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NOTICE OF PROPOSED RULEMAKING
INCLUDING STATEMENT OF NEED & FISCAL IMPACT

CHAPTER 409
OREGON HEALTH AUTHORITY
HEALTH POLICY AND ANALYTICS

FILED
09/27/2023 1:40 PM
ARCHIVES DIVISION
SECRETARY OF STATE

FILING CAPTION: Retiring 5 STAR designation; Creating new Tier 5; PCPCH tiers evenly distributed; Health Equity Designation

LAST DAY AND TIME TO OFFER COMMENT TO AGENCY: 11/03/2023 5:00 PM

The Agency requests public comment on whether other options should be considered for achieving the rule's substantive goals while reducing negative economic impact of the rule on business.

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Filed By:
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HEARING(S)

Auxiliary aids for persons with disabilities are available upon advance request. Notify the contact listed above.

DATE: 10/17/2023
TIME: 11:05 AM - 11:55 AM
OFFICER: Pete Edlund

REMOTE MEETING DETAILS
MEETING URL: Click here to join the meeting
PHONE NUMBER: 669-254-5252
CONFERENCE ID: 1606473594
SPECIAL INSTRUCTIONS:
Meeting ID: 160 647 3594
Passcode: 745132

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NEED FOR THE RULE(S)

The Oregon Health Authority is proposing amendments relating to the recognition criteria for the Patient-Centered Primary Care Home (PCPCH) Program.

DOCUMENTS RELIED UPON, AND WHERE THEY ARE AVAILABLE

The Technical Specifications and Reporting Guidelines:
https://www.oregon.gov/oha/HPA/dsi-pcpch/Documents/2020-PCPCH-TA-Guide.pdf

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STATEMENT IDENTIFYING HOW ADOPTION OF RULE(S) WILL AFFECT RACIAL EQUITY IN THIS STATE

The Oregon Health Authority reconvened the Patient Centered Primary Care Home (PCPCH) Standards Advisory Committee and PCPCH program staff to discuss revisions to the PCPCH model and develop recommendations. The Committee convened from August 2022 to February 2023. Staff have conducted an environmental scan of best and emerging practices in addressing health inequities in primary care settings and medical home models for ideas that could be implemented in Oregon. Amendments that are underway include, revisions to existing PCPCH standards, new standards, and general model changes such as tier thresholds and adding a Health Equity Designation to the model. Standards Advisory Committee adopted recommendations affecting Oregon Administrative Rule:

1. Application of OHA's health equity definition and 10-year strategic goal to eliminate health inequities throughout PCPCH model and standards based on community feedback gathered during the Program's 2021 Health Equity Initiative
2. Revisions to the existing standards and measures based on staff and community experience with the model
3. Integration of new standards and measures related to health equity, culturally and linguistically appropriate care, and health care cost navigation
4. Revisions to the tier level thresholds and special designations

Upon adoption of these recommendations, the PCPCH Program revised its Oregon Administrative Rules to reflect how the PCPCH program will continue to support a primary care system that addresses the community-identified needs of those who experience systemic racism, barriers in accessing care, and health inequities. When revising the model and respective OARs, the PCPCH Program also considered the following priority populations:

- Hispanic and Latino/a/x

- Native Hawaiian and Pacific Islander
- American Indian and Alaska Native
- Black and African American
- Slavic and Russian
- Middle Eastern and North African
- Asian
- LGBTQIA+
- People with Disabilities
- Adolescents
- Pregnant People
- Women
- Parents/Guardians of Children with Special Health Care Needs
- People experiencing houselessness
- People with a severe and persistent mental illness
- Older adults
- Linguistic minorities
- Rural and frontier populations

FISCAL AND ECONOMIC IMPACT:

Amending these rules will have no fiscal impact on the Authority, other state agencies, local government, clients, the public, or businesses, including small businesses.

COST OF COMPLIANCE:

(1) Identify any state agencies, units of local government, and members of the public likely to be economically affected by the rule(s). (2) Effect on Small Businesses: (a) Estimate the number and type of small businesses subject to the rule(s); (b) Describe the expected reporting, recordkeeping and administrative activities and cost required to comply with the rule(s); (c) Estimate the cost of professional services, equipment supplies, labor and increased administration required to comply with the rule(s).

(1) None.
(2a) None. Compliance with the PCPCH Standards is entirely voluntary.
(2b) None. Compliance with the PCPCH Standards is entirely voluntary.
(2c) None. Compliance with the PCPCH Standards is entirely voluntary.

DESCRIBE HOW SMALL BUSINESSES WERE INVOLVED IN THE DEVELOPMENT OF THESE RULE(S):

Technical Advisory Groups and community organizations were convened, which included members from organizations representing small and rural primary care practices.

WAS AN ADMINISTRATIVE RULE ADVISORY COMMITTEE CONSULTED? NO IF NOT, WHY NOT?

No, we received a RAC exception due to the health equity community engagement activities the PCPCH Program convened to help develop the PCPCH standards.

RULES PROPOSED:
409-055-0010, 409-055-0030, 409-055-0040, 409-055-0045, 409-055-0050, 409-055-0060

AMEND: 409-055-0010

RULE SUMMARY: Removed 5 STAR designation, added Health Equity designation and made grammatical revisions.

