

Patient-Centered Primary Care Home Standards Advisory Committee

AGENDA

December 29, 2015

10:00 AM – 11:00 AM

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#	Time	Item	Presenter
1	10:00	Welcome, introductions and review agenda	Amy Harris
2	10:15	PCPCH Committee Report	Committee
3	10:45	Temporary Rule and Statement of Need	Amy Harris
4	10:50	Public Testimony	Amy Harris
5	11:00	Adjourn	Amy Harris

STATEMENT OF NEED AND FISCAL IMPACT

A Notice of Proposed Rulemaking Hearing or a Notice of Proposed Rulemaking accompanies this form.

Oregon Health Authority, Health Policy and Analytics
Agency and Division

409

Administrative Rules Chapter Number

Amendments to Patient-Centered Primary Care Home Program Rules

Rule Caption (Not more than 15 words that reasonably identifies the subject matter of the agency's intended action.)

In the Matter of: **The amendment of OAR 409-055-0030.**

Statutory Authority: **ORS 413.042, 414.655 & 442.210**

Stats. Implemented: **ORS 413.042, 414.655 & 442.210**

Need for the Rule(s): **The Oregon Health Authority, Office for Oregon Health Policy and Research is proposing to make amendments relating to the recognition criteria for the Primary Care Home (PCPCH) Program.**

Documents Relied Upon, and where they are available:

The Technical Specifications and Reporting Guide, <http://www.oregon.gov/oha/pcpch/Documents/TA-Guide.pdf>.

Fiscal and Economic Impact:

No economic impact on individual members of the public is expected.

Statement of Cost of Compliance:

1. Impact on state agencies, units of local government and the public (ORS 183.335(2)(b)(E)):
None.

2. Cost of compliance effect on small business (ORS 183.336):

a. Estimate the number of small businesses and types of business and industries with small businesses subject to the rule:
None. Compliance with the PCPCH Standards is entirely voluntary.

b. Projected reporting, recordkeeping and other administrative activities required for compliance, including costs of professional services:
None. Compliance with the PCPCH Standards is entirely voluntary.

c. Equipment, supplies, labor and increased administration required for compliance:
None. Compliance with the PCPCH Standards is entirely voluntary.

How were small businesses involved in the development of this rule?

The membership of the PCPCH Standard Advisory Committee includes members representing primary care providers from small and rural practices. Public comment was also welcomed at the meetings.

Administrative Rule Advisory Committee consulted? No.

If not, why?: **The PCPCH Standards Advisory Committee served as the Rule Advisory Committee where proposed changes were discussed at several public meetings and public comment was also welcomed. The PCPCH Standards Advisory Committee membership includes primary care providers from small and rural practices.**

Zarie Haverkate, Rules Coordinator

Signature

Printed name

Date



Proposed Revisions to the 2014 PCPCH Model

The following document summarizes the proposed revisions to the 2014 PCPCH model recommended by the PCPCH Standards Advisory Committee.

Please refer to the following definitions when using this document:

- Unchanged:** This measure was part of the 2014 criteria and language and/or point values have not changed.
- Revised:** This measure was part of the 2014 criteria but proposed changes were made to language and/or point values.
- New:** This measure was not part of the 2014 criteria and is proposed as a new measure to the model.
- (D):** Data submission to OHA required.

The advisory committee recommended making the standard related to patient experience of care a new must-pass standard (6.C.0) bringing the total number of must-pass standards in the model to 11. Every recognized clinic needs to meet the must-pass standards. The other standards are optional, allowing clinics to accumulate points towards a total that determines their overall tier of PCPCH recognition. The total points available in the PCPCH model with all proposed changes is 390 points (up from a total of 380 points in the 2014 model).

PCPCH CORE ATTRIBUTE	Unchanged, Revised, Deleted or New?	Must Pass?	Points Available
PCPCH Standard			
PCPCH Measures			
CORE ATTRIBUTE 1: ACCESS TO CARE - "Health care team, be there when we need you."			
Standard 1.A) In-Person Access			
1.A.1 PCPCH surveys a sample of its population on satisfaction with in-person access to care.	Unchanged	No	5
1.A.2 PCPCH surveys a sample of its population using one of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tools on patient satisfaction with access to care.	Unchanged	No	10
1.A.3 PCPCH surveys a sample of its population using one of the CAHPS survey tools, and meets a benchmark on patient satisfaction with access to care.	Unchanged	No	15
Standard 1.B) After Hours Access			
1.B.1 PCPCH offers access to in-person care at least 4 hours weekly outside traditional business hours.	Unchanged	No	5
Standard 1.C) Telephone and Electronic Access			
1.C.0 PCPCH provides continuous access to clinical advice by telephone.	Revised ¹	Yes	0
1.C.1 When patients receive clinical advice via telephone, these telephone encounters (including after hours encounters) are documented in the patient's medical record.	Deleted	No	5
Standard 1.D) Same Day Access			
1.D.1 PCPCH provides same day appointments.	Unchanged	No	5
Standard 1.E) Electronic Access			
1.E.3 Using a method that satisfies either Stage 1 or Stage 2 meaningful use measures, the PCPCH provides patients with an electronic copy of their health information upon request.	Revised ²	No	5
Standard 1.F) Prescription Refills			
1.F.2 PCPCH tracks the time to completion for prescription refills.	Revised ³	No	10
1.F.3 PCPCH tracks and shows improvement, or meets a benchmark, for time to completion for prescription.	New	No	15

¹ Standard language of 1.C.0 is unchanged but in TA guide it will be revised to incorporate former 1.C.1

² Decrease in point value from 15 points to 5 points.

³ Increase in point value from 5 points to 10 points and replaces 1.F.1

PCPCH CORE ATTRIBUTE	Unchanged, Revised, Deleted or New?	Must Pass?	Points Available
PCPCH Standard			
PCPCH Measures			
CORE ATTRIBUTE 2: ACCOUNTABILITY - "Take responsibility for making sure we receive the best possible health care."			
Standard 2.A) Performance & Clinical Quality			
2.A.0 PCPCH tracks one quality metric from the core or menu set of PCPCH Quality Measures.	Unchanged	Yes	0
2.A.1 PCPCH tracks and reports to the OHA two measures from the core set and one measure from the menu set of PCPCH Quality Measures. (D)	Revised⁴	No	5
2.A.2 PCPCH demonstrates improvement on two measures from core set and one measure from the menu set of PCPCH Quality Measures (D)	New	No	10
2.A.3 PCPCH tracks, reports to the OHA and meets benchmarks on two measures from the core set and one measure from the menu set of PCPCH Quality Measures. (D)	Unchanged	No	15
Standard 2.B) Public Reporting			
2.B.1 PCPCH participates in a public reporting program for performance indicators.	Unchanged	No	5
2.B.2 Data collected for public reporting programs is shared within the PCPCH (with providers and staff) for improvement purposes.	Unchanged	No	10
Standard 2.C) Patient and Family Involvement in Quality Improvement			
2.C.1 PCPCH involves patients, caregivers, and patient-defined families as advisors on at least one quality or safety initiative per year.	Unchanged	No	5
2.C.2 PCPCH has established a formal mechanism to integrate patient, caregiver, and patient-defined family advisors as key members of quality, safety, program development and/or educational improvement activities.	Unchanged	No	10
2.C.3 Patient, caregiver, and patient-defined family advisors are integrated into the PCPCH and function in peer support or in training roles.	Unchanged	No	15
Standard 2.D) Quality Improvement			
2.D.1 PCPCH uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and patient experience.	Unchanged	No	5
2.D.2 PCPCH utilizes improvement teams that are multi-disciplinary and meet regularly to review timely, actionable, team-level data related to their chosen improvement project and documents their progress.	Unchanged	No	10

⁴ Used to be 2.A.2 and worth 10 points instead of 5 points.

