out-of-network providers. This includes an explanation that the MCO, PIHP, or PAHP cannot require an enrollee to obtain a referral before choosing a family planning provider.

(ix) Cost sharing, if any is imposed under the State plan.

(x) Enrollee rights and responsibilities, including the elements specified in §438.100.

(xi) The process of selecting and changing the enrollee's primary care provider.

(xii) Grievance, appeal, and fair hearing procedures and timeframes,

(xiii) consistent with subpart F of this part, in a State-developed or State-approved description. Such information must include:

(A) The right to file grievances and appeals.

(B) The requirements and timeframes for filing a grievance or appeal.

(C) The availability of assistance in the filing process.

(D) The right to request a State fair hearing after the MCO, PIHP or PAHP has made a determination on an enrollee's appeal which is adverse to the enrollee.

(E) The fact that, when requested by the enrollee, benefits that the MCO, PIHP, or PAHP seeks to reduce or terminate will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing, and that the enrollee may, consistent with state policy, be required to pay the cost of services provided while the appeal or state fair hearing is pending if the final decision is adverse to the enrollee.

(xiv) How to exercise an advance directive, as set forth in § 438.3(j). For PAHPs, information must be provided only to the extent that the PAHP includes any of the providers described in § 489.102(a) of this chapter.

(xv) How to access auxiliary aids and services, including additional information in alternative formats or languages.

(xvi) The toll-free telephone number for member services, medical management, and any other unit providing services directly to enrollees.

(xvii) Information on how to report suspected fraud or abuse;

(xviii) Any other content required by the State.

(3) Information required by this paragraph to be provided by a MCO, PIHP, PAHP or PCCM entity will be considered to be provided if the MCO, PIHP, PAHP or PCCM entity:

(i) Mails a printed copy of the information to the enrollee's mailing address;

(ii) Provides the information by email after obtaining the enrollee's agreement to receive the information by email;

(iii) Posts the information on the Web site of the MCO, PIHP, PAHP or PCCM entity and advises the enrollee in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that enrollees with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; or

(iv) Provides the information by any other method that can reasonably be expected to result in the enrollee receiving that information.

(4) The MCO, PIHP, PAHP, or PCCM entity must give each enrollee notice of any change that the State defines as significant in the information specified in this paragraph (g), at least 30 days before the intended effective date of the change.

(h) Information for all enrollees of MCOs, PIHPs, PAHPs, and PCCM entities—Provider Directory.

(1) Each MCO, PIHP, PAHP, and when appropriate, the PCCM entity, must make available in paper form upon request and electronic form, the following information about its network providers:

(i) The provider's name as well as any group affiliation.

(ii) Street address(es).

(iii) Telephone number(s).

(iv) Web site URL, as appropriate.

(v) Specialty, as appropriate.

(vi) Whether the provider will accept new enrollees.

(vii) The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.

(viii) Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

(2) The provider directory must include the information in paragraph (h)(1) of this section for each of the following provider types covered under the contract:

(i) Physicians, including specialists;

(ii) Hospitals;

(iii) Pharmacies;

(iv) Behavioral health providers; and

(v) LTSS providers, as appropriate.

(3) Information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after the MCO, PIHP, PAHP or PCCM entity receives updated provider information.

(4) Provider directories must be made available on the MCO's, PIHP's, PAHP's, or, if applicable, PCCM entity's Web site in a machine readable file and format as specified by the Secretary.

(i) Information for all enrollees of MCOs, PIHPs, PAHPs, and PCCM entities: Formulary. Each MCO, PIHP, PAHP, and when appropriate, PCCM entity, must make available in electronic or paper form, the following information about its formulary:

(1) Which medications are covered (both generic and name brand).

(2) What tier each medication is on.

(3) Formulary drug lists must be made available on the MCO's, PIHP's, PAHP's, or, if applicable, PCCM entity's Web site in a machine readable file and format as specified by the Secretary.

(j) Applicability date. This section applies to the rating period for contracts with MCOs, PIHPs, PAHPs, PCCMs, and PCCM entities beginning on or after July 1, 2017. Until that applicability date, states are required to continue to comply with § 438.10 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.

