PacificSource Community Solutions – Lane

TRANSFORMATION and QUALITY STRATEGY

March 2022

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Section 1: Transformation and Quality Program Details

(Complete Section 1 by repeating parts A through F until all TQS components have been addressed)

A. **Project short title**: Project 1: Navigation Support for Members in need of Timely Care

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

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

B. **Components addressed**

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

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

PacificSource Community Solutions (PCS) supports Access: Timely by routine monitoring of provider network adequacy, including time and distance standards and timely appointment access. PCS monitors timely access and network adequacy in two main ways: Provider Network Reporting Analysts run reports of time and distance standards each month and assess network gaps; and Access to Care Analysts collect and analyze provider timely access data using access and availability surveys, which are mailed monthly and emailed weekly. Surveys include provider questions related to Behavioral Health (BH) Care Services, including whether the provider maintains a waitlist, if/when they have available appointments, and whether they can provide timely access according to the standards outlined in OAR 410-141-3515.

PCS reviews network adequacy and timely access reports, including survey results, monthly at a standing Oregon Access to Care Steering Committee meeting. Many internal departments send staff to this meeting, including Provider Network Contracting, Analysis, Access, and Service, Care Management, Utilization Management, Population Health, Community Strategy, and Behavioral Health. If the Committee identifies compliance gaps, it will develop a mitigation strategy, including Provider Network Service (PNS) reaching out to the provider to learn more about the identified issue and PNS issuing a provider corrective action plan. Alternatively, the Committee refers the time and distance issues to the Network Adequacy subcommittee for resolution, which could include pursuing new provider contracts.

In 2021, provider survey data revealed compliance issues concerning timely access standards. In reaching out to those providers who reported timely access non-compliance, PNS learned that most issues resulted from misunderstanding the standard, and they could help the providers resolve through coaching. In some cases, providers shared they had lost staff or their business was affected by the COVID-19 pandemic, and until visits and staffing levels returned to normal, they would struggle to make changes. Importantly, the weekly BH email survey, introduced in April 2021, revealed that many providers routinely maintain waitlists, while other providers had routine appointment openings for prioritized populations, including members with Serious and Persistent Mental Illness (SPMI).

As demonstrated in the graph below, between June and December 2021, the total reported BH appointment availability often exceeded BH waitlisted member counts based on aggregated provider survey data. PCS interpreted these gaps as an important opportunity to move members off waitlists to open appointments to ensure members receive timely access to care. Therefore, PCS developed a pilot navigation program in one of its CCO regions, including

member navigation to specialty BH care for SPMI.

In September 2021, PCS initiated a small pilot effort in the PCS – Marion & Polk (MP) region focused on providing members with access to BH. PCS launched the following process to identify member appointment navigation needs and help them access open appointments. The PCS Access to Care Team created an internal tracking document and workflow to share waitlist and appointment availability data with the Care Management (CM) Team. This process includes the Access to Care Analysts uploading BH appointment availability data weekly, including specialty care options, on a shared internal website accessible to the CM Team. When members call PCS – MP, Member Support Specialists (MSS) on the CM Team complete a brief screening to collect information on priority population status, identify a member's desired outcomes for the call, assess for suicidal thoughts or crisis needs, and active substance use issues. The MSS Team then works to link members to in-network providers and assist with timely and appropriate connections to needed services based on appointment availability data. The MSS Team also addresses access to care barriers during the screenings (i.e., transportation). While the MSS Team assists all members with access, they focus on serving priority populations, including:

- Veterans and their families
- Persons identified as HIV+, having AIDS, or Tuberculosis (TB)
- Pregnant members and women with children
- Children ages zero-to-five at risk of maltreatment
- Intellectual or Developmental Disability (I/DD) identified members
- Those experiencing suspected psychosis
- Members with substance use disorders, including those with alcohol, opioid, or IV drug use
- Members identified as in-crisis, including those experiencing suicidal ideation, homicidal ideation, or recent property damage
- Members flagged as SPMI

PCS CM Team routinely reaches out to members identified as having SPMI following referrals by members or providers, post-inpatient stays, emergency department visits in which behavioral health was a primary diagnosis, or when analytics indicate need (i.e., readmission within 30 days). Identification of members who meet the criteria for SPMI is readily

available. As of Q3 2021, the number of members (including children and adults) who meet the criteria for SPMI was 9,695 members within the PCS – LN CCO.

This pilot could not tackle waitlisted members; however, it created the foundation for 2022 project expansions into all PCS CCO regions.

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

This TQS project is the same for all PCS' CCO regions, except for region-specific data throughout the report.

The Oregon Health Authority and OAR 309-019-0225(24)(a-f) identify the following conditions as meeting the diagnostic criteria of SPMI: schizophrenia or other psychotic disorders, major depressive disorder, bipolar disorders, anxiety disorders limited to obsessive-compulsive disorder (OCD), post-traumatic stress disorder, schizotypal personality disorders, and borderline personality disorder. People living with SPMI conditions are at greater risk of adverse biopsychosocial and health outcomes, including increased risk of incarceration; increased use of tobacco, alcohol, and other recreational drugs in comparison to the general population; shorter life expectancy; and increased incidence of homelessness.[1] People with SPMI are overrepresented in Oregon's houseless population, representing an estimated 14% of the total houseless population in Oregon in 2017.[2] Additionally, access and routine care are more complex for those living with SPMI as these individuals often grapple with other health-related issues that can be left untreated. They often experience challenges in locating community providers. Additional burdens that members with SPMI face include treatment within primary care settings by primary care physicians (PCPs) with less knowledge, comfort, and experience in treating severe mental illness. Mongelli et al. note, "up to 60% of patients with a psychiatric disorder are currently only seen by PCPs. Unfortunately, frequently, PCPs fail to recognize psychiatric disorders, and only 13% of the mental health care delivered is considered to be 'minimally adequate.' The reasons reported are over- or under prescribed psychotropic medications, rarely being provided structured counseling, and infrequent referral of patients for mental health services."[3]

However, in the navigation pilot with PCS – MP CCO, PCS limited the process to members who called PCS seeking assistance or SPMI Emergency Department (ED) follow-up calls. These limitations were due to internal resource needs. PCS requires additional staff and tracking processes to expand opportunities to educate providers that they can directly contact PCS members when a member needs timely access, and the provider cannot accommodate them due to scheduling challenges.

The pilot effort within PCS – MP resulted in 200 members screened and connected to services. Of this population, 27 members identified feeling suicidal thoughts within two weeks prior to calling, 72 identified as calling for themselves (though this data set is incomplete), and 16 members identified substance use issues with oral and inhalants being the primary means of use. Prioritized groups included:

- Seven members identified as women with children
- Three members identified as I/DD
- Two members with suspected psychosis
- One member identified as a veteran

[1] Francesca Mongelli, M.D., Penelope Georgakopoulos, Dr.P.H., Michele T. Pato, M.D., "Challenges and Opportunities to meet the Mental Health Needs of Underserved and Disenfranchised Populations in the United States," *Focus* 18, no. 4 (2020), 16-24, accessed January 17, 2022, https://doi.org/10.1176/appi.focus.20190028.

[2] Megan Bolton, "2017 Point-in-Time estimates of Homelessness in Oregon," Oregon Housing and Community Services, (2017): 1-6, https://www.nhipdata.org/local/upload/file/2017-Point-in-Time-Estimates-Homelessness-Oregon.pdf.