PCPCH CORE ATTRIBUTE	Unchanged, Revised, Deleted or New?	Must Pass?	Points Available
PCPCH Standard			
PCPCH Measures			
2.D.3 PCPCH has a documented clinic-wide improvement strategy with performance goals derived from community, patient, family, caregiver, and other team feedback, publicly reported measures, and areas for clinical and operational improvement identified by the practice. The strategy includes a quality improvement methodology, multiple improvement related projects, and feedback loops for spread of best practice.	Unchanged	No	15
Standard 2.E) Ambulatory Sensitive Utilization			
2.E.1- PCPCH tracks selected utilization measures most relevant to their overall or an at-risk patient population.	Unchanged	No	5
2.E.2 - PCPCH tracks selected utilization measures, and sets goals and works to optimize utilization through: monitoring selected measures on a regular basis, and enacting evidence-based strategies to promote appropriate utilization.	Unchanged	No	10
2.E.3 - PCPCH tracks selected utilization measures, and shows improvement or meets a benchmark on selected utilization measures.	Unchanged	No	15
CORE ATTRIBUTE 3: COMPREHENSIVE WHOLE-PERSON CARE - "Provide or help us get the health care, information, and services we need."			
Standard 3.A) Preventive Services			
3.A.1 PCPCH routinely offers or coordinates recommended preventive services appropriate for your population (i.e. age and gender) based on best available evidence and identifies areas for improvement.	Revised ⁵	No	5
3.A.2 PCPCH routinely offers or coordinates recommended age and gender appropriate preventive services, and has an improvement strategy in effect to address gaps in preventive services offerings as appropriate for the PCPCH patient population.	Unchanged	No	10
3.A.3 PCPCH routinely offers or coordinates 90% of all recommended age and gender appropriate preventive services.	Unchanged	No	15
Standard 3.B) Medical Services			
3.B.0 PCPCH reports that it routinely offers all of the following categories of services: Acute care for minor illnesses and injuries; Ongoing management of chronic diseases including coordination of care; Office-based procedures and diagnostic tests; Preventive services ; Patient education and self-management support.	Revised ⁵	Yes	0

⁵ Language in bold has been added to measure language.

PCPCH CORE ATTRIBUTE	Unchanged, Revised, Deleted or New?	Must Pass?	Points Available
PCPCH Standard			
PCPCH Measures			
Standard 3.C) Mental Health, Substance Abuse, & Developmental Services (check all that apply)			
3.C.0 PCPCH has a screening strategy for mental health, substance use, and developmental conditions and documents on-site, local referral resources and processes .	Revised ⁵	Yes	0
3.C.2 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, or developmental providers .	Revised ⁵	No	10
3.C.3 PCPCH provides integrated behavioral health services, including population-based, same-day consultations by providers/behaviorists specially trained in assessing and addressing psychosocial aspects of health conditions.	New	No	15
Standard 3.D) Comprehensive Health Assessment & Intervention			
3.D.1 PCPCH provides comprehensive health assessment and interventions, when appropriate, for at least three health risk or developmental promotion behaviors.	Unchanged	No	5
Standard 3.E) Preventive Services Reminders			
3.E.1 Using a method that satisfies either Stage 1 or Stage 2 meaningful use measures, the PCPCH sends reminders to patients for preventative/follow-up care.	Revised ⁶	No	5
3.E.2 PCPCH uses patient information, clinical data and evidence-based guidance to generate lists of patients who need reminders. PCPCH also proactively advises patients/families/caregivers and clinicians of needed services and tracks number of unique patients who were sent appropriate reminders .	Revised ⁷	No	10
3.E.3 PCPCH uses patient information, clinical data, and evidence-based guidelines to generate lists of patients who need reminders. PCPCH also proactively advises patients/families/caregivers and clinicians of needed services, tracks number of unique patients who were sent appropriate reminders, and tracks the completion of those recommended preventive services .	Revised ⁸	No	15

⁶ Used to be 3.E.3 and worth 15 points.

⁷ Used to be 3.E.1 and worth 5 points, language in bold is new.

⁸ Used to be 3.E.2 and worth 10 points, language in bold is new

PCPCH CORE ATTRIBUTE	Unchanged, Revised, Deleted or New?	Must Pass?	Points Available
PCPCH Standard			
PCPCH Measures			
CORE ATTRIBUTE 4: CONTINUITY - "Be our partner over time in caring for us."			
Standard 4.A) Personal Clinician Assigned			
4.A.0 PCPCH reports the percentage of active patients assigned to a personal clinician or team. (D)	Unchanged	Yes	0
4.A.3 PCPCH meets a benchmark in the percentage of active patients assigned to a personal clinician or team. (D)	Unchanged	No	15
Standard 4.B) Personal Clinician Continuity			
4.B.0 PCPCH reports the percent of patient visits with assigned clinician or team. (D)	Unchanged	Yes	0
4.B.2 PCPCH tracks and improves the percent of patient visits with assigned clinician or team. (D)	Unchanged	No	10
4.B.3 PCPCH meets a benchmark in the percent of patient visits with assigned clinician or team. (D)	Unchanged	No	15
Standard 4.C) Organization of Clinical Information			
4.C.0 PCPCH maintains a health record for each patient that contains at least the following elements: problem list, medication list, allergies, basic demographic information, preferred language, BMI/BMI percentile/growth chart as appropriate, and immunization record; and updates this record as needed at each visit.	Unchanged	Yes	0
Standard 4.D) Clinical Information Exchange			
4.D.3 PCPCH shares clinical information electronically in real time with other providers and care entities (electronic health information exchange).	Unchanged	No	15
Standard 4.E) Specialized Care Setting Transitions			
4.E.0 PCPCH has a written agreement with its usual hospital providers or directly provides routine hospital care.	Unchanged	Yes	0
Standard 4.F) Planning for Continuity			
4.F.1 PCPCH demonstrates a mechanism to reassign administrative requests, prescription refills, and clinical questions when a provider is not available.	Unchanged	No	5
Standard 4.G) Medication Reconciliation and Management			
4.G.1. Upon receipt of a patient from another setting of care or provider of care (transitions of care), the PCPCH performs medication reconciliation using a method that satisfies either Stage 1 or Stage 2 meaningful use measures.	Revised⁵	No	5