CHANGES TO RULE:

409-055-0010
Definitions ¶

The following definitions apply to OAR 409-055-0000 to 409-055-0090:¶
(1) "Authority" means the Oregon Health Authority.¶
(2) "Health Equity designation" means a designation assigned to Patient-Centered Primary Care Homes meeting specific PCPCH measure criteria.¶
(3) "NCQA" means National Committee for Quality Assurance.¶
(~~3~~4) "Patient Centered Medical Home (PCMH)" means a practice or provider who has been recognized as such by the National Committee for Quality Assurance.¶
(~~4~~5) "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.¶
(~~5~~6) "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.¶
(~~6~~7) "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.¶
(~~7~~8) "Program" means Patient-Centered Primary Care Home Program.¶
(~~8~~9) "Program website" means ~~www.~~https://primarycarehome.oregon.gov.¶
(~~9~~10) "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.¶
(1~~0~~1) "Recognition" means the process through which the Authority determines if a practice has met the Oregon Patient-Centered Primary Care Home Standards.¶
(1~~1~~2) "Recognized" means that the Authority has affirmed that a practice meets the Oregon Patient-Centered Primary Care Home Standards.¶
(1~~2~~3) "Tier" means the level of Patient-Centered Primary Care Home at which the Authority has scored a practice.¶
(1~~3~~4) "Verification" means the process that the Authority shall conduct to ensure that a practice has submitted accurate information to the Authority for purposes of Patient-Centered Primary Care Home recognition.¶
~~(14) "5 STAR" means a designation assigned to Patient-Centered Primary Care Homes meeting advanced PCPCH criteria.~~
Statutory/Other Authority: ORS 413.042, 413.259, 414.655
Statutes/Other Implemented: ORS 413.259, 413.260,-414.655

AMEND: 409-055-0030

RULE SUMMARY: Added application recognition timeline.

CHANGES TO RULE:

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~~must 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~~must include the quantitative data described in OAR 409-055-0040.¶
(2) The Authority ~~shall~~must 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 ~~the~~ Authority ~~shall~~must notify the applicant in writing of the information that is missing and when it must be submitted.¶
(3) The Authority ~~shall~~must 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~~must:¶
(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~~must maintain instructions and criteria for submitting a PCPCH Recognition Application posted on the Program website.¶
(5) The Authority m~~ay~~ust 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~~must inform the practice in writing whether it has reconsidered its decision.¶
(7) Recognition ~~shall~~must expire two years from the recognition effective date issued by the Authority.¶
(a) At the Authority's discretion a 30-day grace period may be allowed for PCPCHs to submit a 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 it's 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) Practices that apply or re-apply for PCPCH recognition between January 2024 and December 2024 must be recognized for one year.
Statutory/Other Authority: ORS 413.042, 413.259, 414.655
Statutes/Other Implemented: ORS 413.259, 413.260, 414.655

AMEND: 409-055-0040

RULE SUMMARY: Revised point thresholds, tier levels, added recognition language around NCQA and health equity designation.

CHANGES TO RULE:

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 1~~1~~3 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 - 6~~60-150 points and all 1~~1~~3 Must-Pass Measures;¶
(b) Tier 2: ~~65 - 12~~155-245 points and all 1~~1~~3 Must-Pass Measures;¶
(c) Tier 3: ~~130 - 25~~250-340 points and all 1~~1~~3 Must-Pass Measures;¶
(d) Tier 4: ~~255 - 4~~345-435 points and all 13 Must-Pass Measures;¶
(e) Tier 5: 440-530 points and all 1~~1~~3 Must-Pass Measures.¶
(5) The Authority m~~ay designate a practice as a Tier 5 STAR~~ust award a Patient-Centered Primary Care Home ~~for implementing multiple advanced PCPCH criteria~~the Health Equity Designation for implementing health equity measures as described in OAR 409-055-0045. ¶
(6) The Authority ~~shall~~must calculate a practice's point score through the recognition process described in OAR 409-055-0030.¶
(7) Table 1, incorporated by reference, contains the detailed list of Measures and corresponding point assignments.¶
(8) ~~Table 2, incorporated by reference, contains a detailed list of the PCPCH Quality Measures.¶~~
~~(9) Measure specifications, thresholds for demonstrating improvement, and benchmarks for quantitative data elements are available on the Program website.¶~~
~~(10)~~ National Committee for Quality Assurance (NCQA) recognition ~~shall~~must 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.¶
(~~11~~9) A practice seeking Oregon PCPCH Tier ~~1, 2, 3 or 4~~5 recognition based on its NCQA recognition must:~~¶~~
~~(a) Submit a PCPCH application~~ submit an abbreviated PCPCH application attesting to selected Oregon PCPCH standards and evidence of its NCQA recognition along with its application;.¶
~~(b) Comply with Table 3, incorporated by reference, for NCQA PCMH practices using 2014 or 2017 NCQA criteria.¶~~
~~(12) A practice seeking Oregon PCPCH Tier 5 (5 STAR desi~~10) A practice seeking Oregon PCPCH Health Equity Designation based on its NCQA recogn~~a~~ition~~)~~ is required to submit a complete PCPCH application and comply with OAR 409-055-0045.
Statutory/Other Authority: ORS 413.042, ORS 413.259, 414.655
Statutes/Other Implemented: ORS 413.259, 413.260, 414.655