Schedule 3

OAR 410-141-3300 - Formatting and Readability Standards

(1) MCEs may engage in activities for existing members related to outreach, health promotion, and health education. The Authority shall approve prior to distribution any written communication by the MCE or its Subcontractors and providers that:

(a) Is intended solely for members; and

(b) Pertains to requirements for obtaining coordinated care services at service area sites or benefits.

(2) MCEs may communicate with providers, caseworkers, community agencies, and other interested parties for informational purposes or to enable care coordination, and address social determinants of health or community health. The intent of these communications should be informational only for building community linkages to impact social determinants of health or member care coordination and not to entice or solicit membership. Communication methodologies may include but are not limited to brochures, pamphlets, newsletters, posters, fliers, websites, health fairs, or sponsorship of health- related events. MCEs shall address health literacy issues by preparing these documents at a low-literacy reading level, incorporating graphics and utilizing alternate formats.

(3) The creation of name recognition because of the MCE's health promotion or education activities may not constitute an attempt by the MCE to influence a client's enrollment.

(4) An MCE or its Subcontractor's communications that express participation in or support for an MCE by its founding organizations or its Subcontractors may not constitute an attempt to compel or entice a client's enrollment.

(5) The following may not constitute marketing or an attempt by the MCE to influence client enrollment:

(a) Communication to notify dual-eligible members of opportunities to align MCE provided benefits with a Medicare Advantage or Special Needs Plan;

(b) Improving coordination of care;

(c) Communicating with providers serving dual-eligible members about unique care coordination needs; or

(d) Streamlining communications to the dually-enrolled member to improve coordination of benefits.

(6) MCEs shall have a mechanism to help members understand the requirements and benefits of the MCE's integrated and coordinated care plan. The mechanisms developed shall be culturally and linguistically appropriate.

(7) MCEs shall have written procedures, criteria, and an ongoing process of member education and information sharing that includes member orientation, member handbook, and health education. MCEs shall update their educational material as they add coordinated services. Member education shall:

(a) Include information about the coordinated care approach and how to navigate the coordinated health care system, including how to access Exceptional Needs Care Coordination (ENCC) or Intensive Care Coordination (ICC) Services, and where applicable for dual-eligible individuals, the process for coordinating Medicaid and Medicare benefits;

(b) Clearly explain how members may receive assistance from advocates, including certified health care interpreters, community health workers, peer wellness specialists, and personal health navigators, and include information to members that interpreter services in any language required by the member, including American Sign Language, auxiliary aids and alternative format materials at provider offices are free to MCE members as stated in 42

CFR 438.10.

(8) Written member education materials shall:

(a) Ensure written materials, including provider directories, member handbooks, appeal and grievance notices, and all denial and termination notices are made available in the prevalent non-English languages in its particular service area;

(b) Be translated or include taglines in the prevalent non-English languages in the state as well as large print (font size 18) explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number of the MCE's member/customer service unit;

(c) Be made available in alternative formats upon request of the member at no cost. Auxiliary aids and services must also be made available upon request of the member at no cost.

(9) Electronic versions of member materials, including provider directories, formularies, and handbooks shall be made available prominently on the MCE website in a form that can be electronically retained and printed, available in a machine readable file and format, and readily accessible, e.g., a PDF document posted on the plan website that meets language requirements of this section. For any required member education materials on the MCE website, the member is informed that the information is available in paper form without charge upon request, and the MCE shall provide it upon request within five business days.

(10) MCE provider directories shall include:

(a) The provider's name as well as any group affiliation;

(b) Street address;

(c) Telephone number;

(d) Website URL, as appropriate;

(e) Provider Specialty, as appropriate;

(f) Whether the provider will accept new members;

(g) Information about the provider's cultural and linguistic capabilities including:

(A) Availability of qualified or certified interpreters at no cost to members ensuring oral interpretation is available in all languages and American Sign Language per CFR §438.10;

(B) Availability of auxiliary aids and services for all members with disabilities upon request and at no cost; and

(C) Whether the provider has completed cultural competence training as required by ORS 413.450 and whether providers have verifiable language fluency in non- English (i.e., such as clinical training in a foreign country or clinical language testing);

(D) Whether the provider's office or facility is accessible and has accommodations for people with physical disabilities, including information on accessibility of providers' offices, exam rooms, restrooms, and equipment.