PCPCH CORE ATTRIBUTE	Unchanged, Revised, Deleted or New?	Must Pass?	Points Available
PCPCH Standard			
PCPCH Measures			
4.G.2 PCPCH develops a process, tracks and reports the percentage of patients whose medication regimen is reconciled at each relevant patient encounter.	Revised ⁵	No	10
4.G.3 PCPCH provides Comprehensive Medication Management for appropriate patients and families.	New ⁹	No	15
CORE ATTRIBUTE 5: COORDINATION AND INTEGRATION - “Help us navigate the health care system to get the care we need in a safe and timely way.”			
Standard 5.A) Population Data Management (check all that apply)			
5.A.1 PCPCH demonstrates the ability to identify, aggregate, and display and utilize up-to-date data regarding its patient population, including the identification of sub-populations.	Revised ¹⁰	No	5
5.A.1a PCPCH demonstrates the ability to identify, aggregate, and display up-to-date data regarding its patient population.	Deleted	No	5
5.A.1b PCPCH demonstrates the ability to identify, track and proactively manage the care needs of a sub-population of its patients using up-to-date information.	Deleted	No	5
5.A.2 PCPCH demonstrates the ability to stratify their population according to health risk such as special health care needs or health behavior.	New	No	10
Standard 5.B) Electronic Health Record			
5.B.3 PCPCH has a certified electronic health record and the PCPCH practitioners must meet the standards to be “meaningful users” of certified electronic health record technology established by the Centers for Medicare and Medicaid Services.	Unchanged	No	15
Standard 5.C) Complex Care Coordination (check all that apply)			
5.C.1 PCPCH demonstrates that members of the health care team have defined roles in care coordination for patients , and tells each patient or family the name of the team member(s) responsible for coordinating his or her care.”	Revised ⁵	No	5
5.C.2 PCPCH describes and demonstrates its process for identifying and coordinating the care of patients with complex care needs.	Unchanged	No	10
5.C.3 PCPCH develops an individualized written care plan for patients and families with complex medical or social concerns. This care plan should include at least the following: self management	Unchanged	No	15

⁹ Replaces former 4.G.3 related to Meaningful Use.

¹⁰ 5.A.1a and 5.A.1b were combined into 5.A.1

PCPCH CORE ATTRIBUTE	Unchanged, Revised, Deleted or New?	Must Pass?	Points Available
PCPCH Standard			
PCPCH Measures			
goals; goals of preventive and chronic illness care; and action plan for exacerbations of chronic illness.			
Standard 5.D) Test & Result Tracking			
5.D.1 PCPCH tracks tests ordered by its clinicians and ensures timely and confidential notification or availability of results to patients and families with interpretation, as well as to ordering clinicians.	Unchanged	No	5
Standard 5.E) Referral & Specialty Care Coordination (check all that apply)			
5.E.1 PCPCH tracks referrals to consulting specialty providers ordered by its clinicians, including referral status and whether consultation results have been communicated to patients and/or caregivers and clinicians.	Unchanged	No	5
5.E.2 PCPCH demonstrates active involvement and coordination of care when its patients receive care in specialized settings (hospital, SNF, long term care facility).	Unchanged	No	10
5.E.3 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.	Unchanged	No	15
Standard 5.F) End of Life Planning			
5.F.O PCPCH has a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from these services.	Unchanged	Yes	0
5.F.1 PCPCH has a process to engage patients in end-of-life planning conversations and completes advance directive and other forms such as POLST that reflect patients' wishes for end-of-life care; forms are submitted to available registries (unless patients' opt out).	Unchanged	No	5
CORE ATTRIBUTE 6: PERSON AND FAMILY CENTERED CARE - "Recognize that we are the most important part of the care team - and that we are ultimately responsible for our overall health and wellness."			
Standard 6.A) Language / Cultural Interpretation			
6.A.0 PCPCH offers and/or uses either providers who speak a patient and family's language at time of service in-person or telephonic trained interpreters to communicate with patients and families in their language of choice.	Unchanged	Yes	0
6.A.1 PCPCH translates written patient materials into all languages spoken by more than 30 households or 5% of the practice's patient population.	Unchanged	No	5

PCPCH CORE ATTRIBUTE	Unchanged, Revised, Deleted or New?	Must Pass?	Points Available
PCPCH Standard			
PCPCH Measures			
Standard 6.B) Education & Self-Management Support			
6.B.1 PCPCH has a process for identifying patient-specific educational resources and providing those resources to patients when appropriate.	Unchanged	No	5
6.B.2 More than 10% of unique patients are provided patient-specific education resources.	Unchanged	No	10
6.B.3 More than 10% of unique patients are provided patient-specific education resources and self-management services.	Unchanged	No	15
Standard 6.C) Experience of Care			
6.C.0 PCPCH surveys a sample of its patients and families at least annually on their experience of care. The patient survey must include questions on access to care, provider or health team communication, coordination of care, and staff helpfulness. The recommended patient experience of care survey is one of the CAHPS survey tools.	Revised ¹¹	Yes	0
6.C.2 – PCPCH surveys a sample of its population at least every two years on their experience of care using of one of the CAHPS survey tools and demonstrates the utilization of survey data in quality improvement process.	Revised ¹²	No	10
6.C.3 - PCPCH surveys a sample of its population at least every two years on their experience of care using of one of the CAHPS survey tools, demonstrates the utilization of survey data in quality improvement process and meets benchmarks on the majority of domains regarding provider communication, coordination of care, and practice staff helpfulness.	Revised ¹²	No	15
Standard 6.D) Communication of Rights, Roles, and Responsibilities			
6.D.1 PCPCH has a written document or other educational materials that outlines PCPCH and patient/family rights, roles, and responsibilities and has a system to ensure that each patient or family receives this information at the onset of the care relationship.	Unchanged	No	5

¹¹ Used to be 6.C.1 but is now a new must-pass standard.

¹² Language in bold is new, also changed from annually to every two years.