RULE ATTACHMENTS DO NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

Table 1 Recognition Criteria for Patient Centered Primary Care Homes

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available	Health Equity Designation
CORE ATTRIBUTE 1: ACCESS TO CARE - *"Health care team, be there when we need you."*				
Standard 1.A) ~~In-Person Access~~ Timely Access and Communication				
1.A.1 PCPCH regularly tracks timely access and communication to clinical staff and care teams.	**Unchanged**	No	5	**No**
1.A.2 PCPCH regularly tracks timely access and communication to clinical staff and care teams, and **either meets specific targets or** has implemented an improvement plan to improve ~~their~~ outcomes.	**Revised**	No	10	**No**
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	**Yes**
Standard 1.C) Telephone ~~and Electronic~~ Access				
1.C.0 PCPCH ~~provides~~ **assures that its patients have** continuous access to clinical advice by telephone.	**Revised**	Yes	0	**No**
1.C.1 PCPCH assures that its patients have continuous access to clinical advice by telephone in their primary language.	**New**	**No**	**5**	**Yes**
Standard 1.D) Same Day Access				
1.D.1 PCPCH ~~provides~~ **offers** same day appointments.	**Revised**	No	5	**No**
Standard 1.E) Electronic Access (~~*Progressive*~~ *Check all that apply*)				
~~**1.G.1**~~ **1.E.1** PCPCH regularly communicates with patients through a patient portal.	**Revised**	No	5	**No**
~~**1.E.1**~~ **1.E.2** PCPCH provides patients with access to an electronic copy of their health information **in an accessible format.**	**Revised**	No	~~5~~ **10**	**Yes**
Standard 1.F) Prescription Refills				

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available	Health Equity Designation
1.F.2 PCPCH tracks the time to completion for prescription refills.	**Unchanged**	No	10	**No**
1.F.3 PCPCH tracks and shows improvement, or meets a benchmark, for time to completion for prescription.	**Unchanged**	No	15	**No**
Standard 1.G) Alternative Access *(Check all that apply)*				
1.G.1 ~~PCPCH regularly communicates with patients through a patient portal.~~ **PCPCH offers telehealth services to its patients in their primary language.**	**New**	**No**	**5**	**Yes**
1.G.2 ~~PCPCH has identified patient populations that would benefit from alternative visit types and offers at least one.~~ **PCPCH offers at least one alternative visit type to its patients and can demonstrate that it improves access.**	**Revised**	No	10	**Yes**
1.G.3 PCPCH regularly provides patient care in community-based settings.	**New**	**No**	**15**	**Yes**
CORE ATTRIBUTE 2: ACCOUNTABILITY - *"Take responsibility for making sure we receive the best possible health care."*				
Standard 2.A) Performance and ~~&~~ Clinical Quality *(Check all that apply)*				
2.A.0 PCPCH tracks and reports to ~~the~~ OHA three ~~measures from the set of PCPCH Quality Measures~~ **primary care quality measures.**	**Revised**	Yes	0	**No**
~~**2.A.1** PCPCH engages in a Value-based Payment arrangement with payers covering a significant portion of the clinic population that includes three measures from the set of PCPCH Quality Measures.~~	**Deleted**	~~No~~	~~5~~	**N/A**
2.A.1 PCPCH tracks and reports to OHA disparities in three primary care quality measures.	**New**	**No**	**5**	**No**
2.A.2 PCPCH tracks, reports to ~~the~~ OHA, and demonstrates a combination of improvement and meeting benchmarks on ~~of the PCPCH Quality measures~~ **three primary care quality measures.**	**Revised**	No	10	**No**

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available	Health Equity Designation
2.A.3 PCPCH tracks, reports to OHA, and demonstrates improvement on disparities in three primary care quality measures.	**New**	**No**	**15**	**Yes**
Standard 2.B) ~~Public Reporting~~ Value-Based Payment				
~~2.B.1~~ ~~PCPCH participates in a public reporting program for performance indicators and data collected for public reporting programs is shared with providers and staff within the PCPCH.~~	**Deleted**	~~No~~	~~5~~	**N/A**
2.B.1 PCPCH has a value-based payment arrangement in the Health Care Payment and Learning Action Network (HCP-LAN) category 2C or higher with one payer.	**New**	**No**	**5**	**No**
2.B.2 PCPCH has a value-based payment arrangement in the Health Care Payment and Learning Action Network (HCP-LAN) category 2C or higher with at least two payers or with one payer that covers a portion of the practice's patient population.	**New**	**No**	**10**	**No**
2.B.3 PCPCH has a value-based payment arrangement in the Health Care Payment and Learning Action Network (HCP-LAN) category 3A or higher with at least two payers or with one payer that covers a portion of the practice's patient population.	**New**	**No**	**15**	**No**
Standard 2.C) Patient and Family Involvement in Quality Improvement				
2.C.1 PCPCH involves patients, families, and caregivers as advisors on at least one quality or safety initiative per year.	**Unchanged**	No	5	**No**
2.C.2 PCPCH has established a formal mechanism to integrate patient, family, and caregiver, advisors as key members of quality, safety, program development ~~and/~~or educational improvement activities.	**Revised**	No	10	**Yes**
2.C.3 Patient, family, and caregiver advisors are integrated into the PCPCH and function in peer support or training roles.	**Unchanged**	No	15	**No**
Standard 2.D) Quality Improvement				

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available	Health Equity Designation
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	**No**
2.D.2 PCPCH utilizes multi-disciplinary improvement teams that meet regularly to review timely, actionable, team-level data related to their chosen improvement project and documents their progress.	**Unchanged**	No	10	**No**
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	**No**
Standard 2.E) ~~Ambulatory Sensitive Utilization~~ Ambulatory Care Sensitive Conditions Utilization *(Check all that apply)*				
~~**2.E.1** PCPCH engages in a Value-based Payment arrangement with payers covering a significant portion of the clinic population that includes at least one selected utilization measure.~~	**Deleted**	~~No~~	~~5~~	**N/A**
2.E.2 PCPCH identifies patients **experiencing** ~~with~~ unplanned or adverse patterns ~~for~~ **in** at least one ~~selected~~ utilization measure and contacts patients, families or caregivers for follow-up care. ~~if needed, within an appropriate period of time.~~	**Revised**	No	10	**No**
~~**2.E.3** PCPCH tracks at least one selected utilization measure and shows improvement or meets a benchmark on the selected utilization measure.~~	**Deleted**	~~No~~	~~15~~	**N/A**
2.E.3 PCPCH identifies patients experiencing disparities in unplanned or adverse patterns in at least one utilization measure and contacts patients, families or caregivers for follow-up care.	**New**	**No**	**15**	**Yes**
Standard 2.F) PCPCH Staff Vitality				