[3] Mongelli et al., 19.

Preliminary data also shows 89.5% of members that PCS supported via this Pilot were connected to services the same day or within one business day. Although the initial data is promising, the current data sets did not capture children ages zero to five, members with SDOH needs, and members with SPMI specifically. Additionally, data is specific to PCS – MP only, and we did not collect this information for the other PCS regions due to resource limitations. This data, albeit limited, demonstrated the beneficial impact targeted supports have for those members seeking timely access to BH services. Due to the success of this pilot, PCS intends to expand this effort to all of PCS CCO regions led by a new team tentatively called the BH Access Team.

To mitigate member access limitations, PCS is adding specific full-time equivalent (FTE) positions as part of the new BH Access Team to allow a team of MSS to:

- Work with providers who indicate they maintain waitlists to assist members in quickly accessing available appointments within time and distance standards.
- Provide proactive outreach to members placed on waitlists by community providers, and assist with immediate access to services, pending members' willingness.
- Engage OAR identified prioritized populations, including members with SPMI, to ensure timely access to services.
- Support the Utilization Management teams in accessing support for members denied services with out-of-network providers when comparable providers or services are available within the CCO service area.

Additionally, the new BH Access Team will allow PCS to scale and implement a screening tool to identify exact services members need to ensure timely navigation to the services required. This effort will create an immediate access point for this population that does not exist within current PCS workflows. The screening tool will identify members with SDOH concerns. When members identify an SDOH need, the BH Access to Care Team will initiate an Intensive Care Coordination (ICC) screening for members not currently open to CM services. Screening results will funnel members to the appropriate team for outreach, ensuring PCS address their needs. Inevitably, PCS will identify members with potential BH needs who express ambivalence or reticence to engage with services. In these instances, the BH Access Team will refer members to CM for long-term services and assist in connecting members back to their PCP to explore potential recommendations for support (e.g., referral to a Behavioral Health Consultant, Traditional Health Worker, or peer-based services). This effort aims to provide members with collaborative care within an integrated setting. In all instances, the BH Access Team will support members' rights of self-determination and patient-centeredness by honoring and respecting how members choose to receive care. Additionally, the team will utilize motivational enhancement practices for those expressing ambivalence to care and treatment.

As the access work evolves, PCS intends to test our learnings and assumptions about barriers and engagement with this population, such as members' willingness to engage. Data collection will help identify the primary needs of our community and the prioritized populations not readily seeking care. The work of the BH Access Team will help inform our engagement and outreach processes and identify best practices in meeting the needs of our membership. PCS hopes to expand this effort in the future by offering support to providers who identify members needing BH services including PCP, specialists, or other BH providers within the community.

E. **Brief narrative description**:

PCS will continue to survey providers to identify the number of members on BH provider waitlists, as well as the number of available appointments. The weekly BH emailed surveys collect vital appointment availability data, and PCS will utilize this information to identify and expand navigation opportunities. Access to Care Analysts will post the weekly survey data on an internal website, which the CM Team will use to identify providers holding waitlists for outreach.

PCS CM Team will hire a team of four MSS covering all PCS CCO regions to provide outreach to members and providers. PCS will also add a new CM Clinician Team Lead responsible for overseeing the new team and developing tracking systems and workflows to ensure members with SPMI timely access to appointments.

Member navigation will include the following components to expand timely access support for members with SPMI:

- Educate providers to direct members to the new BH Access to Care Team if they cannot schedule an appointment aligned with timely access standards, including for SPMI populations.
    - Upon hire and training of the team, PCS will send an email to BH providers who reported maintaining a waitlist in the BH survey to indicate OAR timely access standards, and provide the contact information for the BH Access to Care Team for member navigation support.
- Develop a scaled workflow to manage incoming member calls and provider outreach to offset waitlists.
- Implement the member-screening tool across all PCS CCO regions to ensure appointment alignment.
- Develop an internal tracking process to monitor BH provider waitlist change over time and member navigation data by health needs.
- Analyze and report navigation statistics and waitlist change over time in monthly Oregon Access to Care Steering Committee meetings.
- Facilitate member access to community-based crisis services in an acute behavioral health crisis.
- Identify if SDOH needs exist for a member. If present, refer to the internal CM Team for support.
- Offer CM services to members eligible for ICC. Initiate a referral and ICC screening for transition to the CM Team for follow-up for members who indicate interest.

CM Team will begin sharing navigation data quarterly with the Oregon Access to Care Steering Committee in Quarter 2. This review of SPMI appointment navigation will become part of PCS routine timely access network monitoring, including developing a baseline to set 2023 navigation goals.

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

Activity 1 description: PCS will hire a CM BH Access Team to monitor timely access to services for members with BH needs, including SPMI.

☒ Short term or ☐ Long term

Monitoring measure 1.1	Hire a new CM MSS team.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
PCS CCO regions do not have a specific BH Access Team.	PCS will add four MSS as primary staff on the BH Access Team serving all PCS CCO regions.	05/2022	MSS team integrates into CM Team and launches a new navigation process.	07/2022
Monitoring measure 1.2	Hire a new Clinical CM Team Lead.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No CM Clinical Team Lead exists to oversee the new BH Access Team.	Hire one CM Clinical Team Lead to the BH Access Team.	05/2022	Clinical CM Team Lead integrates into CM Team to develop and oversee new navigation processes.	07/2022
Monitoring measure 1.3	Launch provider timely access call survey process.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**

Mailed provider timely access surveys have a five percent or less response rate.	Increase response rate by moving to vendor-delivered provider live testing/call survey.	02/2022	Provider response rate increases by at least five percent.	12/2022

Activity 2 description: Develop and launch new, scaled SPMI timely access navigation processes.

☒ Short term or ☐ Long term

Monitoring measure 2.1	Scale member screening tool and screened/navigated member tracking process.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Existing screening tool and navigation tracking process limited to PCS – MP.	Scale to cover PCS – LN with the ability to report out by member needs, including SPMI.	07/2022	PCS fully integrates the process and PCS reports out data quarterly to demonstrate waitlist management.	12/2022
Monitoring measure 2.2	Educate providers on the new BH Access Team and applicable OARs.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Providers are not aware they can refer members directly to PCS CM Team for appointment support.	PCS educates providers within its provider network on the new access support so providers can connect members to the BH Access Team when unable to meet timeline requirements.	09/2022	PCS fully integrates new processes, monitors, and reports out quarterly. PCS emails a letter to providers maintaining a waitlist to inform them of OARs and provides information regarding BH Access Team assistance to support access to timely appointments for members with SPMI.	12/2022
Monitoring measure 2.3	Add SDOH questions to the screening process.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
The existing screening tool does not ask members if they need an SDOH referral.	The BH Access Team adds an SDOH screening for members who call for appointments. The BH Access Team will refer members	05/2022	At least 75% of members PCS navigates to BH appointments are screened for SDOH and referred to CM Team.	12/2022

	identified with a need CM Team.			
Monitoring measure 2.4	Demonstrate SPMI member access to timely appointments			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
PCS is not currently tracking service navigation for members with SPMI needs.	PCS develops a mechanism to track and report successful navigation to appointments for members with SPMI and other needs.	5/2022	CM Team and BH Access Team collaborate to develop a baseline of the number of members successfully navigated to timely appointments via the new navigation process.	12/2022

A. **Project short title**: Project 2: PCPCH Plus Value-based Payment program

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

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

B. **Components addressed**

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

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

Approximately 80, 790 PacificSource Community Solutions – Lane (PCS – LN) members reside in Lane County. PCS – LN has approximately 88.6% of members attributed to Patient Centered Primary Care Homes (PCPCH). Lane County has 43 recognized PCPCHs, with 23 unrecognized PCPCHs. The table below describes the percentage of members assigned to PCPCH clinics above Tier 3. PCS – LN provides a per-member per-month (PMPM) to all recognized PCPCH clinics. In addition, clinics have the option to apply for the PCPCH Plus Value-Based Payment (VBP) program, which offers an additional PMPM in exchange for engaging in technical assistance (TA) to achieve higher Tier levels and PCPCH standards focused on quality, access, health information exchange, and patient experience.