1. Access to Care

1.A In-Person Access	1.B After Hours Access	1.C Telephone & Electronic Access	1.D Same Day Access	1.E Electronic Access	1.F Prescription Refills	1.G. Timely Access (New)	1.H Access even if unable to pay (New)
1.A.1 BHH surveys a sample of its population on satisfaction with in-person access to care.	1.B.1 BHH offers access to in-person care for bh services at least 4 hours weekly outside traditional business hours.	1.C.0 BHH provides continuous access to behavioral health advice by telephone. (Must-pass)	1.D.1 BHH provides same-day and walk-in appointments for BHH services.	1.E.3 Using a method that satisfies either Stage 1 or Stage 2 meaningful use measures, the BHH provides clients with an electronic copy of their health information upon request.	1.F.1 BHH tracks the time to completion for prescription refills.	CCBHC: 1. All new consumers requesting or being referred for bh services will, at the time of first contact, receive a preliminary screening & risk assessment to determine acuity of needs. 2. The preliminary screening will be followed by: (1) initial evaluation, (2) a comprehensive person-centered & family-centered diagnostic & treatment planning evaluation.	CCBHC: 1. The CCBHC ensures no individuals are denied behavioral health care services, including but not limited to crisis management services, because of an individual's inability to pay for such services. 2. The CCBHC has a published sliding fee discount schedule(s) that includes all services the CCBHC proposes to offer pursuant to these criteria
1.A.2 BHH surveys a sample of its population using the Experience of Care & Health Outcomes (ECHO) or CAHPS survey tools on consumer satisfaction with access to care	1.B.3 (New) BHH offers access to in-person care for primary care services at least 4 hours weekly outside traditional business hours.	1.C.3 (New) BHH provides continuous access to primary care advice by telephone that is then documented in the client's medical record	1.D.3 (New) BHH provides on-site same day appointments for primary care services.			(cont.) 3. Outpatient clinical services for established CCBHC consumers seeking an appt for routine needs must be provided within 10 bus. days of requested date for service.	(cont.) 3. The CCBHC ensures no individual is denied bh care services because of place of residence or homelessness or lack of a permanent address.
1.A.3 BHH surveys a sample of its population using the Experience of Care & Health Outcomes (ECHO) or CAHPS survey tools, and meets a benchmark on consumer satisfaction with access to care.	CCBHC: The CCBHC provides outpatient clinical services during times that ensure accessibility and meet the needs of the consumer population to be served, including some nights and weekend hours.					(cont.) 4. The CCBHC provides crisis management services that are available & accessible 24/7 & delivered within 3 hrs. 5. Following a psychiatric emergency or crisis involving a CCBHC consumer, the CCBHC creates, maintains, & follows a crisis plan to prevent & de-escalate future crisis situations, w/ goal of preventing future crises.	

2. Accountability

2.A Performance & Clinical Quality	2.B Public Reporting	2.C Consumer/Family Involvement in QI	2.D Quality Improvement	2.E Ambulatory Sensitive	2.F Care Team Involvement (New)	2.G Evidence-based Data-Driven Care (New)
2.A.0 BHH tracks one quality metric from the core or menu set of PCPCH Quality Measures. (Must-pass)	2.B.1 BHH participates in a public reporting program for performance indicators.	2.C.1 BHH involves consumers, caregivers, and consumer-defined families as advisors on at least one quality or safety initiative per year	2.D.1 BHH uses performance data to identify opportunities for improvement and acts to improve clinical quality, efficiency and client experience.	2.E.1- BHH tracks selected utilization measures most relevant to their overall or an at-risk patient population.	2.F.1 BHH uses an interdisciplinary team including peer supports & involves consumer/family in treatment planning & care coordination activities. A care coordination agreement is developed that helps establish which provider is reasonable for what aspects of care & its coordination.	2.G.1 BHH uses data-driven, evidence-based care to guide treatment decisions and delivery of care including use of validated assessment tools, information systems like registries to track data over time.
2.A.2 BHH tracks and reports to the OHA two measures from the core set and one measure from the menu set of PCPCH/BHH Quality Measures.	2.B.2 Data collected for public reporting programs is shared within the BHH (with providers & staff) for improvement purposes.	2.C.2 BHH has established formal mechanism to integrate consumer/caregiver/consumer-defined family advisors as key members of quality, safety, prog. Dev. &/or ed. imp. activities.	2.D.2 BHH utilizes improvement teams that are multi-disciplinary and meet regularly to review timely, actionable, team-level data related to their chosen improvement project and documents their progress.		CCBHC: The CCBHC treatment team includes the consumer, the family/caregiver of child consumers, the adult consumer's family and any other person the consumer chooses. All treatment planning and care coordination activities are person-centered and familycentered	2.G.2 BHH embeds clinical guidelines into routine delivery of care.
2.A.3 BHH tracks, reports to the OHA and meets benchmarks on two measures from the core set and one measure from the menu set of PCPCH Quality Measures		2.C.3 Consumer caregiver, and consumer-defined family advisors are integrated into the BHH and function in peer support or in training roles.	2.D.3 BHH has doc. clinic-wide imp. strategy w/ performance goals derived from community, consumer, family, caregiver, & other team feedback, publicly reported measures, & areas for clinical & operational imp. identified by practice. The strategy includes a QI methodology, multiple imp. related projects, & feedback loops		CCBHC: The CCBHC designates an interdisciplinary treatment team that is responsible, with the consumer or family/caregiver, for directing, coordinating, and managing care and services for the consumer. The interdisciplinary team is composed of individuals who work together to coordinate the medical, psychosocial, emotional, therapeutic, and recovery support needs of CCBHC consumers.	
CCBHC: has capacity to collect, report, & track encounter, outcome, & quality data, inc. but not limited to data capturing: consumer char.; staffing; access to services; use of services; screening, prevention, & treatment; care coordination other processes of care; costs; & consumer outcomes			CCBHC: The CCBHC develops, implements, & maintains an effective, CCBHC-wide data-driven continuous quality improvement (CQI) plan for clinicalservices and clinical management.			