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available	Health Equity Designation
2.F.1 PCPCH ~~uses a structured process to identify opportunities~~ **develops and implements a strategy** to improve the vitality of its staff.	**Revised**	No	5	**No**
2.F.2 PCPCH develops, implements, and evaluates a strategy to improve the vitality of its staff.	**Unchanged**	No	10	**No**
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 **age and gender appropriate** preventive services ~~appropriate~~ for its **patient** population ~~(i.e. age and gender)~~ based on best available evidence, and identifies areas for improvement.	**Revised**	No	5	**No**
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 service offerings as appropriate for ~~the~~ **its** patient population.	**Revised**	No	10	**No**
3.A.3 PCPCH routinely offers or coordinates 90% of all recommended age and gender appropriate preventive services.	**Unchanged**	No	15	**No**
Standard 3.B) Medical Services				
3.B.0 PCPCH ~~reports that it~~ routinely offers all of the following categories of services: 1) acute care for minor illnesses and injuries, 2) ongoing management of chronic diseases including coordination of care, 3) office-based procedures and diagnostic tests, 4) preventive services including recommended immunizations, and 5) patient education and self-management support.	**Revised**	Yes	0	**No**
Standard 3.C) Behavioral Health Services *(Check all that apply)*				
3.C.0 PCPCH has a ~~screening strategy~~ **routine assessment** ~~for~~ **to identify patients with** mental health, substance use, and developmental conditions, ~~documents on-site and local referral resources and processes.~~ **and coordinates their care.**	**Revised**	Yes	0	**No**

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available	Health Equity Designation
~~3.C.1~~ 3.C.2.a PCPCH collaborates ~~and coordinates care~~ or is co-located, **and coordinates care,** with specialty mental health, substance use disorder, and developmental providers. ~~PCPCH also provides co-management based on its patient population needs.~~	**Revised**	No	~~5~~ **10**	**No**
~~3.C.2~~ 3.C.2.b PCPCH provides ~~onsite~~ pharmacotherapy to patients with substance use disorders and routinely offers recovery support in the form of behavioral counseling or referrals.	**Revised**	No	10	**No**
3.C.3 PCPCH provides integrated behavioral health services including population-based, same-day consultations by behavioral health providers.	**Unchanged**	No	15	**No**
Standard 3.D) ~~Comprehensive Health Assessment & Intervention~~ Health-Related Social Needs (*~~Progressive~~ Check all that apply*)				
~~3.D.1~~ ~~PCPCH has a routine assessment to identify health-related social needs in its patient population.~~	**Deleted**	~~No~~	~~5~~	**N/A**
3.D.2 ~~PCPCH tracks referrals to community-based agencies for patients with health-related social needs.~~ **PCPCH has a routine assessment to identify health-related social needs (HRSNs) in its patient population and refers patients to community-based resources.**	**Revised**	No	10	**Yes**
3.D.3 ~~PCPCH describes and demonstrates its process for health-related social needs interventions and coordination of resources for patients with health-related social needs.~~ **PCPCH has a routine assessment to identify health-related social needs (HRSN) in its patient population and assures that patients can access an intervention for at least one HRSN through referral tracking, collaborative partnerships, or offering it directly.**	**Revised**	No	15	**Yes**
Standard 3.E) Preventive Services Reminders				
3.E.1 PCPCH generates lists of patients who need reminders for preventive services and ensures that they are sent appropriate reminders.	**New**	**No**	**5**	**No**
3.E.2 ~~PCPCH uses patient information, clinical data, and evidence-based guidelines to generate lists of patients who need reminders. PCPCH proactively advises patients, families, caregivers and clinicians of needed services and tracks number of unique patients who were sent appropriate reminders.~~ **PCPCH generates lists of patients who need reminders for preventive services,**	**Revised**	No	10	**No**

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available	Health Equity Designation
ensures that they are sent appropriate reminders, and tracks the completion of those recommended preventive services.				
~~**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.~~	**Deleted**	~~No~~	~~15~~	**N/A**
3.E.3 PCPCH generates lists of patients who need reminders for preventive services, ensures that they are sent appropriate reminders, and tracks the completion of those recommended preventive services. PCPCH also identifies patients experiencing disparities in preventive services and develops an alternative reminder or outreach strategy.	**New**	**No**	**15**	**Yes**
Standard 3.F) Oral Health Services				
3.F.1 PCPCH ~~utilizes a screening and/or assessment strategy~~ **screens or assesses its patients** for oral health needs.	**Revised**	No	5	**No**
3.F.2 PCPCH ~~utilizes a screening and/or assessment strategy~~ **screens or assesses its patients** for oral health needs and provides age-appropriate interventions.	**Revised**	No	10	**No**
3.F.3 PCPCH provides oral health services by dental providers.	**Unchanged**	No	15	**No**
CORE ATTRIBUTE 4: CONTINUITY - *"Be our partner over time in caring for us."*				
Standard 4.A) ~~Personal Clinician Assigned~~ Personal Clinician Assignment and Continuity				
4.A.0 PCPCH reports the percent of active patients assigned to a personal clinician or team **and has a process for considering patient choice in assignment. PCPCH also reports the percent of visits in which a patient saw their assigned clinician or team.**	**Revised**	**Yes**	0	**No**
~~**4.B.2**~~ **4.A.2** PCPCH tracks and improves the percent of ~~patient~~ visits ~~with~~ **in which a patient saw their** assigned clinician or team.	**New**	**No**	**10**	**No**