(h) The provider directory must include the information for each of the following provider types covered

under the contract, as applicable to the MCE contract:

(A) Physicians, including specialists;

(B) Hospitals;

(C) Pharmacies;

(D) Behavioral health providers; including specifying substance use treatment providers;

(E) Dental providers.

(i) Information included in the provider directory must be updated at least monthly, and electronic provider directories must be updated no later than 30 days after the MCE receives updated provider information. Updated materials shall be available on the MCE website in a readily accessible and machine readable file, e.g., a PDF document posted on the plan website, per form upon request and other alternative format;

(j) Each MCE shall make available in electronic or paper form the following information about its formulary:

(A) Which medications are covered both generic and name brand;

(B) What tier each medication is on.

(11) Within 14 days or a reasonable timeframe of an MCE's receiving notice of a member's enrollment, MCEs shall mail a welcome packet to new members and to members returning to the MCE 12 months or more after previous enrollment. The packet shall include, at a minimum, a welcome letter, a member handbook, and information on how to access a provider directory, including a list of any in-network retail and mail-order pharmacies.

(12) For existing MCE members, an MCE shall notify members annually of the availability of a member handbook and provider directory and how to access those materials. MCEs shall send hard copies upon request within five days.

(13) MCEs shall facilitate materials as follows:

(a) Translate the following written materials into the prevalent non-English languages served by the MCE:

(A) Welcome Packets that include welcome letters and member handbooks;
and

(B) Notices of medical benefit changes.

(b) Information on disability access, alternate format and language statement inserts with:

(A) Communications regarding member enrollment; and
(B) Notice of Adverse Benefit Determination Adverse Benefit Determination to deny, reduce, or stop a benefit, and Verification of Services Letter.

(c) Accommodate requests of the member to translate written materials into prevalent non-English languages served by the MCE. Written and spoken language preferences are indicated on the Oregon Health Plan application form and reported to plans in 834 enrollment updates. MCEs shall honor requests made by other sources such as members, family members, or caregivers for language accommodation, translating to the member's language needs as requested;

(d) Make oral interpretation services available free of charge to each potential member and member. This applies to all non-English languages and American Sign Language, not just prevalent non-English languages.

(14) MCEs must notify enrollees:

(a) That oral interpretation is available free of charge for any language, including American Sign Language, and written information is available in prevalent non-English languages and alternate formats that include but are not limited to audio recording, close- captioned videos, large type (18 font), and braille; and

(b) The process for requesting and accessing interpreters or auxiliary aids and alternative formats, including where appropriate how to contact specific providers responsible through sub-contracts to ensure provision of language and disability access;

(c) Language access services also applies to family members and caregivers with hearing impairments or limited English proficiency who need to understand the member's condition and care.

(15) An MCE shall electronically provide to the Authority for approval each version of the printed welcome packet that includes a welcome letter, member handbook, and information on how to access a provider directory. At a minimum, the member handbook shall contain the following:

(a) Revision date;

(b) Tag lines in English and other prevalent non-English languages, as defined in this rule, spoken by populations of members. The tag lines shall be located at the beginning of the document for the ease of the member and describe how members may access free sign and oral interpreters, as well as translations and materials in other formats. Alternate formats may include but are not limited to readily accessible formatted materials, audio recordings, close-captioned videos, large (18 point) type, and braille;

(c) MCE's office location, mailing address, web address, office hours, and telephone numbers including TTY;

(d) Availability and access to coordinated care services through a patient-centered primary care home or other primary care team with the member as a partner in care management. Explain how to choose a PCP, how to make an appointment, and how to change PCPs, and the MCE's policy on changing PCPs;