3. Comprehensive Whole-Person Care

3.A Preventive Services	3.B Provision of Services	3C Coordination & Integration with Primary Care (3.C.1 is must-pass for Tier 1, 3.C.2 is must-pass for Tier 2, 3.C.3 is must-pass for Tier 3)	3.D Comprehensive Health Assessment & Intervention	3.E Preventive Services Reminders
3.A.1 BHH routinely offers or coordinates recommended age and gender appropriate preventive services based on best available evidence.	3.B.0 BHH reports that it routinely offers all of the following categories of BH services: screening, assessment and diagnosis including risk assessment, person-centered treatment planning, outpatient mental health services, targeted case management services and psychiatric rehabilitation. (Must-pass)	3.C.1 BHH conducts screenings, links consumers to PCPs and coordinates primary care with PCP. BHH has designated staff that serves as bridge between consumer, bh providers and primary care provider. BHH has a cooperative referral process with primary care providers . Both BHH and primary care staff receive cross training. BHH must assist consumer identify medical provider who will provide continued care.	3.D.1 BHH provides comprehensive health assessment and interventions, when appropriate, for at least three health risk or developmental promotion behaviors.	3.E.1 BHH uses consumer information, clinical data, and evidence-based guidelines to generate lists of consumer who need reminders and to proactively advise consumers/families/caregivers and clinicians of needed services.
3.A.2 BHH routinely offers or coordinates recommended age and gender appropriate preventive services, and has an improvement strategy in effect to address gaps in preventive services offerings as appropriate for the BHH consumer population	3.B.2 (new) BHH incorporates prevention and wellness support services including nutrition consultation, health ed & literacy, peer specialists & self-help/management programs into individualized wellness plans.	3.C.2 BHH is co-located with primary care and provides access to primary care services for a defined percentage of hours that the clinic is open.		3.E.2 BHH tracks the number of unique consumers who were sent appropriate reminders.
3.A.3 BHH routinely offers or coordinates 90% of all recommended age and gender appropriate preventive services.	3.C.3 (New) BHHs offer or coordinate 24/7 access to crisis management services	3.C.3 BHH is integrated with primary care and provides access to primary care services during all clinic hours of operation.		3.E.3 Using a method that satisfies either Stage 1 or Stage 2 meaningful use measures, the BHH sends reminders to consumers for preventative/follow-up care.
	CCBHC: CCBHCs are responsible for the provision of all care specified in PAMA, including crisis services; screening, assessment & diagnosis; person-centered treatment planning; outpatient bh services; outpatient pc screening & monitoring; targeted case management; psychiatric rehabilitation; peer & family supports; & intensive community-based outpatient bh care fo Armed Forces & veterans. May be provided either directly by the CCBHC or through formal relationships w/ other providers that are DCOs but either way the CCBHC is ultimately clinically responsible for all care provided.	CCBHC: The CCBHC has an agreement establishing care coordination expectations with FQHCs & as applicable, Rural Health Clinics [RHCs]) to provide health care services, to the extent the services are not provided directly through the CCBHC. For consumers who are served by other PCPs, the CCBHC has established protocols to ensure adequate care coordination.		

4. Continuity

4.A Organization of BHH Info	4.B Clinical Info Exchange	4.C Specialized Care Setting Transitions	4.D Planning for Continuity (See separate sheet for options)	4.E Medication Reconciliation
<p>4.A.0 BHH maintains a health record for each consumer that contains at least the following elements: problem list, medication list, allergies, basic demographic information, preferred language; and updates this record as needed at each visit. (Must-pass)</p>	<p>4.B.3 BHH shares clinical information electronically in real time with other providers and care entities (electronic health information exchange).</p>	<p>4.C.0 BHH has a written agreement with its usual hospital providers or directly provides routine hospital care. (Must-pass)</p>	<p>4.D.1 BHH demonstrates a mechanism to reassign administrative requests, prescription refills, and clinical questions when a provider is not available.</p>	<p>4.E.1 Upon receipt of a consumer from another setting of care or provider of care (transitions of care) the BHH performs medication reconciliation.</p>
		<p>CCBHC: 1. CCBHCs maintain a working relationship w/ local EDs & agreements in place with inpatient acute-care hospitals, including EDs, hospital outpatient clinics, urgent care centers, residential crisis settings, medical detoxification inpatient facilities & ambulatory detoxification providers 2. Protocols are established for CCBHC staff to address the needs of CCBHC consumers in psychiatric crisis who come to those EDs. 3 The CCBHC has an agreement establishing care coordination expectations with a variety of community or regional services, supports, and providers. 4. inpatient acute-care hospitals, including emergency departments, hospital outpatient clinics, urgent care centers, residential crisis settings, med detox inpatient facilities and ambulatory detox providers. 5. The CCBHC will make and document reasonable attempts to contact all CCBHC consumers who are discharged from these settings within 24 hours of discharge.</p>		<p>4.E.2 BHH tracks the percentage of consumers whose medication regimen is reconciled.</p>
		<p>CCBHC: The CCBHC has an agreement establishing care coordination expectations w/ programs that can provide inpatient psychiatric treatment, w/ ambulatory & medical detox, post-detox step-down services, & residential programs to provide those services for CCBHC consumers. The CCHBC is able to track when consumers are admitted to facilities providing the services listed above, as well as when they are discharged, unless there is a formal transfer of care to a non-CCBHC entity. The CCBHC has established protocols and procedures for transitioning individuals from EDs, inpatient psychiatric, detoxification, and residential settings to a safe community setting.</p>		<p>4.E.3 The BHH makes and documents reasonable attempts to determine any medications prescribed by other providers for BHH consumers and to provide such information to other providers not affiliated with the BHH to the extent necessary for safe and quality care.</p>

5. Coordination and Integration

5.A Population Data Management (Check all that apply)	5.B Electronic Health Record	5.C Care Coordination	5.D Test & Result Tracking	5.E Referral & Speciality Care Coordination	5.F End of Life Planning
5.A.1a BHH demonstrates the ability to identify, aggregate, and display up-to-date data regarding its consumer population.	5.B.3. The BHH establishes or maintains a HIT system that includes EHRs. The HIT system has the capability to capture structured info in consumer records (including demographic information, diagnoses, & med lists), provide clinical decision support, & electronically transmit prescriptions to pharmacy. Uses HIT system to conduct activities such as pop. health management, QI, reducing disparities, & for research & outreach.	5.C.0 BHH demonstrates that members of the health care team have defined roles in care coordination for consumers, and tells each consumer or family the name(s) of the team member(s) responsible for coordinating his or her care. (Must-Pass)	5.D.1 BHH tracks tests ordered by its clinicians and ensures timely and confidential notification or availability of results to consumers and families with interpretation, as well as to ordering clinicians.	5.E.1 BHH tracks referrals to consulting specialty providers ordered by its clinicians, including referral status and whether consultation results have been communicated to consumers and/or caregivers and clinicians.	5.F.0 BHH has a process to offer or coordinate hospice and palliative care and counseling for consumers and families who may benefit from these services. (Must-pass)
5.A.1b BHH demonstrates the ability to identify, track and proactively manage the care needs of a sub-population of its consumers using up-to-date information		5.C.3 BHH describes and demonstrates its process for identifying and coordinating of consumers with complex care needs. BHH develops an individualized written care plan with consumers/families. This care plan should include at least the following: self management goals, goals of preventive and chronic illness care and action plan for exacerbations of chronic illness. BHH uses single shared care plan that whole team uses and that addresses physical, behavioral, and wellness needs of client. Care plan must document specific services and supports to be provided, arranged or coordinated to assist consumer/family to achieve intended outcomes.	5.D.3 (NEW) BHH tracks outcomes related to tests and results.	5.E.2 BHH demonstrates active involvement and coordination of care when its consumers receive care in specialized settings (hospital, SNF, long term care facility).	
				5.E.3 BHH tracks referrals and cooperates with community service providers outside the BHH such as social services, housing, ed systems, & employment opportunities as necessary to facilitate wellness and recovery of the whole person.	
				<p>CCBHC: The CCBHC coordinates care across the spectrum of health services, including access to high-quality physical health (both acute & chronic) & bh care, as well as social services, housing, ed systems, & employment opportunities as necessary to facilitate wellness and recovery of the whole person.</p> <p>2. The CCBHC assists consumers and families of children & youth, referred to ext. providers or resources, in obtaining an appt & confirms appt was kept</p>	