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available	Health Equity Designation
~~**4.A.3 PCPCH meets a benchmark in the percent of active patients assigned to a personal clinician or team.**~~	**Deleted**	~~**No**~~	~~**15**~~	**N/A**
~~**4.B.3**~~ **4.A.3** PCPCH meets a benchmark ~~in~~ **for** the percent of ~~patient~~ visits ~~with~~ **in which a patient saw their** assigned clinician or team**.**	**Revised**	No	15	**No**
~~**Standard 4.B) Personal Clinician Continuity**~~				
4.B.0 ~~PCPCH reports the percent of patient visits with assigned clinician or team. (D)~~	**Deleted**	~~Yes~~	~~0~~	**N/A**
4.B.2 ~~PCPCH tracks and improves the percent of patient visits with assigned clinician or team.~~	**Deleted**	~~No~~	~~10~~	**N/A**
4.B.3 ~~PCPCH meets a benchmark in the percent of patient visits with assigned clinician or team.~~	**Deleted**	~~No~~	~~15~~	**N/A**
Standard ~~4.G~~ 4.B) Medication Reconciliation and Management (*~~Progressive~~ Check all that apply*)				
~~**4.G.2**~~ **4.B.2** PCPCH **provides** ~~**has a process for**~~ medication reconciliation **and medication management for** its patients. ~~with complex or high-risk medication concerns~~	**Revised**	No	10	**No**
~~**4.G.3**~~ **4.B.3** PCPCH provides medication management for **its** patients **by a pharmacist.** ~~with complex or high-risk medication concerns.~~	**Revised**	No	15	**No**
Standard 4.C) Organization of Clinical Information				
4.C.0 PCPCH uses an electronic health record (EHR) technology that is certified by the ~~Centers for Medicare and Medicaid Services~~ **Office of the National Coordinator for Health Information Technology (ONC) Health IT Certification Program** and includes the following elements: problem list, medication list, allergies, basic demographic information, preferred language, BMI/BMI percentile/growth chart as appropriate, and immunization record; PCPCH updates this EHR as needed at each visit.	**Revised**	Yes	0	**No**
4.C.1 PCPCH documents its patients' race, ethnicity, language, disability, sexual orientation, or gender identity in their electronic health record.	**New**	**No**	**5**	**No**

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available	Health Equity Designation
4.C.2 PCPCH meets a benchmark for the percentage of patients with their race, ethnicity, language, disability, sexual orientation, or gender identity documented in their electronic health record.	**New**	**No**	**10**	**Yes**
Standard 4.D) Clinical Information Exchange				
4.D.2 PCPCH exchanges clinical information electronically ~~to~~ **with** another provider or setting of care.	**Revised**	No	10	**No**
4.D.3 PCPCH shares clinical information electronically in real time with other providers and care entities ~~(electronic health information exchange)~~ **through an electronic health information exchange.**	**Revised**	No	15	**No**
Standard 4.E) ~~Specialized Care~~ Hospital Setting Transitions				
4.E.0 PCPCH has a ~~written agreement~~ **documented process for transitions of care** with its usual hospital providers or directly provides routine hospital care.	**Revised**	Yes	0	**No**
4.E.2 PCPCH has a process for following up with its patients post-discharge from the hospital and emergency department.	**New**	**No**	**10**	**No**
Standard 4.F) Planning for Continuity				
~~**4.F.1**~~ **4.F.0** PCPCH **has a process for reassigning** ~~demonstrates a mechanism to reassign~~ administrative requests, prescription refills, and clinical questions when a provider is not available.	**Revised**	~~No~~ **Yes**	~~5~~ **0**	**No**
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*~~ *Progressive*)				
5.A.1 ~~PCPCH demonstrates the ability to identify, aggregate, and display and utilize up-to-date data regarding its entire patient population, including the identification of sub-populations.~~ **PCPCH uses data on its entire patient population to track overall health needs or engage in proactive patient population management.**	**Revised**	No	5	**No**

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available	Health Equity Designation
5.A.2 PCPCH ~~demonstrates the ability to stratify~~ **stratifies** its entire patient population according to health risk. ~~such as special health care needs or health behavior.~~	**Revised**	No	10	**No**
5.A.3 PCPCH stratifies its entire patient population according to health risk, and by at least one health-related social need or demographic category.	**New**	**No**	**15**	**Yes**
Standard 5.B) Health Care Cost Navigation *(Check all that apply)*				
5.B.1 PCPCH informs its patients of preventive services that do not require cost-sharing.	**New**	**No**	**5**	**No**
5.B.3 PCPCH assists its patients in navigating the cost and payment options for their care.	**New**	**No**	**15**	**Yes**
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. PCPCH tells each patient, as well as their family or caregiver if relevant, the name of the team member(s) responsible for coordinating the patient's care~~. **PCPCH assigns care coordination responsibilities to specific practice staff and informs patients, families, and caregivers on how to access care coordination services.**	**Revised**	No	5	**No**
5.C.2 PCPCH ~~describes and demonstrates its process for identifying and coordinating the care of diverse~~ **identifies** patients with complex care needs **and coordinates their care.**	**Revised**	No	10	**No**
5.C.3 PCPCH collaborates with ~~diverse~~ patients, families, or caregivers to develop individualized **and culturally appropriate** written care plans for complex medical or social concerns.	**Revised**	No	15	**No**
Standard 5.D) Test and Result Tracking				
5.D.1 PCPCH tracks tests ordered by its clinicians and ensures timely, confidential notification and explanation of results to patients, family, or caregivers as well as to ordering clinicians.	**Unchanged**	No	5	**No**
Standard 5.E) Referral and ~~& Specialty~~ Care Coordination with Specialists, Care Facilities, and Governmental Systems *(Check all that apply)*				

