RFA 4690-19 Evaluation Deficiency Letter

Umpqua Health Alliance

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

Applicants that were awarded a 1-year conditional contract will develop a remediation plan to correct deficiencies identified during the evaluation process and provide evidence to substantiate that the issues identified have been corrected to OHA's satisfaction. The timeline and submission requirements for correction will be established during the negotiation period prior to contract signing.

Where possible, deficiencies that are within the scope of the Readiness Review documentation submission will be addressed via the Readiness Review performed by OHA's contracted vendor. Items that require additional or supplementary documentation will be addressed through the remediation plan. If the Applicant fails to demonstrate sufficient progress towards resolving the deficiencies the contract will expire at the end of the 1-year term and will not renew. If the deficiencies are appropriately remedied during the term of the remediation plan, OHA will award the remainder of the 5-year contract.

OHA will schedule individual meetings with 1-year awardees to discuss the plan for remediation in more detail, including next steps for resolving issues.

OVERVIEW:

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

EVALUATION DEFICIENCIES BY TEAM:

FINANCE

- Details on performance and operations were limited, and more robust efforts are needed to evaluate HRS and SDOH programs and investment strategies

- Not enough information regarding the rationale for decisions, or regarding what components are provided for PCPCH funding.
- There was also insufficient detail relating to new VBPs for targeted care delivery areas. Applicant may already be meeting high level VBP targets, but the application lacked detail on this topic. Overall, the Umpqua may be sufficient in value-based payment, but this aspect of the application was poorly written and explained.
- No demonstration for evaluating the cost-effectiveness of HRS programs or interventions. While Umpqua is emphasizing the importance of efficiency, at no point did they define efficiency, or put a specific type or value regarding efficiency.
- No demonstration linking payments to quality, and while there are strategies regarding cost containment, there is no evidence of the effectiveness of these strategies.

BUSINESS ADMINISTRATION

Administrative Functions

- Pharmacy network was poorly described and reasons why it meets CCO needs were not addressed.
- Pharmacy was missing detail on how formulary changes and pharmacy benefits in general will be communicated.
- For TPL - there is limited detail on how Applicant will identify members with Medicare and how frequently member coverage is reviewed.

Health Information Technology

- EHR adoption questions lacked detail on current operations and future plans.
- No indication of how providers would be trained on EHR or how new data sources would be integrated.
- Questions addressing how HIT would be used for VBP and population health management failed to address how Applicant will support contracted providers with VBP arrangements and how Applicant would use HIT for population management.
- Very little detail on how VBP reports are used in Applicant network and how they would be shared with providers.
- No evidence of an overall plan for VBP that addressed all 5 years of the contract.

Member Transition

- Missing detail on how care coordination will work during the transition period and what the warm handoff/transition activities will be.
- Missing detail on how data will be transferred to receiving CCOs and any HIPPA considerations.
- Description of transition activities only include those members transferring in, not for members transferring out.
- Details missing on how members with special needs will be identified.

- No indication of how continuity of care will be maintained with regard to prior auths, prescriptions, treatment plans, case management or transportation services.
- Details lacking on how Applicant will help members in the transition process, to understand their coverage.

Social Determinants of Health (SDOH) & Health Equity

- No info on existing diversity policies, how diverse personnel would be recruited or retained.
- Appears to be a lack of understanding about what health equity is – a non-discrimination policy is pointed to as evidence of a health equity policy.
- A description of how the Applicant will collect and analyze SDOH-HE data is missing.
- There is no description of limitations or concerns about collecting or analyzing REAL-D data.

CARE COORDINATION

Behavioral health services

- Applicant's responses on behavioral health benefit plans lacked detail on planned efforts to support workforce capacity.
- Description of plans surrounding behavioral health covered services lacked clear strategies for addressing high-needs populations including provision of initial assessments.
- Applicant challenged aspects of care coordination requirements, describing them as not in rule (11.E.3). Responses in this section lacked detail on Person-centered training, Trauma-informed care and Member engagement during transitions.

Care Coordination

- Care coordination plans included no specific plans for dual eligible populations, children or members with behavioral health needs.
- Description of current agreements with behavioral health services partners was not provided.
- Applicant failed to demonstrate how other agencies and family members would be involved in care planning.
- Limited detail was provided in the Applicant's description of behavioral health partnerships and planned monitoring activities surrounding member care plans do not meet OHA requirements.