6. Person and Family Centered

6.A Language / Cultural Interpretation	6.B Education & Self-Management Support	6.C Experience of Care (Will be changed to reflect new language for this standard related to	6.D Communication of Rights, Roles & Responsibilities
<p>6.A.0 BHH offers and/or uses either providers who speak a consumer's and family's language at time of service in-person or telephonic trained interpreters to communicate with consumers and families in their language of choice. (Must-pass)</p>	<p>6.B.1 BHH has a process for identifying consumer-specific educational resources and providing those resources to clients when appropriate.</p>	<p>6.C.1 BHH surveys a sample of its consumers and families at least annually on their experience of care. The patient survey must include questions on access to care, provider or health team communication, coordination of care, and staff helpfulness. The recommended consumer experience of care survey is the ECHO or CAHPS survey tools</p>	<p>6.D.1 BHH has a written document or other educational materials that outlines BHH and consumer/family rights, roles, and responsibilities and has a system to ensure that each consumer or family receives this information at the onset of the care relationship.</p>
<p>6.A.1 BHH translates written consumers materials into all languages spoken by more than 30 households or 5% of the practice's consumers population.</p>	<p>6.B.2 More than 10% of unique consumers are provided consumer-specific education resources. BHH tracks usage of these resources and outcomes that occur as a result of usage.</p>	<p>6.C.2 BHH surveys a sample of its population at least annually on their experience of care using the ECHO or CAHPS survey tools. The consumer survey must at least include questions on provider communication, coordination of care, and practice staff helpfulness.</p>	
<p>CCBHC: 1. Auxiliary aids & services are readily available , ADA compliant & responsive to the needs of consumers w/ disabilities. 2. Documents or messages vital to a consumer's ability to access CCBHC services are available in languages common in community served, taking account of literacy levels & alternative formats. Such materials are provided in a timely manner at intake</p>	<p>6.B.3 More than 25% of unique consumers are provided consumer-specific education resources and self-management services. BHH tracks usage of these resources and outcomes that occur as a result of usage.</p>	<p>6.C.3 BHH surveys a sample of its population at least annually on their experience of care using the ECHO or CAHPS survey tools and meets benchmarks on the majority of the domains regarding provider communication, coordination of care, and practice staff helpfulness.</p>	

**CHAPTER 409
OREGON HEALTH AUTHORITY,
OFFICE FOR OREGON HEALTH POLICY AND RESEARCH**

**DIVISION 55
PATIENT-CENTERED PRIMARY CARE HOME PROGRAM**

409-055-0000

Purpose and Scope

These rules (OAR 409-055-0000 to 409-055-0090) establish the Patient-Centered Primary Care Home (PCPCH) Program and define criteria and process that the Authority shall use to recognize and verify status as PCPCHs. The PCPCH is a model of primary care that has received attention in Oregon and across the country for its potential to advance the “triple aim” goals of health reform: a healthy population, extraordinary patient care for everyone, and reasonable costs, shared by all. PCPCHs achieve these goals through a focus on wellness and prevention, coordination of care, active management and support of individuals with special health care needs, and a patient and family-centered approach to all aspects of care. PCPCHs emphasize whole-person care in order to address a patient and family’s physical and behavioral health care needs.

Stat. Auth: ORS 413.042, 414.655 & 442.210

Stat. Implemented: 413.042, 414.655 & 442.210

409-055-0010

Definitions

The following definitions apply to OAR 409-055-0000 to 409-055-0090:

~~(1) “Administrator” means the administrator or designee of The Office for Oregon Health Policy and Research as defined in ORS 442.011.~~

(12) “Authority” means the Oregon Health Authority.

(23) “CHIPRA Core Measure Set” means the initial core set of children’s health care quality measures released by the Centers for Medicare and Medicaid Services in 2009 for voluntary use by Medicaid and CHIP programs.

(34) “NCQA” means National Committee for Quality Assurance.

~~(5) “Office” means the Office for Oregon Health Policy and Research.~~

(46) “Patient Centered Medical Home (PCMH)” means a practice or provider who has been recognized as such by the National Committee for Quality Assurance.

- (~~57~~) “Patient-Centered Primary Care Home (PCPCH)” means a health care team or clinic as defined in ORS 414.655, meets the standards pursuant to OAR 409-055-0040, and has been recognized through the process pursuant to OAR 409-055-0040.
- (~~68~~) “Personal Health Information” means demographic information, medical history, test and laboratory results, insurance information and other data that is collected by a health care professional to identify an individual and determine appropriate care.
- (~~79~~) “Practice” means an individual, facility, institution, corporate entity, or other organization which provides direct health care services or items, also termed a performing provider, or bills, obligates and receives reimbursement on behalf of a performing provider of services, also termed a billing provider (BP). The term provider refers to both performing providers and BP(s) unless otherwise specified.
- (~~810~~) “Program” means Patient-Centered Primary Care Home Program.
- (~~911~~) “Program website” means www.primarycarehome.oregon.gov.
- (~~1012~~) “Provider” means an individual, facility, institution, corporate entity, or other organization which provides direct health care services or items, also termed a performing provider, or bills, obligates and receives reimbursement on behalf of a performing provider of services, also termed a billing provider (BP). The term provider refers to both performing providers and BP(s) unless otherwise specified.
- (~~1113~~) “Recognition” means the process through which the Authority determines if a practice has met the Oregon Patient-Centered Primary Care Home Standards.
- (~~1214~~) “Recognized” means that the Authority has affirmed that a practice meets the Oregon Patient-Centered Primary Care Home Standards.
- (~~1315~~) “Tier” means the level of Patient-Centered Primary Care Home at which the Authority has scored a practice.
- (~~1416~~) “Verification” means the process that Office for Oregon Health Policy and Research shall conduct to ensure that a practice has submitted accurate information to the Authority for purposes of Patient-Centered Primary Care Home recognition.
- (~~1517~~) “3 STAR” means a designation assigned to Patient-Centered Primary Care Homes meeting advanced PCPCH criteria.

Stat. Auth: ORS 413.042, 414.655 & 442.210
Stat. Implemented: 413.042, 414.655 & 442.210

409-055-0020

Program Administration

- (1) The Program is intended to ensure that there is a uniform process for recognizing PCPCHs throughout the State of Oregon in order to support primary care transformation.
- (2) The Authority shall recognize practices as PCPCHs upon meeting defined criteria through the Program.
- (3) The Authority shall administer the Program, including data collection and analysis, recognition, and verification that a practice meets the defined PCPCH criteria. The Authority may also provide technical assistance as is feasible.
- (4) The Authority may contract for any of the work it deems necessary for efficient and effective administration of the Program.