Lane County Member Enrollment and PCPCH Tier Levels

Tier 3	Tier 4	Tier 5	Total PCPCH Member Attribution
2.9% (4 clinics)	70.6% (26 clinics)	15.1% (6 clinics)	88.6%

In 2021, PCS – LN made several advances to increase PCPCH: Member Enrollment and PCPCH: Tier Advancement by streamlining our processes for clinic engagement through the PCPCH Plus VBP program. In addition to implementing programmatic improvements, PCS – LN engaged in internal process improvement efforts to identify unrecognized clinics and monitor tier levels. PCS – LN convened an internal workgroup consisting of members from the Analytics Team, Population Health Team, Clinical Quality Team, and other internal stakeholders to review monthly audits of clinics' tier status to inform outreach efforts. PCS – LN coordinates with Creach Consulting to offer TA to clinics to become recognized PCPCHs or advance in tier levels. In addition, PCS – LN creates regular reports that identify clinics that are not recognized PCPCHs to help inform strategies to increase PCPCH: Member Enrollment.

In 2021, PCS – LN also developed a new VBP program to further encourage and support clinics to advance Tier levels and become recognized PCPCH clinics. The new Community Health Worker (CHW) VBP program provides financial support for CHWs at PCPCHs who are Tier 3 and above. To be eligible for the CHW VBP program, PCPCHs must have a certified CHW on-site at the PCPCH who collaborates as part of the care team and routinely works with patients and community partners to achieve identified PCPCH standards such as 3.D.2, 3.D.3, or 5.E.3 related to tracking community-based referrals for health-related social needs.

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

This TQS project is the same for most PSC' CCO regions except for region-specific data throughout the report and in the Monitoring Measures.

PCS – LN reviewed the feedback received from OHA for the PCPCH: Member Enrollment and PCPCH: Tier Advancement components in 2021. We designed a new project to highlight the PCPCH Plus VBP program and the variety of TA offered to PCPCHs to advance Tier levels and increase member enrollment. Over the course of 2021, PCS – LN developed and offered a variety of TA and provided enhanced financial support through the PCPCH Plus VBP program. PCS – LN reduced reporting requirements in 2020 and 2021 due to COVID-19 and only required bi-annual reporting to participate in the VBP program. Beginning in 2022, reporting requirements will return to quarterly to ensure that PCPCHs continue high performance and meet all program requirements.

PCS – LN has sixteen PCPCHs enrolled in the PCPCH Plus VBP Plus program. PCPCHs who chose not to enroll in the VBP program still receive the base rate for being a recognized PCPCH. PCS – LN contracted with Creach Consulting to offer TA and one-on-one coaching to PCPCHs and unrecognized clinics. In 2021, four clinics chose to receive TA. Clinics who chose to engage in TA received assistance with completing the OHA application renewal process and coaching to achieve advanced PCPCH measures to become eligible for the PCPCH Plus VBP program. In addition to this, Creach Consulting and Dr. Amy Stoeber, a licensed Psychologist who provides training and consultation in building resilient relationships, offered one free learning collaborative in the summer of 2021 to help clinics with the new PCPCH standard *2.F: Staff Vitality*. PCS – LN also provides clinics access to a Clinical HIT Informaticist through Creach Consulting to help meet PCPCH standard *4.D.3: Clinical Information Exchange* and assist with Electronic Health Records (EHR) functions in support of PCPCH: Tier Advancement. In 2021, PCS – LN identified the need to have more targeted TA provided to clinics for PCPCH Standards *3.C.1: Behavioral Health Services*, *5.A.1 & 5.A.2: Population Health Management*, and *5.C.2: Complex Care Coordination*.

In addition to offering TA to recognized PCPCHs, PCS – LN also offered TA to unrecognized clinics to increase PCPCH: Member Enrollment. In 2021, PCS – LN offered TA to multiple clinics. This included Nova Primary Care clinics, which has twelve primary care sites in Lane County, Bethel School-based Health Center (SBHC), and Women' Care. Bethel SBHC and Women's Care engaged in TA and PCS will continue to offer them TA in 2022. Together, over 4,270 CCO members receive care at these clinics. By offering TA to clinics to become recognized, PCS – LN is making advancements toward achieving our targets to increase PCPCH: Member Enrollment.

PCS – LN identified opportunities to provide VBPs to support the integration of Traditional Health Workers (THWs) through partnerships with PCS's THW Liaison and community PCPCH partners. The THW type that best fits the PCPCH model and population needs are CHWs. In addition, CHWs can bill for services outside of a Certificate of Approval agency. By adding a CHW VBP program, PCPCHs will further be able to meet OHA's PCPCH standard for 3.D.2, 3.D.3, or 5.E.3, therefore, advancing population health and member needs. PCS – LN exceeded the target state by developing the CHW VBP program in 2021, which will offer both financial support and TA opportunities to PCPCHs to further integrate CHWs in PCPCHs.

E. **Brief narrative description**:

PCS – LN will outreach and offer financial support and TA to recognized PCPCHs to advance Tier levels, and will offer TA to unrecognized clinics to become certified PCPCHs and increase member enrollment. In addition to paying higher PMPM for increased Tier levels, PCS – LN will promote the PCPCH Plus VBP program. Clinics that meet specified high-value PCPCH standards may opt to participate in the program. Please reference the PCS' VBP program description in the attachments for full details on TA and PMPMs offered to PCPCHs. PCS – LN will collaborate with Creach Consulting to offer TA to recognized PCPCH clinics and achieve the standards outlined below. To receive the enhanced PCPCH Plus rates, clinics must meet all the following parameters and reporting requirements:

- Be recognized by OHA as PCPCH Tier 3, 4, or 5
- Maintain or improve their PCPCH Tier of recognition

- Participate in any OHA PCPCH program site visits.
- Submit quarterly reports to PCS – LN, including a copy of the most recent OHA PCPCH application.
- Acknowledge that expectations of clinics will continue to rise in subsequent years to ensure continuous quality improvement.
- Report on progress toward meeting all the PCPCH standards & measures outlined below:

PCPCH Standard to report on	Description of Reporting Requirements
2.D.2 or 2.D.3 Quality Improvement	Quality improvement and population health activities should include a minimum of four hours/month of scheduled, paid team time for activities such as, reviewing CCO performance metrics, conducting quality improvement projects, and proactive population health management activities.
3.C.1 Behavioral Health Services	Collaborate, coordinate, and have a cooperative referral process with outside specialty mental health, substance use, and developmental providers including a mechanism for co-management (as needed). Submit to PCS – LN de-identified examples of two-way communication and care coordination.
4.D.3 Electronic Health Information Exchange	Participate in real-time electronic health information exchange (HIE) and report on the clinic's HIE capabilities.
5.A.1 and 5.A.2. Population Data Management	Demonstrate the ability to identify, aggregate, display and utilize up-to-date data regarding entire patient population, including the identification of subpopulations. Demonstrate the ability to stratify entire patient population according to health risk such as special health care needs or health behavior.
5.C.2 Complex Care Management	Care management activities should include a minimum of four hours/month of scheduled, paid team time for activities such as registry review, conducting quality improvement projects, reviewing CCO performance metrics, and proactive population health management for patients with asthma, diabetes, hypertension, coronary artery disease or congestive heart failure, mental health, substance abuse, or other prevalent chronic conditions.
6.C.2 or 6.C.3 CAHPS Patient Experience of Care Surveys	Assess patients' experience of care by administering and reporting on a CAHPS Clinician & Group Survey (version 3.0 recommended). Submit top-box composite scores to PCS - LN for the following two CAHPS domains: Access to Care (Getting timely appointments, care, and information) and Care Coordination (Provider's Use of Information to Coordinate Care). Clinics will report domain scores to PCS – LN and, if not meeting the PCPCH benchmark for one or both domains, submit an improvement plan.

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

Activity 1 description: PCPCH: Tier Advancement: PCS – LN will offer TA to clinics participating in the PCPCH Plus VBP program. PCS - LN will offer TA to PCPCHs to meet standards 3.C.1, 5.A.1, 5.A.2, and 5.C.2 (outlined in the above table). This will support further implementation of population health management in addition to the adoption of platforms to work with members on health-related social needs. PCS – LN will monitor clinics' progress toward meeting identified PCPCH standards through quarterly reporting and by providing TA.

☒ Short term or ☐ Long term

Monitoring measure 1.1	PCS - LN will monitor TA outcomes through quarterly reporting. PCS - LN will outreach to Tier 3 PCPCHs and offer TA to increase Tier levels. PCS - LN will offer TA to clinics participating in the PCPCH Plus VBP program to meet standards 3.C.1, 5.A.1, 5.A.2, and 5.C.2 (outlined in the above table).			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Four clinics are Tier 3 PCPCHs.	PCS – LN will continue to offer TA to the Tier 3 PCPCHs to work towards advancing their tier level.	12/2022	PCS – LN will continue to offer TA to the Tier 3 PCPCHs to work towards advancing their tier level.	12/2022
Sixteen clinics are enrolled in the PCPCH Plus VBP program. PCS – LN has not offered TA specifically focused on identified VBP 2022 program standards.	PCS – LN will offer TA to clinics that are currently not meeting specified high-value PCPCH Plus standards.	12/2022	Eight clinics not meeting the specified PCPCH Plus standards will implement them.	12/2022
Monitoring measure 1.2	PCS – LN will promote the CHW VBP program and at least one clinic will enroll in the VBP program by 12/2022.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No PCPCHs are receiving a VBP to integrate CHWs.	At least one PCPCH will enroll in the CHW VBP program and have an integrated CHW.	06/2022	20% of PCPCHs will have integrated CHWs and be eligible to enroll in the CHW VBP program.	12/2022

Activity 2 description: PCPCH: Member Enrollment: PCS – LN will contract with Creach Consulting to offer TA to unrecognized clinics to increase PCPCH member enrollment. Clinics who choose to engage in TA will receive support with completing their OHA application.

☒ Short term or ☐ Long term

Monitoring measure 2.1	PCS – LN will offer TA to at least one unrecognized clinic to become a recognized PCPCH by 12/2022. Clinics who choose to engage in TA will receive support with completing their OHA application.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Twenty-three clinics are not recognized PCPCHs.	PCS – LN will continue to offer TA to unrecognized	12/2022	PCS – LN will continue to offer TA to unrecognized clinics. One	12/2022

PCS – LN offered TA to 14 unrecognized clinics to become a recognized PCPCH in 2022.	clinics to become a recognized PCPCH.		unrecognized clinic will become a PCPCH.	

A. **Project short title**: Project 3: Behavioral Health Integration Value-Based Payment Program (new project title)

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

If continued, insert unique project ID from OHA: 181

B. **Components addressed**

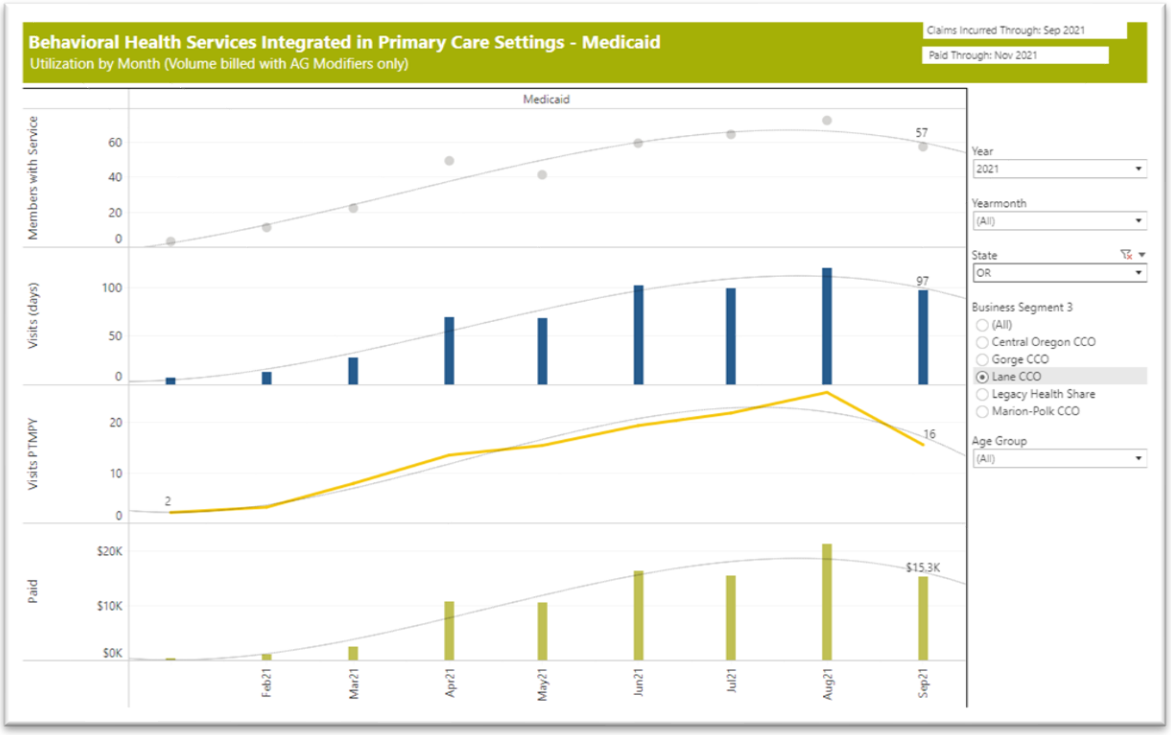
i. Component 1: Behavioral health integration
ii. Component 2 (if applicable): Choose an item.
iii. Component 3 (if applicable): Choose an item.
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this project addresses social determinants of health & equity, which domain(s)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

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

In 2021, PacificSource Community Solutions- Lane (PCS – LN) continued to offer and promote the Behavioral Health Integration (BHI) value-based payment (VBP) program. The BHI VBP program promotes the implementation and maintenance of an integrated care team structure and provides financial support to Patient-Centered Primary Care Homes (PCPCHs) to do so (please see ATTM 8 – PacificSource 2022 PCPCH VBP Program Description, which includes full details about the reporting requirements and program metrics). The number of clinics able to maintain integrated behavioral fluctuated across 2021, as some clinics dropped from the program due to staff attrition related to COVID-19. By the end of 2021, six PCPCHs had robust integrated behavioral health programs.