(e) How to access information on contracted providers currently accepting new members and any restrictions on the member's freedom of choice among participating providers;

(f) Which participating or non-participating provider services the member may self-refer;

(g) Policies on referrals for specialty care, including prior authorization requirements and how to request a referral;

(h) Explanation of Intensive Care Coordination (ICC) services or Exceptional Needs Care Coordination (ENCC) and how members with the following special health care needs may access these care coordination services: Members who are aged, blind, disabled or who have complex medical needs, high health needs, multiple chronic conditions, mental illness, chemical dependency, or receive additional Authority Medicaid-funded long-term care or long-term services and supports;

(i) Information about the coordinated care approach, how to navigate the coordinated care health care system as applicable to dual-eligible individuals, the process for coordinating Medicaid and Medicare benefits;

(j) How and where members are to access urgent care services and advice, including how to access these services and advice when away from home;

(k) How and when members are to use emergency services, both locally and when away from home, including examples of emergencies;

(l) Information on contracted hospitals in the member's service area;

(m) Information on post-stabilization care after a member is stabilized in order to maintain, improve, or resolve the member's condition;

(n) Information on the MCE's grievance and appeals processes and the Authority's contested case hearing procedures, including:

(A) Information about assistance in filling out forms and completing the grievance process available from the MCE to the member as outlined in OAR 410-141-3230;

(B) Information about the member's right to continued benefits during the grievance process as provided in OAR 410-141- 3240.

(o) Information on the member's rights and responsibilities, including the availability of the OHP Ombudsman;

(p) Information on charges for non-covered services, and the member's possible responsibility for charges if they go outside of the MCE network for non-emergent care; including information specific to deductibles, copays and coinsurance for dually-enrolled qualified Medicare beneficiaries;

(q) Information about when providers may bill clients for services and what to do if they receive a bill, including information specific to payment responsibilities for dually- enrolled qualified Medicare beneficiaries;

(r) The transitional procedures for new members to obtain prescriptions, supplies, and other necessary items and services in the first month of enrollment if they are unable to meet with a PCP or PCD, other prescribing provider, or obtain new orders during that period; including specific communications for members who are becoming new Medicare enrollees;

(s) Information on advance directive policies including:

(A) Member rights under federal and Oregon law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;

(B) The MCE's policies for implementation of those rights, including a statement of any limitation regarding the implementation of advanced directives as a matter of conscience.

(t) Whether or not the MCE uses provider contracts including alternative payment methodologies or incentives;

(u) The member's right to request and obtain copies of their clinical records, whether they may be charged a reasonable copying fee, and that they may request the record be amended or corrected;

(v) How and when members are to obtain ambulance services;

(w) Resources for help with transportation to appointments with providers and scheduling process for use of non-emergency medical transportation (NEMT) services;

(x) Explanation of the covered and non-covered coordinated care services in sufficient detail to ensure that members understand the benefits to which they are entitled;

(y) How to access in-network retail and mail-order pharmacies;

(z) How members are to obtain prescriptions including information on the process for obtaining non-formulary and over-the-counter drugs;

(aa) The MCE's confidentiality policy;

(bb) How and where members may access any benefits that are available under OHP but are not covered under the MCE's contract, including any cost sharing;

(cc) When and how members may voluntarily and involuntarily disenroll from MCEs and change MCEs;

(dd) MCEs shall, at a minimum, annually review their member handbook for accuracy and update it with new and corrected information to reflect OHP program changes and the MCE's internal changes. If changes affect the member's ability to use services or benefits, the MCE shall offer the updated member handbook to all members;

(ee) The "Oregon Health Plan Client Handbook" is in addition to the MCE's member handbook, and an MCE may not use it to substitute for any component of the MCE's member handbook.