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available	Health Equity Designation
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, families, or caregivers and clinicians.	**Unchanged**	No	5	**No**
5.E.2 ~~PCPCH demonstrates active involvement and coordination of care when its patients receive care in specialized settings (e.g. hospital, SNF, long term care facility).~~ **PCPCH coordinates care when its patients receive care in specialized settings such as hospitals, skilled nursing or other long-term care facilities, and in-patient behavioral health facilities.**	**Revised**	No	10	**No**
5.E.3 ~~PCPCH tracks referrals and cooperates with community service providers outside the PCPCH in one or more of the following: dental, education, social service, foster care (either adult or child), public health, traditional health workers, school-based health center, behavioral health providers and organizations, and pharmacy services.~~ **PCPCH coordinates care for its patients who are engaged with or receiving services from the Oregon Department of Human Services, criminal justice, education or public health systems.**	**Revised**	No	15	**No**
Standard 5.F) End of Life Planning				
5.F.0 PCPCH ~~demonstrates~~ **has** a process ~~to~~ **for** ~~offer or coordinate~~ **offering or coordinating** hospice and palliative care and counseling for patients, families, or caregivers who may benefit from these services.	**Revised**	Yes	0	**No**
5.F.1 PCPCH has a process **for engaging** ~~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.~~	**Revised**	No	5	**No**
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) Meeting Language and ~~&~~ ~~Cultural~~ Health Literacy Needs (~~*Progressive*~~ *Check all that apply*)				
6.A.0 PCPCH offers time-of-service ~~translation~~ **interpretation** to communicate with patients, families, or caregivers in their ~~language of choice~~ **primary language**.	**Revised**	Yes	0	**No**
6.A.1 PCPCH provides written patient materials in **languages other than English.** ~~non-English languages spoken by populations served at the clinic.~~	**Revised**	No	5	**Yes**

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available	Health Equity Designation
6.A.2 PCPCH assures that patient communications and materials are at an appropriate health literacy level.	**New**	No	10	**Yes**
Standard 6.B) Education and ~~&~~ Self-Management Support				
6.B.1 PCPCH provides **culturally and linguistically appropriate** patient-specific education resources to **its** ~~their~~ patient population.	**Revised**	No	5	**No**
6.B.2 PCPCH provides **culturally and linguistically appropriate** patient-specific education resources and offers **or connects patients, families, and caregivers with** self-management support resources. ~~to their patient population.~~	**Revised**	No	10	**Yes**
Standard 6.C) Experience of Care				
6.C.0 PCPCH surveys a sample of its population on their experience**s with specific areas** of care **and shares results with clinic staff.** ~~The patient survey includes questions on access to care, provider or health team communication, coordination of care, and staff helpfulness.~~ **PCPCH also meets a survey completion benchmark or has a strategy to increase the number of surveys completed.**	**Revised**	Yes	0	**No**
6.C.1 PCPCH surveys a sample of its population on their experience**s with specific areas** of care **and demonstrates the utilization of survey data in quality improvement activities.** ~~The patient survey includes questions on access to care, provider or health team communication, coordination of care, and staff helpfulness. PCPCH also has a survey planning strategy in place and shares data with clinic staff.~~	**Revised**	No	5	**No**
6.C.2 PCPCH surveys a sample of its population on their experience**s with specific areas** of care, **including health equity, and demonstrates the utilization of survey data in quality improvement activities.** ~~using of one of the CAHPS survey tools, has a survey planning strategy, and demonstrates the utilization of survey data in quality improvement process(es).~~	**Revised**	No	10	**Yes**
~~**6.C.3** PCPCH surveys a sample of its population on their experience of care using of one of the CAHPS survey tools, meets the benchmarks or shows improvement on a majority of domains, has a survey planning strategy, and demonstrates the utilization of survey data in quality improvement process(es).~~	**Deleted**	~~No~~	~~15~~	**N/A**

PCPCH CORE ATTRIBUTE PCPCH Standard PCPCH Measures	Unchanged, Revised, Deleted or New	Must Pass	Points Available	Health Equity Designation
Standard 6.D) Communication of Rights, Roles, and Responsibilities				
~~**6.D.1**~~ **6.D.0** 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, family, or caregiver receives this information at the onset of the care relationship.	**Revised**	~~No~~ **Yes**	~~5~~ **0**	**No**
Standard 6.E) Cultural Responsiveness of Workforce				
6.E.0 PCPCH assures that its staff is trained in delivering culturally and linguistically appropriate, trauma-informed, or trust-building care.	**New**	**Yes**	**0**	**No**
6.E.3 PCPCH partners with one or more traditional health workers or traditional health worker services.	**New**	**No**	**15**	**Yes**

AMEND: 409-055-0045

RULE SUMMARY: Added health equity designation criteria, removed 5 STAR designation language.