PCS – LN reinitiated site visits and bi-annual reporting for the BHI VBP Program, despite challenges stemming from COVID-19. PCS – LN continues to contract with Creach Consulting to offer technical assistance (TA) and learning collaboratives, create and review reporting, and conduct site visits. All PCPCHs enrolled in the BHI VBP program submitted data and bi-annual reporting in the summer of 2021. PCS – LN worked closely with Creach Consulting to review all site visit reports and population reach data. PCS – LN compiled qualitative data from the site visits, which resulted in the following insights: PCPCHs reported high levels of caregiver burnout in combination with increased patient needs for behavioral health services, which has markedly increased since the beginning of the pandemic. Because of COVID-19 and workforce shortages, there has been limited access in the community to specialty behavioral health. In addition, more patients with serious and persistent mental illness (SPMI) are having their care managed through integrated primary care settings with Behavioral Health Clinicians (BHC). The shift to remote work has affected team-based care, which has led to a need for TA to help re-implement important activities such as huddles, curbside consults, and warm hand-offs. Lastly, PCS – LN identified the need to provide more TA to help PCPCHs understand and implement true team-based care with BHCs and PCPs, rather than just providing referrals to on-site BHCs.

Clinics that participated in the BHI VBP program submitted population reach data for the first half of 2021. Lane counties population reach ranged from 5% to 32%, with the average being 11.7%. In addition to clinic reported population reach, PCS - LN has Behavioral Health Utilization dashboards, which includes claims data for members who received integrated behavioral health services (see example below). The top line indicates Medicaid member in the Lane County who had a service. The variation of population reach highlights the opportunity for continued TA specifically with clinics that reported lower rates.



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

This TQS project is the same for all PCS' CCO regions, except for region-specific data throughout the report and in the monitoring measures.

In 2021, this project also included components for Behavioral Health Integration, PCPCH: Member Enrollment, and PCPCH: Tier Advancement. After reviewing OHA feedback for 2021, PCS – LN adapted this project to focus on the BHI component for 2022. PCS – LN met its 2021 targets for program expansion and population health reach (see table below). At the beginning of 2021, 12 PCPCHs enrolled in BHI VBP program, including one new clinic who newly enrolled. Over the course of 2021, Creach Consulting conducted site visits with 12 participating clinics in the BHI VBP Program to verify program requirements and determine TA opportunities with clinics. Five clinics passed there site visits, and one clinic received TA to stay in the program. After conducting site visits, PCS – LN learned some PCPCHs were not meeting program criteria. Due to staff attrition, some clinics no longer had BHC's on-site providing integrated services. Therefore, they were no longer able to continue with the program structure. In the fall, PCS - LN postponed site visits for remaining clinics until 2022, to help with provider relief related to the pandemic. In cases where clinics had staffing shortages, Creach Consulting provided assistance with hiring a new BHC. Creach Consulted offered TA to support the clinics with mental health access points and support to hire a BHC in the future. By the end of 2021, six clinics remained in the BHI VBP Program.

In 2020, due to COVID-19 and provider relief, PCS – LN waived program reporting requirements. In 2021, again because of COVID-19, PCS – LN only required biannual reporting and reduced population health reach requirements to 5%. In 2021, PCPCHs reported this population health reach data in July, and all clinics met or exceeded the 5% targets. In 2022, participating PCPCHs will have new population reach requirements, including the addition of reporting reach on a priority subpopulation. The subpopulation data reporting is aimed at decreasing health disparities.

2020 Baseline or current state	2021 Target/future state	Progress toward target
11 PCPCH clinics signed VBP contracts for fidelity-based BHI.	At least one additional PCPCH will enroll in VBP arrangements for BHI in 2021.	Target met. One new PCPCH enrolled, despite some clinics dropping from the program.
Due to COVID-19, PCS – LN waived reporting requirements in 2020.	PCPCHs who participated in BHI Program in 2020 will maintain at least a 5% population reach in 2021.	Target Met. All clinics achieved at least 5% population health reach.
Due to COVID-19, PCS - LN waived reporting requirements in 2020.	PCPCHs new to BHI Program will achieve a 5% population reach in 2021.	Target met. All new clinics achieved at least 5% population health reach.

PCS – LN also offered TA and learning collaboratives to all PCPCHs participating in the BHI VBP program in 2021. Six PCPCHs engaged in targeted TA focused on improving population reach; helping with recruitment, hiring and training for BHCs; and improving psychiatric access. In addition, PCS - LN held learning collaboratives in 2021 that provided information about different BHI models of care, PCS' program requirements, and TA available. Further, based on lessons learned during site visits and by popular request, PCS - LN sponsored a new virtual Primary Care BHC Community of Practice aimed at creating a peer community, clinical skill-building, and addressing burnout.

2020 Baseline or current state	2021 Target/future state	Progress toward goal
No Virtual Learning Collaboratives occurred in 2020.	Conduct two Learning Collaboratives.	Target reached. PCS - LN planned and held two Primary Care Community of Practice meetings and held two Psychiatric Access Learning Collaboratives.

E. **Brief narrative description**:

PCS - LN will provide financial support and TA to implement high-value BHI elements in PCPCHs that serve our members. For clinics to participate in the fidelity-based BHI program, they must be a Tier 3 PCPCH or higher. Each participating clinic is required to submit quarterly reporting in order to receive payments. To qualify for the payments, clinics must be:

- Be an OHA-certified Tier 3 or higher PCPCH
- Meet minimum standards outlined in Tier 3 PCPCH by the Integrated Behavioral Health Alliance (IBHA)
- Have a minimum of 0.5 FTE on-site BHC (with minimum staffing ratios of 1.0 BHC FTE per 6.0 PCP FTEs)

The BHI VBP Program specifies that the role of a BHC is to provide the following open access services:

- Prevention and early intervention for common behavioral health issues
- Same-day brief patient consultations, assessments & interventions
- Warm hand-offs between the primary care team and BHC(s)
- Consultations between the primary care team and BHC(s)

- Care management and care coordination with entities outside the PCPCH including specialty behavioral health clinicians, psychiatrists, other specialist providers, hospitals, schools, substance use providers, and community mental health programs.
- Each eligible BHC must have at least half of their hours at the practice each week available for same-day open access services**.**

In 2022, the program will offer two different levels of retrospective PMPM payments based on reporting total population reach and priority subpopulation reach. To be eligible for Level 1 reimbursement, clinics must achieve 8% total population reach and 10% priority subpopulation reach. To receive a higher Level 2 reimbursement, clinics must achieve 12% total population reach and 25% priority subpopulation reach. The priority subpopulation metrics aim to assess and then decrease health disparities within integrated health care settings, by requiring clinics to report on members receiving open access services in primary care. Clinics have the option to choose and report on one of three different priority subpopulation metrics:

- Percentage of patients who identify as a person of color or whose preferred language is not English who were seen by a BHC.
- Percentage of patients with diabetes and a positive depression screening who were seen by a BHC.
- Early childhood social-emotional health: Percentage of patients who received a developmental screening score (ASQ-3 or ASQ: SE-2) in the monitoring zone who were seen by a BHC.