Care Integration

- Additional detail on plans for referrals and information sharing was requested.
- A description of qualifications needed to provide services to members of special-needs population was missing.

Health Information Exchange

- Applicant's ability to support Health Information Exchanges (HIE) was not clearly demonstrated.
- Responses regarding HIE were folded into responses on Electronic Health Records (EHR).
- Details on hospital event notifications were not provided.
- Roadmap documentation was high-level and failed to provide a clear description of planned activities.

CLINICAL AND SERVICE DELIVERY

Administrative Functions

- The network adequacy response did not include BH; Applicant didn't indicate how they calculate FTE; and the methodology used to analyze capacity was missing;
- It was unclear how the Applicant would use the grievance and appeal data to improve their system was unclear; Applicant did not appear to use their G&A data to monitor for the correct application of medical necessity criteria.

Behavioral Health Benefit

- No clear process for warm handoffs and no barriers were discussed in this section.

Behavioral Health Covered Services

- There were no processes mentioned for matching a person's level of needs with correct level of services.
- There is a high barrier to access care coordination services - members have to receive, complete and return something in the mail – this is difficult to do for those who are struggling.
- Some answers appear provider-centric rather than member-centric -ex: Agency policy is to connect people with teams of care instead of a certain provider.
- Monitoring of services was not addressed.
- The SUD services questions addressed only women in with SUD post-partum but not at other stages of pregnancy.
- Only talked about OHA sponsored PCIT when addressing the question about dyadic therapies and didn't mention any of the other dyadic therapies that are used.

Service Operations

- Detail on access to care and determining medical necessity is missing.

- There are no timelines for prior authorization included.
- There is no mention of any data sources or monitoring processes to ensure access to services.
- There does not appear to be a process for requesting out-of-state services.
- It is unclear how Applicant will provide access to LTSS services and no info was provided on the four LTSS models.

DELIVERY SYSTEM TRANSFORMATION

Accountability and Monitoring:

- *Accountability* – Applicant failed to provide details describing the measurement and reporting system, specifically the measures and how they are reported, how the system provides data to stakeholders, and how standards and expectations are communicated and enforced with providers and sub-contractors.
- Lack of sufficient information about the purpose of the external program and how it is administered.
- Lack of sufficient information on complaints, grievances and appeals, including how information is shared with providers and sub-contractors.
- *Quality Improvement Program* – Applicant failed to provide details describing data systems and process, such as collecting data, performance benchmarks, and using the data to incentivize quality care.
- Lack of sufficient information about referrals and prior authorization processes, including continuity of care and coordination across the delivery system.
- Lack of sufficient information about the process for communicating and enforcing expectations with providers.
- *CCO Performance* - Lacking sufficient information about the process for measuring, tracking and improving quality and outcomes while focusing on value and efficiency.
- Lack of information about evaluating quality of hospital services, including tracking by population sub-category (by REALD).

Delivery Service Transformation:

- *Provision of Covered Services* – Applicant failed to provide comprehensive analysis, including details describing data collection and analysis by sub-categories (by REALD).
- *Transforming Models of Care* – Applicant failed to provide details describing oversight of PCPCH and engagement of potential new PCPCH providers.

COMMUNITY ENGAGEMENT

- Doesn't include agencies or organizations in Douglas county
- Member voice is not elevated appropriately
- Not clear how they were defining members or if it was the appropriate way to measure (physical services report)
- Not clear how the CAC and board work together or how input is shared with the CCO governance other than through public comment.
- Really only spoke to member engagement and barriers for the CAC members
- Majority of the parties listed are not SDOH-HE partners
- No substantive information around member engagement on Quality Improvement; QI efforts are mostly only grievance driven – no role for members is described
- Lacks detail in how members are engaged in their own care planning

- No information about how the CAC members were selected or how the community is represented.
- No mention of how they've addressed or plan to address regional, cultural, socioeconomic and racial disparities in health care
- Applicant notes that CHA/CHP is main means for community engagement which is not sufficient
- Member voice is not elevated appropriately
- Not clear how they were defining members or if it was the appropriate way to measure (physical services report)
- Not clear how the CAC and board work together or how input is shared with the CCO governance other than through public comment.

HIT ROADMAP

- HIT Roadmap deficiencies will be addressed in a separate communication from the Office of Health Information Technology. The letter will identify whether the HIT Roadmap was approved as submitted or whether the CCO will be required to develop a work plan for the submitted roadmap.