Stat. Auth: ORS 413.042, 414.655 & 442.210

Stat. Implemented: 413.042, 414.655 & 442.210

409-055-0030

Practice Application and Recognition Process

- (1) Practices, or other entities on behalf of the practice, that wish to be recognized as a PCPCH shall submit a PCPCH Recognition Application electronically to the Authority via the Program's online application system found on the Program website or by mail to the address posted on the Program website. The application shall include the quantitative data described in OAR 409-055-0040.
- (2) The Authority shall review the application within 60 days of its submission to determine whether it is accurate, complete, and meets the recognition requirements. If the application is incomplete the applicant will be notified in writing of the information that is missing and when it must be submitted.
- (3) The Authority shall review a complete application within 60 days of submission. If the Authority determines that the applicant has met the requirements of these rules the Authority shall:
 - (a) Inform the applicant in writing that the application has been approved as a recognized PCPCH,
 - (b) Assign a Tier level, and
 - (c) Include the effective recognition date.

- (4) The Authority shall maintain instructions and criteria for submitting a PCPCH Recognition Application posted on the Program website.
- (5) The Authority may deny PCPCH recognition if an applicant does not meet the requirements of these rules.
- (6) A Practice may request that the Authority reconsider the denial of PCPCH recognition or reconsider the assigned tier level. A request for reconsideration must be submitted in writing to the Authority within 90 days of the date of the denial or approval letter and must include a detailed explanation of why the practice believes the Authority's decision is in error along with any supporting documentation. The Authority shall inform the practice in writing whether it has reconsidered its decision.
- (7) Practices submitting applications on or after September 3, 2013 must apply to renew their recognition once every two years. Recognition will expire two years from the effective date of recognition that was issued by the Authority.
 - (a) At the Authority's discretion a 30-day grace period may be allowed for PCPCHs to submit their renewal application without having a lapse in recognition status.
 - (b) If a PCPCH believes that it meets the criteria to be recognized at a higher tier or increase its point threshold by at least 15 points, it may request to have its tier status reassessed by re-submitting an application not more than once every six months. The Authority may grant exceptions to the six month time period for good cause shown.
 - (c) Currently recognized PCPCHs that are due to reapply between January 1, 2016 and December 31, 2016 will be granted an extension of their PCPCH recognition until January 1, 2017.
 - (d) Currently recognized PCPCHs that choose to reapply for recognition between January 1, 2016 and December 31, 2016 will be recognized until January 1, 2017.
 - (e) Practices applying for PCPCH recognition for the first time between January 1, 2016 and December 31, 2016 will be recognized until January 1, 2017.

Stat. Auth: ORS 413.042, 414.655 & 442.210

Stat. Implemented: 413.042, 414.655 & 442.210

409-055-0040

Recognition Criteria

- (1) The PCPCH recognition criteria are divided into “Must-Pass” measures and other measures that place the practice on a scale of maturity or ‘tier’ that reflect basic to more advanced PCPCH functions.
- (2) Must-Pass and 5 point measures focus on foundational PCPCH elements that should be achievable by most practices in Oregon with significant effort, but without significant financial outlay.
- (3) 10 and 15 point measures reflect intermediate and advanced functions.
- (4) Except for the 10 Must-Pass measures, each measure is assigned a point value. A practice must meet the following point allocation criteria to be recognized as a PCPCH:
 - (a) Tier 1: 30 - 60 points and all 10 Must-Pass Measures
 - (b) Tier 2: 65 - 125 points and all 10 Must-Pass Measures
 - (c) Tier 3: 130 points or more and all 10 Must-Pass Measures
- (5) The Authority shall calculate a practice’s point score through the recognition process described in OAR 409-055-0030.
- (6) Table 1, incorporated by reference, contains the detailed list of Measures and corresponding point assignments.
- (7) Table 2, incorporated by reference, contains a detailed list of the PCPCH Quality Measures.
- (8) Measure specifications, thresholds for demonstrating improvement, and benchmarks for quantitative data elements are available on the Program website.
- (9) National Committee for Quality Assurance (NCQA) recognition shall be acknowledged in the Authority’s PCPCH recognition process; however, a practice is not required to use its NCQA recognition to meet the Oregon PCPCH standards. A practice that does not wish to use its NCQA recognition to meet the Oregon PCPCH standards must indicate so during the PCPCH application process and submit a complete PCPCH application.
- (10) A practice seeking Oregon PCPCH recognition based on its NCQA recognition must:
 - (a) Submit a PCPCH application and evidence of its NCQA recognition along with its application;

- (b) Comply with Table 3, incorporated by reference, for NCQA PCMH practices using 2008 NCQA criteria; or
 - (c) Comply with Table 4, incorporated by reference, for NCQA PCMH practices using 2011 NCQA criteria.
- (11) The Authority may designate a practice as a [Tier](#) 3 STAR Patient-Centered Primary Care Home for ~~implementing multiple those practices attesting to a large number of~~ advanced PCPCH criteria [as described in OAR 409-055-0045](#). ~~The Authority will determine the criteria for this designation no later than June 2014.~~

[ED. NOTE: Tables referenced are not included in rule text. [Click here for PDF copy of table\(s\).](#)]

Stat. Auth: ORS 413.042, 414.655 & 442.210

Stats. Implemented: 413.042, 414.655 & 442.210

409-055-0045

3 STAR Designation

- (1) The Authority shall award 3 STAR designations to practices implementing multiple advanced PCPCH measures.
- (2) A practice seeking 3 STAR designation, must meet the following criteria:
 - (a) Be recognized as a Tier 3 PCPCH under the Measures in Table 1, adopted and incorporated by reference;
 - (b) Attest to 275 points or more on the PCPCH application; and
 - (c) Attest to 11 or more of the 13 PCPCH Measures in Table 5, adopted and incorporated by reference.
- (3) The Authority shall review PCPCH applications of practices attesting to the Measures in Table 1, to determine which practices meet the criteria in section (2) of this rule
- (4) The Authority shall notify a practice meeting 3 STAR designation criteria in writing of their eligibility.
- (5) The Authority shall contact the eligible practice to schedule an on-site verification visit as described in OAR 409-055-0060.
- (6) A practice seeking 3 STAR designation must comply with an on-site verification site visit.

- (7) The Authority shall award 3 STAR designation to a practice after verifying the practice meets all 3 STAR designation criteria.
- (8) 3 STAR designation is valid for the duration of the practice's current PCPCH recognition as described in OAR 409-055-0030(7).