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

Activity 1 description: PCS – LN will offer continued and expanded support for the implementation of fidelity-based BHI in PCPCHs using a VBP strategy. PCPCHs will report on their total population health reach in addition to subpopulation reach to determine the appropriate level of payment (Level 1 or Level 2.)

☒ Short term or ☐ Long term

Monitoring measure 1.1	PCS – LN will monitor population reach through quarterly reporting and annual site visits.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
In 2021, six clinics currently enrolled in the BHI VBP program. (Population health reach metric ranged from 5% to 36%)	All clinics will report on BHC total population reach.	6/2022	All clinics will achieve 12% total BHC population reach.	12/2022

Monitoring measure 1.2	PCS – LN will monitor Priority Sub-Population reach through clinics' quarterly reporting on one of three metrics.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Subpopulation reach benchmark was not required to be eligible for VBP payment in 2021.	All clinics will identify their priority subpopulation population metric to target increased access to integrated behavioral health services.	6/2022	Five clinics will successfully achieve 10% priority subpopulation reach.	12/2022

Activity 2 description: PCS – LN will offer TA and conduct annual site visits with participating PCPCHs in the BHI VBP program. TA will focus on helping clinics fully understand how to aggregate and report data via their electronic health records. In addition, Creach Consulting will convene regular BHC Community of Practice meetings designed to improve BHC skill-building, team-based care development, and other identified clinical and operational support needed.

☒ Short term or ☐ Long term

Monitoring measure 2.1	PCS – LN will track clinic requests for TA in addition to data outcomes from quarterly reporting.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
In 2021, 12 clinics received a site visit and five passed. Six clinics engaged in TA.	All clinics participating in the 2022 BHI VBP program will receive an annual site visit and TA as needed.	12/2022	All clinics who did not pass their site visit will be offered TA to meet program requirements.	12/2022
In 2021, PCS – LN held two BHC Community of Practices meetings.	PCS – LN will plan 6 BHC Community of Practice meetings.	12/2022	PCS – LN will hold 6 BHC Community of Practice meetings.	12/2022

A. **Project short title**: Project 4: Advancing CLAS Standards with a focus on Language Access and use of Preferred Language Cards

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

If continued, insert unique project ID from OHA: 182

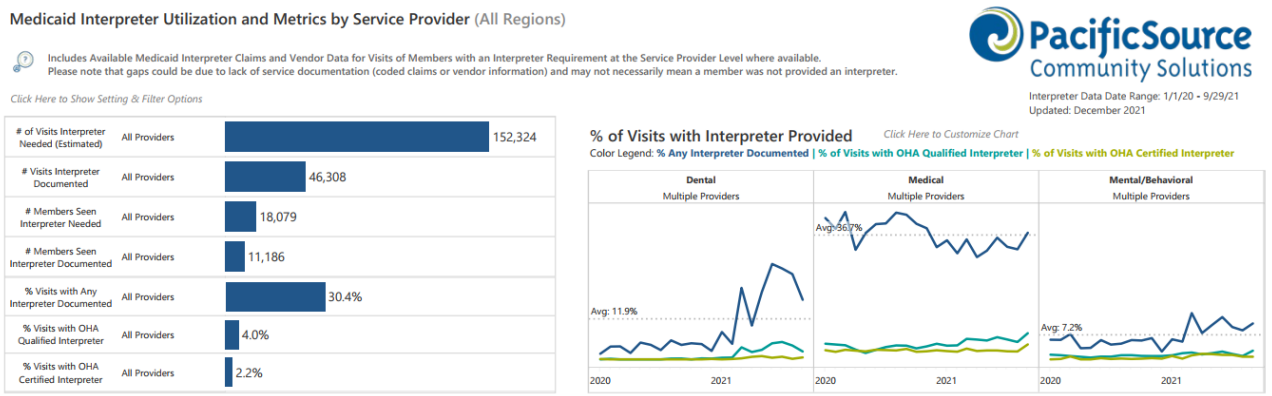
B. **Components addressed**

i. Component 1: CLAS standards
ii. Component 2 (if applicable): Access: Cultural considerations
iii. Component 3 (if applicable): Health equity: Data
iv. Does this include aspects of health information technology? ☐ Yes ☒ No
v. If this project addresses social determinants of health & equity, which domain(s) does it address?
☐ Economic stability ☐ Education
☐ Neighborhood and build environment ☐ Social and community health
vi. If this project addresses CLAS standards, which standard does it primarily address? 5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services

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

In 2021, PacificSource Community Solutions - Lane (PCS - LN) made progress on Health Equity: Data with advancements to the Medicaid Interpreter Utilization and Metrics Dashboards. These data visualizations display information for Dental Health, Behavioral Health, and Medical Health providers by service location in connection to the provision of interpreter services. Previously, the dashboards focused on interpreter service gaps attributed to primary care groups. This enhancement allows us to have more information to understand gaps in interpreter services across different types of health providers. Based on these findings, PCS - LN continued provider outreach to promote interpreter resources such as informing providers on vendors available, how to schedule interpreters from PCS - LN's vendor list, and the reimbursement process for certified or qualified interpreters. PCS' Provider Service team planned outreach and provided technical support to providers via phone. However, due to COVID-19, the provider's capacity to engage via phone was limited. In response, PCS - LN created a web-based form for providers to complete on their own time.

The Medicaid Interpreter Utilization and Metrics by Service Provider Dashboard, exhibited below, provides a view of utilization at the actual provider service level, when available claims data exists. This information informs where members with interpreter needs are accessing care and the percentage of those services with a documented interpreter service. While this new dashboard allows us to view interpreter metrics by service provider, PCS - LN continues use the Health Equity: REALD dashboard to have a comprehensive view of gaps, e.g., utilization metrics by members' preferred language and zip code.



Service Provider Tax Name Only Click on Provider Below to Customize Report Change the provider name display in the settings	Dental						Medical						Mental/Behavioral					
	# of Visits Interpreter Needed (Estimated)	# Visits Interpreter Documented	% Visits with Any Interpreter Documented	% In Person Interpreter Documented	% Visits with OHA Certified Interpreter	% Visits with OHA Qualified Interpreter	# of Visits Interpreter Needed (Estimated)	# Visits Interpreter Documented	% Visits with Any Interpreter Documented	% In Person Interpreter Documented	% Visits with OHA Certified Interpreter	% Visits with OHA Qualified Interpreter	# of Visits Interpreter Needed (Estimated)	# Visits Interpreter Documented	% Visits with Any Interpreter Documented	% In Person Interpreter Documented	% Visits with OHA Certified Interpreter	% Visits with OHA Qualified Interpreter
Vendor Data without Matching Claim Found	1,348	1,348	100.0%	86.6%	3.1%	17.4%	33,123	33,123	100.0%	81.1%	5.1%	11.9%	428	428	100.0%	32.5%	12.6%	7.7%
	3,912	14	0.4%	0.3%	0.0%	0.0%	11,462	428	3.7%	3.2%	0.1%	0.5%	729	25	3.4%	2.7%	0.3%	0.5%
							6,464	1,305	20.2%	19.6%	0.8%	1.8%	120	20	16.7%	16.7%	1.7%	1.7%
	1,104	0	0.0%	0.0%	0.0%	0.0%	3,813	17	0.4%	0.4%	0.0%	0.0%	445	0	0.0%	0.0%	0.0%	0.0%
							4,674	149	3.2%	3.1%	0.1%	0.6%	177	3	1.7%	1.1%	0.0%	0.6%
	3,954	79	2.0%	1.8%	0.1%	0.2%												
	548	0	0.0%	0.0%	0.0%	0.0%	2,808	1,142	40.7%	30.6%	34.3%	4.8%	511	40	7.8%	4.5%	7.2%	0.0%
							3,365	18	0.5%	0.0%	0.0%	0.2%	135	0	0.0%	0.0%	0.0%	0.0%
	53	0	0.0%	0.0%	0.0%	0.0%	2,838	19	0.7%	0.6%	0.1%	0.2%	382	2	0.5%	0.5%	0.3%	0.0%
							389	10	2.6%	2.3%	0.0%	0.0%	2,462	42	1.7%	1.4%	0.0%	0.6%
							2,710	280	10.3%	10.0%	0.4%	1.1%						
							2,646	741	28.0%	21.7%	0.3%	1.0%	78	34	43.6%	33.3%	0.0%	2.6%
							2,359	10	0.4%	0.4%	0.0%	0.1%	169	4	2.4%	2.4%	0.0%	1.8%