(16) Member health education shall include:

(a) Information on specific health care procedures, instruction in self-management of health care, promotion and maintenance of optimal health care status, patient self-care, and disease and accident prevention. MCE providers or other individuals or programs approved by the MCE may provide health education. MCEs shall make every effort to provide health education in a culturally sensitive and linguistically appropriate manner in order to communicate most effectively with individuals from non-dominant cultures;

(b) Information specifying that MCEs may not prohibit or otherwise restrict a provider acting within the lawful scope of practice from advising or advocating on behalf of a member who is his or her patient for the following:

(A) The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

(B) Any information the member needs to decide among all relevant treatment options;

(C) The risks, benefits, and consequences of treatment or non-treatment.

(c) MCEs shall ensure development and maintenance of an individualized health educational plan for members whom their provider has identified as requiring specific educational intervention. The Authority may assist in developing materials that address specifically identified health education problems to the population in need;

(d) Explanation of Intensive Care Coordination (ICC) services or Exceptional Needs Care Coordination (ENCC) and how to access this care coordination through outreach to members with special health care needs including those who are aged, blind, or disabled, or who have complex medical needs or high health care needs, multiple chronic conditions, mental illness, chemical dependency, or receive additional Authority Medicaid-funded long- term care or long-term services and supports;

(e) The appropriate use of the delivery system, including proactive and effective education of members on how to access emergency services and urgent care services appropriately;

(f) MCEs shall provide written notice to affected members of any significant changes in program or service sites that affect the member's ability to access care or services from MCE's participating providers. The MCE shall provide, translated as appropriate, the notice at least 30 days before the effective date of that change, or as soon as possible if the participating provider has not given the MCE sufficient notification to meet the 30-day notice requirement. The Authority shall review and approve the materials within two working days.

(17) Informational materials that MCEs develop for members shall meet the language requirements identified in this rule and be culturally and linguistically sensitive to members with disabilities or reading limitations, including

members whose primary language is not English as previously outlined in this rule.

(18) MCEs shall provide an identification card to members unless waived by the Authority that contains simple, readable, and usable information on how to access care in an urgent or emergency situation. The cards are solely for the convenience of the MCE, members, and providers.

10.0 Revision History and Approvals

Revision History			
Rev.	**Contributors**	**Summary of Changes**	**Effective Date**
2	A.Atkin, L.Lorincz, A.Warner	Major rewrite of procedure to ensure accurate documentation of current process, positions, and committees involved, as well as compliance with all relevant elements of CCO contract, OAR, ORS, and CFR. Incorporated attached Schedules 1-4. Reorganized procedure sections and steps to improve clarity and consistency.	6/19/2018
3	A.Warner, L.Lorincz, OHA	Revised the definition of "Adverse Benefit Determination" to incorporate feedback from OHA's review of Rev 2. Revisions to 1(l), 4(d), and 4(j) to maintain compliance with the November 26, 2018 memo from OHA RE: Responsibility for final decisions on CCO Member Appeals	1/28/2019
4	A.Atkin, L.Lorincz, A.Warner	Revisions for clarity of procedure. Updates in anticipation of 2020 CCO Contract requirements	7/31/2019
5	A.Warner, L.Wells	Minor revisions for grammar and typos. Change position title from RN HSC to Grievance System Coordinator. Re-formatted to new Advanced Health Policy and Procedure manual template. Added 6.0 Responsibilities section. Expanded 7.0 Related Documents section to indicate which documents are controlled by OHA vs. Advanced Health. Also added relevant Member Notice Templates. Removed Schedule 4 "OHA Grievance and Appeal Log Instructions" as an attachment, instead referenced the CCO Contract Forms webpage where the instructions are posted and updated.	10/31/2019
6	L.Wells	Corrected OAR and various form number references. Added language to clarify that providers may file a complaint or appeal on behalf of the member with the member's written consent. Moved responsibility for accepting, documenting, and processing requests for appeal and contested case hearings from Customer Service Representative to Grievance System Coordinator.	3/3/2021

Approvals/Reviewers		
Title	**Effective Date**	**Signature**
Executive Program Director	3/3/2021	

Clinical Practice Guidelines Policy and Procedures

Company: Advanced Health & SW Oregon IPA, Inc	Approved by: Kent Sharman, MD Title: Chief Medical Officer
Department: Compliance	
Policy: Clinical Practice Guidelines: Selection and Dissemination	Approved Date: 7/23/2020
	Revision Dates: 5/5/2015, 4/28/2017, 4/23/2018, 5/9/2018, 7/19/2019, 7/23/2020

CONTENTS Page

1.0 PURPOSE

1.1 Advanced Health uses evidence-based practice guidelines to promote the highest quality clinical and health outcomes for Advanced Health Members.