[ED. NOTE: Tables referenced are not included in rule text. [Click here for PDF copy of table\(s\).](#)]

Stat. Auth: ORS 413.042, 414.655 & 442.210

Stats. Implemented: 413.042, 414.655 & 442.210

409-055-0050

Data Reporting Requirements for Recognized PCPCHs

- (1) To be recognized as a PCPCH, a practice must attest to meeting the criteria and submit quantitative data elements to support its attestation in accordance with Tables 1 & 2, incorporated by reference.
- (2) Quantitative data shall be aggregated at the practice level, not the individual patient level, and a practice may not transfer any personal health information to the Authority during the PCPCH application process.
- (3) PCPCHs must submit new quantitative and attestation data as a part of the recognition renewal process and must use the specifications found on the Program website for calculating application data.
- (4) If approved by the practice, other entities may submit information on behalf of a practice, as long as appropriate practice staff has reviewed all application information and data prior to submission.
- (5) A practice may request an exception to any of the quantitative data reporting requirements in Table 2 or the Must-Pass criteria by submitting a form prescribed by the program. The Authority may grant exceptions for good cause shown.
- (6) Practices are required to submit 12 months of quantitative data in order to meet standards 2.A., 4.A., and 4.B. A practice may request an exception to the 12 month data reporting period by submitting a form prescribed by the program. The Authority may grant exceptions for good cause shown.
- (7) The Authority shall notify the practice within 60 days of complete application and exception submission whether or not the requested exception has been granted.

[ED. NOTE: Tables referenced are not included in rule text. [Click here for PDF copy of table\(s\).](#)]

Stat. Auth: ORS 413.042, 414.655 & 442.210
Stats. Implemented: 413.042, 414.655 & 442.210

409-055-0060

Verification

- (1) The Authority shall conduct at least one on-site verification review of each recognized PCPCH to determine compliance with PCPCH criteria every five years and at such other times as the Authority deems necessary or at the request of the [Health Systems Division \(HSD\)](#) ~~Division of Medical Assistance Programs (DMAP)~~, or any other applicable program within the Authority. The purpose of the review is to verify reported attestation and quantitative data elements for the purposes of confirming recognition and Tier level.
- (2) PCPCHs selected for verification shall be notified no less than 30 days prior to the scheduled review.
- (3) PCPCHs shall permit Authority staff access to the practice's place of business during the review.
- (4) A verification review may include but is not limited to:
 - (a) Review of documents and records.
 - (b) Review of patient medical records.
 - (c) Review of electronic medical record systems, electronic health record systems, and practice management systems.
 - (d) Review of data reports from electronic systems or other patient registry and tracking systems.
 - (e) Interviews with practice management, clinical and administrative staff.
 - (f) On-site observation of practice staff.
 - (g) On-site observation of patient environment and physical environment.
- (5) Following a review, Authority staff may conduct an exit conference with the PCPCH representative(s). During the exit conference Authority staff shall:
 - (a) Inform the PCPCH representative of the preliminary findings of the review; and
 - (b) Give the PCPCH a reasonable opportunity to submit additional facts or other information to the Authority staff in response to those findings.

- (6) Following the review, Authority staff shall prepare and provide the PCPCH specific and timely written notice of the findings.
- (7) If the findings result in a referral to [HSDDMAP](#) per OAR 409-055-0070, Authority staff shall submit the applicable information to [HSDDMAP](#) for its review and determination of appropriate action.
- (8) If no deficiencies are found during a review, the Authority shall issue written findings to the PCPCH indicating that fact.
- (9) If deficiencies are found, the Authority shall take informal or formal enforcement action in compliance with OAR 409-055-0070.
- (10) The Authority may share application information and content submitted by practices and/or verification findings with managed or coordinated care plans, and/or insurance carriers.

Stat. Auth: ORS 413.042, 414.655 & 442.210

Stat. Implemented: 413.042, 414.655 & 442.210

409-055-0070

Compliance

- (1) If the Authority finds that the practice is not in compliance with processes as attested to, the Authority shall issue a written warning requiring the practice to submit an improvement plan to the Program within 90 days of the date of the written warning. The improvement plan must include a description of the practice's plan and timeline to correct the deficiency and proposed documentation or other demonstration that would verify the practice is in compliance.
- (2) Authority will review the improvement plan and any documentation the practice submits in accordance with the deficiency, and if remedied, no further action will be taken.
- (3) If a practice fails to submit the improvement plan or move into compliance within 90 days of the date of the written warning, the Authority may issue a letter of non-compliance and amend the practice's PCPCH recognition to reflect the appropriate Tier level or revoke its PCPCH status.
- (4) If the Authority amends a practice's tier level or revokes PCPCH status this information will be made available to [HSDDMAP](#), the coordinated care or managed care plans, and insurance carriers.

- (5) A practice that has had its PCPCH status revoked may have it reissued after reapplying for recognition and when the Authority determines that compliance with PCPCH Standards has been achieved satisfactorily.
- (6) In order for the Authority to receive federal funding for Medicaid clients receiving services through a PCPCH, documentation of certain processes are required by the Centers for Medicare and Medicaid Services. Documentation requirements can be found in OAR 410-141-0860. If non-compliance is due to lack of service documentation required per OAR 410-141-0860, a referral may be made to the [HSD DMAP](#).
- (7) If the Authority finds a lack of documentation per OAR 410-141-0860 to support the authorized tier level, the Authority may make a referral to the [HSD DMAP](#) and may conduct an audit pursuant to the standards in OAR 943-120-1505.

Stat. Auth: ORS 413.042, 414.655 & 442.210

Stat. Implemented: 413.042, 414.655 & 442.210

409-055-0080

Insurance Carrier, Managed Care Plan, and Public Stakeholder Communication

- (1) The Authority shall develop a system for making recognized PCPCH Tier status recognition information available to insurance carriers and managed care organizations.
- (2) The Authority shall maintain and update monthly the recognized PCPCH Tier status lists.
- (3) The Authority shall develop a system for making recognized PCPCH practice names available to the general public through the Program website.
- (4) Practices who do not wish to have their name listed on the publicly available list should send an e-mail to PCPCH@state.or.us with the title "opt-out" in the subject line within 10 business days of receiving confirmation of Tier status per OAR 409-055-0040.

Stat. Auth: ORS 413.042, 414.655 & 442.210

Stat. Implemented: 413.042, 414.655 & 442.210

409-055-0090

Reimbursement Objectives

- (1) One objective of these standards is to facilitate appropriate reimbursement for PCPCHs consistent with their recognized Tier levels. The standards and Tier recognition process established in this rule are consistent with statutory objectives to align financial incentives to support utilization of PCPCHs, in recognition of the standards that are required to be met at different Tiers.

- (2) Managed care plans and insurance carriers may obtain from the Authority the Tier level recognition of any practice.
- (3) Within applicable programs, the Authority shall develop and implement reimbursement methodologies that reimburse practices based on recognition of Tier level, taking into consideration incurred practice costs for meeting the Tier criteria.

Stat. Auth: ORS 413.042, 414.655 & 442.210

Stat. Implemented: 413.042, 414.655 & 442.210