PCS - LN made advancements with Access: Cultural Considerations by sharing existing materials and creating new materials to promote Health Care Interpreter (HCI) requirements and resources. These materials explain how to access interpretation services as well as how to become an HCI. PCS - LN shared these materials with providers through three communication channels: email, website, and telephonic communication. In 2021, PCS - LN expanded from three HCI vendors to 10 HCI vendors, which improved wait times and vendor choice in cultural appropriateness. These efforts served to assist providers with identifying their patients' cultural and linguistic needs and engaging patients in their care (CLAS Standard #5).

In 2021, the Provider Manual received a robust update on HCI services. PCS - LN expanded content from one page to three pages to outline the following resources for provides and members:

- Members' rights to HCI services and providers' responsibility.
- Payment responsibility for HCI services
- Details on how a provider can arrange and bill for HCI services, including promotion of billing code T1013
- Contact information for HCI vendors, showing an increase from three contracted vendors in 2020 to 10 contracted vendors in 2021
- Definition of a "credentialed" interpreter
- The differences among qualified, certified, and bilingual interpreters
- Learning to work with a medical interpreter

PCS – Lane distributed information through the enhanced provider Site Visit and Evaluation Form that includes additional technical assistance around HCI access. Provider Service developed a virtual site-visit survey for providers. PCS - LN sent the new communication tool electronically through the PCS – Lane's *Provider Bulletin*. The bulletin and survey included questions about providers' policy and procedure for language access, as well as, inquiries and opportunities for technical assistance for HCI interpreter access and billing.

PCS - LN's work in this area has been in close alignment with the Health Equity Plan (HEP) Focus Area 7: Language Access. One strategy in the HEP is to establish tracking mechanisms and new processes to improve access to

interpretation services across healthcare settings. Additionally, the Health Equity Quality Incentive Measure provides PCS - LN and providers with direction on priority focus areas to support meaningful language access for members.

In 2021, PCS - LN focused on improving CLAS Standards by focusing on CLAS Standard 5: Offering language assistance to individuals who have limited English proficiency (LEP) and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services. PCS - LN adapted the OHA Preferred Language Card to a JPEG format that is shareable with members via email and mail when they call Customer Service. The available JPEG file format of the Preferred Language Card allows providers to communicate the card with members via text message.

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

This TQS project is the same for all PCS' CCO regions, except for region-specific data throughout the report and in the monitoring measures.

Health Equity: Data

PCS - LN met its target to expand the Medicaid Interpreter Utilization and Metrics Dashboards to include Behavioral and Oral Health providers. PCS – LN utilized the Medicaid Interpreter Utilization and Metrics Dashboards (Health Equity: REALD and Service Provider) to identify providers who would benefit from outreach based on interpreter gaps in members' care. The new Medicaid Interpreter Utilization and Metrics Dashboards provide PCS - LN staff with enhanced views to identify the service provider and interpreter utilization. PCS - LN provided outreach to Behavioral Health providers in Q4 2021. In addition, PCS - LN identified an additional data source to improve the accuracy of interpreter service utilization reporting for dental care providers. The Dental Care Organizations (DCOs) provide PCS - LN with language access reporting, which includes visit level information on interpreter services provided (including the interpreter's OHA Credential and Registry Number). PCS' Analytics team has integrated these additional data into the dashboards to support future outreach efforts. In 2021, PCS - LN delayed outreach to DCOs to 2022 to identify the best strategy to share data from the Medicaid Interpreter Utilization and Metrics Dashboards and determine next steps. PCS' Diversity, Equity and Inclusion (DEI) team is working on establishing additional opportunities to share the dashboard with other internal departments. An analysis of survey responses and dashboard data will be concluded by 2023, and this information will guide strategies.

PCS - LN updated the Interpreter Services Survey that Provider Service sent to provider groups to understand their experience providing interpreters during medical appointments. PCS - LN conducted outreach to providers through a new online provider survey, rather than via phone, to alleviate provider capacity issues. Twenty providers received the Interpreter Survey, of which one provider has responded to the survey. The DEI team continues to work with Provider Service to outreach to the remaining providers who have not responded to the survey.

Access: Cultural Considerations

PCS - LN met its benchmark to distribute an FAQ and create at least one additional tool to promote HCI requirements and resources. Listed below are the tools and distribution channels. The resources include how to access interpretation services and how to become an HCI. PCS - LN shared the materials with providers through three communication channels: email, website, and telephonic communication.

Name of Material	New or Updated	Channels of promotion
Quick Guide to Becoming a Healthcare Interpreter	New	Provider email blast Website
Health Care Interpreter (HCI) Guidelines and FAQ	Updated	Provider email blast Website

Provider Manual	Updated	Website Welcome email upon contracting Provider email blast
Site Visit and Evaluation Form	Updated	Verbal exchange with a Provider Service Representative
Virtual site visit survey	New	Provider Bulletin (email)

HCI Guidelines and FAQ summarize the provider's responsibility to meet the language access needs of members with LEP. It outlines how to bill for clinic staff who are certified and qualified interpreters and how to access PCS – Lane's contracted HCI vendors.

PCS - LN developed the *Quick Guide to Becoming an HCI* to support clinical workforce development. Best practice is for clinics to have onsite interpreters. The best way to guarantee this is to have multi-cultural/multi-lingual clinical staff trained as interpreters. This new tool outlines the step-by-step process to become a qualified or certified interpreter in Oregon. Additionally, PCS - LN distributed the new flier, which includes promotion of the *HCI Guidelines and FAQ*, the new T1013 billing code, and contact information to receive help from the PCS – Lane's Population Health team to navigate the interpreter credentialing process.

CLAS Standards

PCS - LN achieved its benchmark to improve Preferred Language Cards and promote them to providers through two channels. PCS - LN identified opportunities for improvement and distribution of the OHA's Preferred Language Cards. PCS - LN focused improvements in the following areas: ordering process, printing format, and need for additional languages. PCS - LN reported its findings to the OHA using different types of communication and contacted at least six different individuals and departments, including the official *Language Access* email, Languageaccess.info@state.or.us.