2.0 SCOPE

2.1 This policy and procedure applies to Advanced Health network providers, staff, and Members.

3.0 Policy

3.1 Advanced Health shall adopt practice guidelines, specified in 42 CFR 438.236 (b)(c)(d), that are based on valid and reliable clinical evidence or a consensus of health care professionals and that consider the needs of Members.

3.2 Advanced Health shall adopt these guidelines in consultation with network providers and the Clinical Advisory Panel.

3.3 Practice guidelines shall be reviewed at least annually and updated as appropriate.

3.4 Advanced Health shall disseminate the practice guidelines to all affected providers and, upon request, to Members, Potential Members, or Member Representatives.

3.5 Advanced Health's decisions for utilization management, Member education, coverage of services, or other areas to which the guidelines apply, must be consistent with the adopted practice guidelines.

4.0 Procedure

4.1 Clinical practice guidelines may be recommended by the Advanced Health Clinical Advisory Panel, the Advanced Health Board of Directors, the Advanced Health Pharmacy and Therapeutics Committee, Physical Health providers, Oral health providers, Substance Use Treatment providers, Behavioral Health providers, or any provider in the Advanced Health network. The Advanced Health Chief Medical Officer, Executive Program Director, or Interagency Quality Committee may also recommend clinical practice guidelines for the improvement of health outcomes for Advanced Health Members based on prevalent conditions in the community and other identified needs.

4.2 The Advanced Health Clinical Advisory Panel reviews recommendations for clinical practice guidelines and determines which guidelines to adopt.

4.3 Previously adopted guidelines are reviewed annually by the Clinical Advisory Panel to determine whether to continue adoption or if revisions are needed.

4.4 Adopted guidelines, whether new or revised, are disseminated to:

4.4.1 All affected providers through the Advanced Health website and may be disseminated by other methods such as provider education, new provider orientation, provider manual, email, or newsletter

4.4.2 Members, Potential Members, or Member Representative upon request, by a method determined to be accessible by the member. Methods may include the Advanced Health website, member education, mail, email, or in the Advanced Health office or provider office.

4.5 Advanced Health staff and contracted organizations that perform utilization management functions will make utilization management and coverage decisions consistent with the adopted clinical practice guidelines.

4.6 Advanced Health monitors data from the Member Grievance system, including Notices of Adverse Benefit Determination, Requests for Appeal, and Member Complaints to ensure coverage decisions and utilization management decisions are consistent with the adopted clinical practice guidelines.

5.0 Reference Sources

5.1 OAR 410-120-0000 (92); OHA CCO Contract Exhibit B- Part 4(11) - Providers and Delivery System; 42 CFR 438.236 (b)(c)(d)

6.0 Responsibilities

6.1 Advanced Health Clinical Advisory Panel reviews and adopts evidence-based clinical practice guidelines

6.2 Chief Medical Officer ensures clinical practice guidelines are disseminated to providers in the Advanced Health network.

6.2 Utilization management staff make authorization and coverage decisions consistent with the adopted clinical practice guidelines.

6.3 Grievance System Coordinator monitors data from the grievance system to ensure coverage decisions are consistent with the adopted clinical practice guidelines. The Grievance System Coordinator notifies the Chief Medical Officer of any discrepancies or trends.