CHANGES TO RULE:

409-055-0045
~~5 STAR~~Health Equity Designation ¶

(1) The Authority ~~shall~~must award ~~5 STAR~~Health Equity designations to practices implementing multiple ~~advanced PCPCH~~PCPCH Health Equity measures.¶
(2) A practice seeking ~~5 STAR~~the Health Equity designation, must meet the following criteria:¶
(a) Be recognized as a ~~Tier 4~~ PCPCH under the Measures in Table 1, adopted and incorporated by reference;¶
(b) Attest to ~~255 points~~15 or more o~~n~~f the 20 PCPCH ~~application; and¶~~
~~(c) Attest to 13 or more of the 16 PCPCH Measures in Table 4, adopted and incorporated by reference~~Health Equity Measures in Table 2, adopted and incorporated by reference; and¶
(c) Submit all required documentation for the Health Equity Measures in Table 2 attested to at the time of application.¶
(3) The Authority ~~shall~~must review PCPCH applications of practices attesting to the Measures in Table ~~1,~~2 and the documentation submitted to determine which practices meet the criteria in section (2) of this rule.¶
(4) The Authority ~~shall~~must notify a practice meeting ~~5 STAR~~Health Equity designation criteria in writing of their eligibility.¶
(5) The Authority ~~shall contact the eligible practice to schedule a verification review as described in OAR 409-055-0060.¶~~
~~(6) A practice seeking 5 STAR designation must comply with a verification review.¶~~
~~(7) The Authority shall award 5 STAR~~must award Health Equity designation to a practice after verifying the practice meets all ~~5 STAR~~Health Equity designation criteria.¶
(~~8~~6) ~~5 STAR~~Health Equity designation is valid for the duration of the practice's current PCPCH recognition as described in OAR 409-055-0030(7).
Statutory/Other Authority: ORS 413.042, ORS 413.259, 414.655
Statutes/Other Implemented: ORS 413.259, 413.260, 414.655

RULE ATTACHMENTS DO NOT SHOW CHANGES. PLEASE CONTACT AGENCY REGARDING CHANGES.

Table 2. Required PCPCH Measures for Health Equity designation
Practices seeking the health equity designation must meet 15 or more of the measures listed

1	1.B.1 PCPCH offers access to in-person care at least 4 hours weekly outside traditional business hours.
2	1.C.1 PCPCH assures that its patients have continuous access to clinical advice by telephone in their primary language.
3	1.E.2 PCPCH provides patients with access to an electronic copy of their health information in an accessible format.
4	1.G. PCPCH offers telehealth services to its patients in their primary language.
5	1.G.2. PCPCH offers at least one alternative visit type to its patients and can demonstrate that it improves access.
6	1.G.3 PCPCH regularly provides patient care in community-based settings.
7	2.A.3 PCPCH tracks, reports to OHA, and demonstrates improvement on disparities in three primary care quality measures.
8	2.C.2 PCPCH has established a formal mechanism to integrate patient, family, and caregiver, advisors as key members of quality, safety, program development and educational improvement activities.
9	2.E.3 PCPCH identifies patients experiencing disparities in unplanned or adverse patterns in at least one utilization measure and contacts patients, families or caregivers for follow-up care.
10	3.D.2 PCPCH has a routine assessment to identify health-related social needs (HRSNs) in its patient population and refers patients to community-based resources.
11	3.D.3 PCPCH has a routine assessment to identify health-related social needs (HRSN) in its patient population and assures that patients can access an intervention for at least one HRSN through referral tracking, collaborative partnerships, or offering it directly.
12	3.E.3 PCPCH generates lists of patients who need reminders for preventive services, ensures that they are sent appropriate reminders, and tracks the completion of those recommended preventive services. PCPCH also identifies patients experiencing disparities in preventive services and develops an alternative reminder or outreach strategy.
13	4.C.2 PCPCH meets a benchmark for the percentage of patients with their race, ethnicity, language, disability, sexual orientation, or gender identity documented in their electronic health record.
14	5.A.3 PCPCH stratifies its entire patient population according to health risk, and by at least one health-related social need or demographic category.
15	5.B.3 PCPCH assists its patients in navigating the cost and payment options for their care.
16	6.A.1 PCPCH provides written patient materials in languages other than English.
17	6.A.2 PCPCH assures that patient communications and materials are at an appropriate health literacy level.
18	6.B.2 PCPCH provides culturally and linguistically appropriate patient-specific education resources and offers or connects patients, families, and caregivers with self-management support resources.
19	6.C.2 PCPCH surveys a sample of its population on their experiences with specific areas of care, including health equity, and demonstrates the utilization of survey data in quality improvement activities.
20	6.E.3 PCPCH partners with one or more traditional health workers or traditional health worker services.

Adult Quality Measure Set			
Measure #	**Source**	**Measure**	**Benchmark**
1	NQF0421	BMI Screening and Follow-up	90%
2	NQF0028	Tobacco Use: Screening and Cessation Intervention	82%
3	NQF2372	Breast Cancer Screening Ages 50-74	64%
4	NQF0032	Cervical Cancer Screening	78%
5	NQF 0034	Colorectal Cancer Screening	62%
6	NQF0059	Comprehensive Diabetes Care: Hemoglobin poor Control (>9.0%)	23%
7	NQF0418	Screening for Clinical Depression	63%
8	NQF0018	Controlling High Blood Pressure	67%
9	NQF0041	Influenza Vaccination	46%
10	NQF0043	Pneumonia Vaccination for Older Adults	81%
11	NQF0033	Chlamydia Screening in Women Ages 16-24	66%
12	NQF1884	Depression Response at 6 Months – Progress Towards Remission	TBD
13	NQF0067	Coronary Artery Disease (CAD): Antiplatelet Therapy	TBD
14	NQF1517	Pre-Natal and Post-Partum Care – Pre-Natal Care Rate	69%
15	NCQA	Statin Therapy for Patients with Diabetes	67%
16	NCQA	Statin Therapy for Patients with Cardiovascular Disease	81%
17	NQF0004	Initiation and Engagement of Alcohol and other Use Disorder treatment	IET Initiation-46.8% IET Engagement-18.5%
Pediatric Quality Measure Set			
18	NQF0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	30%
19	NQF0038	Childhood Immunization Status (Combo 7)	63%
20	Medicaid/CHIP Child Core Set	Measure AWC-CH Adolescent well-care visits (12-21 years)	63%
21	NQF1448	Developmental Screening in the First 3 Years of Life	74%
22	NQF1392	Well Child Care (0 – 15 months)	75%
23	NQF1516	Well Child Care (3 – 6 years)	78%