7.0 Related Documents

#	Doc #	Document Title
7.0		
7.2		

8.0 Acronyms and Definitions

8.1 Evidence-Based Medicine - the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice. Increased expertise is reflected in many ways, but especially in more effective and efficient diagnosis and in the more thoughtful identification and

compassionate evaluation [sic] of individual patients' predicaments, rights, and preferences in making clinical decisions about their care. By best available external clinical evidence we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient-centered clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens. External clinical evidence both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer. (Source: BMJ 1996; 312:71-72 (13 January)). In addition, Evidence-Based Medicine takes into account the quality of evidence and the confidence that may be placed in findings. OAR 410-120-0000 (92)

9.0 Attachments

9.1

10.0 Approvals

Document Owner: Kent Sharman, MD, Chief Medical Officer — Name, title

Collaborators: Anna Warner, Executive Program Director

Approvals

- Committees: Advanced Health Clinical Advisory Panel — Name, title
- Signers:

Original Effective Date: 5/5/2015

Revision Date: 4/28/2017, 4/23/2018, 5/9/2018, 7/19/2019, 7/23/2020

Review Date:

Title:	**CLINICAL ADVISORY PANEL CHARTER**
Date Chartered:	September 2013
Timeline:	This is a standing committee
Purpose:	The Clinical Advisory Panel exists to provide a platform for collaboration and coordination between Advanced Health's leadership, delegate organizations, and community partners purposed at achieving the Triple Aim: improved outcomes in individual and population health; enhancement of the patient's experience of care and cost efficacy. The Clinical Advisory Panel provides a clinical perspective to Advanced Health. This committee is responsible for the development of recommendations regarding the use of health information to improve workflow and clinical decision making.
Goals:	1. Work collaboratively to build relationships and systems that support Advanced Health members and providers by designing, measuring, assessing and improving performance in the areas of medical management, medical outcomes, cost efficiency, operations, and member engagement. 2. Coordinate with community leadership to define and advocate for: • The clinical delivery of services • The optimal delivery of care • Innovative cost saving programs • Identify how to reduce overutilization of costly services • Quality performance measures / metrics • Evidence based practices • Provider development • Provider satisfaction / wellness • Provider input to the CCO Board regarding clinical credentialing • Electronic Medical Record / Health Information Exchange • Equitable access to services and health outcomes 3. Shall make recommendations to the Advanced Health Board regarding: • Implementation of Clinical Guidelines 4. Identify barriers and gaps to achieving transformation and improvement. 5. Assuring evidence based best practices and/or community standards are adopted and utilized by the CCO. 6. Analyzing utilization patterns, data and metrics, including identification of patterns. When opportunities to improve clinical outcomes are noted, the CAP will be responsible for creating strategies to address deficiencies and setting targets for ongoing performance. 7. Evaluate coordination and integration of services within the provider network, including transitions of care. When opportunities are identified, the CAP will work on strategies to enhance coordination and integration, and optimal transition. 8. Evaluation and monitoring of Performance Improvement Projects (PIPs). 9. Monitoring the expansion and development of Patient Centered Primary Care Homes in the Primary Health network. 10. Oversight of a portion of the CCO's Annual Work Plan

	11. Provide oversight of the CCO's Quality Improvement Plan Effectiveness.
Committee Chair:	The committee will be chaired by Advanced Health's Chief Medical Officer
Committee Membership	Advanced Health's Chief Medical Officer, Advanced Health's CEO, Advanced Health's Chief Operating Officer, Advanced Health's Director of Quality and Accountability, Behavioral Health Representatives, Physical Health Representatives, and an Oral Health Representative Additional members will be added as needed. ** CAP meetings are closed to the public.
Committee Members' Responsibilities:	• Actively participate in meetings to achieve the committee's goals • Work effectively with other committee members • Act as role models to inspire their organization's engagement • Provide support to the Advanced Health Board of Directors • The CAP will clarify its decision-making model. 51% of CAP members constitutes a quorum. A majority of voting members present after a quorum has been established will be adequate to make all decisions.
Meeting Frequency:	Full committee will meet the 2nd and 4th Fridays for 1 hour to accomplish the purpose of the committee
Term:	Ongoing
Review Charter:	The Charter will be reviewed annually by the CAP members. Any amendments will be brought to the Advanced Health Board for final approval.
Date(s) Revised:	February 2016, April 2017, July 2018, January 2021