~~24~~	~~Medicaid/CHIP Child Core Set~~	~~Measure AMR-CH Asthma Medication Ratio~~	~~68%~~
~~25~~	~~NQF0108~~	~~Follow-up Care for Children Prescribed ADHD Medication~~	~~Initiation - 56% Continuation & maintenance - 69%~~
~~26~~	~~NQF1407~~	~~Adolescent Immunizations up to Date at 13 Years Old (Combo 2)~~	~~40%~~

Table 3: Oregon PCPCH application requirements for practices recognized by the National Committee for Quality Assurance as a Patient-Centered Medical Home (NCQA PCMH)

~~Table 3: Oregon PCPCH application requirements for practices recognized by the National Committee for Quality Assurance as a Patient-Centered Medical Home (NCQA PCMH)~~

	~~Practices with 2014 NCQA PCMH Recognition *(Practice will be recognized at equal NCQA tier level)*~~				
~~Oregon PCPCH Tier Level~~	~~Submit abbreviated PCPCH application~~	~~Submit full PCPCH application~~	~~Provide evidence of NCQA recognition~~	~~Attest to PCPCH Performance & Clinical Quality Standard 2. A.0~~	~~Attest to PCPCH Coordination and Integration Standard 5. F.0~~
~~Tiers 1 - 3~~	~~✓~~		~~✓~~	~~✓~~	~~✓~~
~~Tier 4 or Tier 5~~		~~✓~~		~~✓~~ (included in full application)	~~✓~~ (included in full application)

	~~Practices with NCQA PCMH Recognition awarded after 2017 *(Practice will be recognized as a Tier 4 PCPCH)*~~				
~~Oregon PCPCH Tier Level~~	~~Submit abbreviated PCPCH application~~	~~Submit full PCPCH application~~	~~Provide evidence of NCQA recognition~~	~~Attest to PCPCH Performance & Clinical Quality Standard 2. A.0~~	~~Attest to PCPCH Coordination and Integration Standard 5. F.0~~
~~Tiers 1 - 3~~	~~-~~	~~-~~	~~-~~	~~-~~	~~-~~
~~Tier 4~~	~~✓~~		~~✓~~	~~✓~~ (included in full application)	~~✓~~ (included in full application)
~~Tier 5~~	~~-~~	~~✓~~		~~✓~~ (included in full application)	~~✓~~ (included in full application)

Table 4. Required PCPCH Measures for 5 STAR designation

Practices seeking 5 STAR designation must attest to 11 of the 13 PCPCH measures listed.

PCPCH Measure
1.B.1) After Hours Access
2.D.3) Quality Improvement
3.C.2) Referral Process or Co-location with Mental Health, Substance Abuse and Developmental Providers
3.C.3) Integrated Behavioral Health Services
4.B.3) Personal Clinician Continuity
5.C.1) Defined Roles in Care Coordination
5.C.2) Coordination of Care
5.C.3) Individualized Care Plan
5.E.1) Referral Tracking For Specialty Care
5.E.2) Coordination with Specialty Care
5.E.3) Cooperation with Community Service Providers
6.A.1) Language/Cultural Interpretation
6.C.2/6.C.3) Experience of Care

AMEND: 409-055-0050

RULE SUMMARY: Removed 5 STAR designation, added Health Equity designation and made grammatical revisions.

CHANGES TO RULE:

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 Table~~s~~ 1 ~~& 2~~, incorporated by reference.¶
(2) Quantitative data ~~shall~~must be aggregated at the practice level, not the individual patient level, and a practice m~~ay~~ust 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 PCPCH 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~~6) The Authority ~~shall~~must notify the practice within 60 days of complete application and exception submission whether or not the requested exception has been granted.¶
[ED. NOTE: Tables reference are available from the agency.]
Statutory/Other Authority: ORS 413.042, 413.259, 414.655
Statutes/Other Implemented: ORS 413.259, 413.260, 414.655

AMEND: 409-055-0060

RULE SUMMARY: Grammatical revisions.

CHANGES TO RULE:

409-055-0060
Verification ¶

(1) The Authority ~~shall~~must 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 (Division), 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 a verification ~~shall~~review must be notified no less than 30 days prior to the scheduled review.¶
(3) PCPCHs ~~shall~~must 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 verification review, Authority staff may conduct an exit conference with the PCPCH representatives. During the exit conference Authority staff ~~shall~~must:¶
(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~~must prepare and provide the PCPCH specific and timely written notice of the findings.¶
(7) If the findings result in a referral to the Division pursuant to OAR 409-055-0070, Authority staff ~~shall~~must submit the applicable information to the Division for its review and determination of appropriate action.¶
(8) If no deficiencies are found during a review, the Authority ~~shall~~must issue written findings to the PCPCH indicating that fact.¶
(9) If deficiencies are found, the Authority ~~shall~~must take informal or formal enforcement action pursuant to OAR 409-055-0070.¶
(10) The Authority may share application information and content submitted by practices and verification findings with managed or coordinated care plans, and insurance carriers.
Statutory/Other Authority: ORS 413.042, 413.259, 414.655
Statutes/Other Implemented: ORS 413.259, 413.260, 414.655