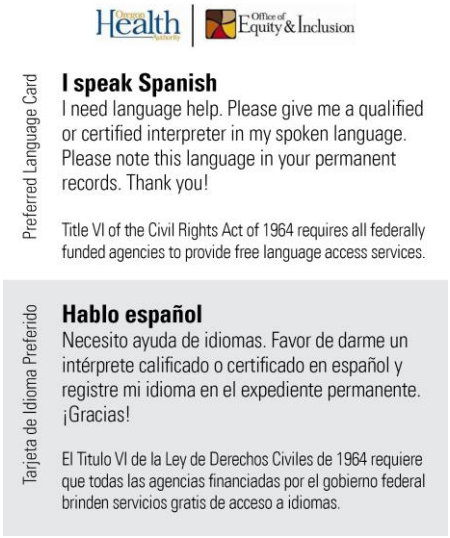
Preferred Language Card Feedback Provided to OHA

Topic	**Identified opportunities**
Ordering process	The Preferred Language Cards on the COVID smart sheet are different from cards available through the traditional ordering process. The traditional process has 26 languages, whereas the smart sheet process only has 12.
Access	Several language cards are inaccessible and the hyperlinks are broken.
Printing format	Users are to print the cards double-sided and fold. However, the text does not line up on both sides when printed. If printed as-is, half the text is upside down.
Additional language needs	PCS – Lane needs Mam language cards in our regions.
Translation improvements	Spanish and French appear to be word-for-word translations, resulting in unclear messaging.

To make the cards more user-friendly, PCS - LN adapted Preferred Language Cards from the OHA web page into a format that can be shared via email, mobile device, or web. Prior to these enhancements the cards could not be displayed in a way that allowed members to view both English and non-English language on the same screen. See examples below of PCS – LN's enhancement. If requested by a member or provider, we will be able to produce the same friendly format in

other languages (if they are available on the OHA web page). PCS - LN shared these resources with providers via two communication channels: our website and in two emails, including the *Provider Bulletin*.

Example of the jpeg format created by PCS - LN:



OHA PDF Printable Preferred Language Card:

E. **Brief narrative description**:

This project outlines new activities within Analytics, Communications, and Provider Network departments. The primary focus of this project will be to advance CLAS Standards 5: Language Access and Quality by focusing on Health Equity: Data and Access: Cultural Considerations. PCS - LN created the Medicaid Interpreter Utilization and Metrics by Service Provider Dashboard to analyze interpreter gaps from Medical, Dental, and Behavioral Health providers. These dashboards identify areas of high need for linguistic support, monitor provider technical assistance opportunities, and work to improve linguistically appropriate access where interpreter service gaps persist.

In 2022, PCS - LN will utilize service provider and interpreter utilization dashboards to establish workflows for monitoring interpreter service claims and technical assistance to determine language access needs and improve quality of services (CLAS Standard #5). We will leverage the Medicaid Interpreter Utilization and Metrics Dashboards to help implement processes and procedures to improve culturally and linguistically appropriate services, including Behavioral Health, Oral Health, and Medical care, which includes Specialty (CLAS Standard #9). To assist with this goal, PCS - LN will outreach to 1-3 providers and/or community-based organizations that support members with cultural and linguistic needs. PCS - LN will also develop a needs assessment on member and provider education (CLAS Standard #13). We will use the dashboards to distribute materials about the use of HCIs and THWs to providers accompanied with outreach through educational activities and provider network workshops.

Activities will focus on:

- Health Equity: Data: Establishing a workflow from the Medicaid Interpreter Utilization and Metrics Dashboards to monitor and identify technical assistance needs around language access to support providers and inform annual updates of PCS - LN's Language Access Plan (LAP) (CLAS Standard # 11).
- Access: Cultural Considerations: We will develop technical assistance for providers to ensure equitable access to care for members in need of language access services and the delivery of culturally responsive care (CLAS Standard #13).
- CLAS Standards: PCS - LN will continue to inform and educate providers about the use of preferred language cards to support language access for LEP members. We will distribute preferred language promotional material

to providers including THWs. PCS - LN will track provider feedback on the utilization of preferred language cards. (CLAS Standard #5).

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

Activity 1 description Health Equity: Data: PCS - LN will use the established workflow from the service provider and interpreter utilization dashboards to monitor and identify technical assistance needs around language access to support providers and inform annual updates of PCS - LN's LAP.

☐ Short term or ☒ Long term

Monitoring measure 1.1	PCS - LN will outreach to 25 providers and review survey responses by 6/30/2023.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
PCS - LN has outreached to 20 PCP and BH provider groups to identify technical assistance needs in 2021.	PCS – LN will do additional outreach to 25 PCP/BH provider groups.	12/2022	PCS – LN will review survey responses from provider groups. PCS - LN will train Provider Service Representatives on how to support providers with language access.	06/2023 03/2022
Monitoring measure 1.2	PCS - LN will outreach to three DCOs by 9/30/2022.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
PCS – LN will outreach to DCOs based on findings of the interpreter dashboards.	Outreach to DCOs to share findings from dashboards and provide technical assistance.	09/2022	Create or update a tool based on findings.	12/2023

Activity 2 description: Access: Cultural Considerations: PCS - LN will outreach to 1-3 providers or Community-based Organizations (CBOs) who support members with cultural and linguistic needs, such as LEP and Deaf, and deaf or hard of hearing. Identified providers and CBOs will be distributed benefit information on how to access available services that help reduce health disparities and increase access to care (e.g. interpreter services, Non-Emergent Medical Transportation (NEMT), THWs). Through this outreach, PCS - LN will explore and assess the opportunities, gaps, and challenges to holding a member education event in Spanish, or a language other than English about these benefits.

☒ Short term or ☐ Long term

Monitoring measure 2.1	PCS - LN will outreach to 1-3 providers or CBOs who support members with cultural and linguistic needs by 12/31/2022.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
Limited personalized outreach to providers/CBOs who serve members with linguistic needs to ensure understanding of benefits and resources.	PCS - LN will identify 1-3 providers who serve members with linguistic needs for outreach using the Interpreter Services Survey 2021 information. CBOs may be identified based on language needs in the community.	06/2022	Identified providers/CBOs receive information and materials on how to support members with language access needs. PCS - LN will identify opportunities, gaps, and challenges to holding a member event in a language other than English and develop a needs assessment.	12/2022

Activity 3 description: CLAS Standards: PCS - LN will continue to inform and educate providers about the use of preferred language cards to support language access for LEP members. We will distribute preferred language promotional material to providers, including THWs. PCS - LN will also track provider feedback on the utilization of preferred language cards.

☒ Short term or ☐ Long term

Monitoring measure 3.1	PCS - LN will promote the use of preferred language cards in provider encounters, including at least two trainings or presentations by 12/31/2022.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
PCS – LN distributed the special edition of the Preferred Language Cards for phone/web use to providers using two different channels.	PCS - LN will promote the use of preferred language cards in provider encounters, including at least two trainings or presentations by 12/31/2022 PCS - LN will develop a tracking mechanism for provider utilization and feedback of preferred language cards.	12/2022	PCS – LN will distribute preferred language promotional material to key providers. PCS - LN will implement tools to track provider utilization and feedback (e.g. survey).	12/2022

A. **Project short title**: Project 5: Monitoring of CCO and Subcontractor Grievance and Appeals Data

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

If continued, insert unique project ID from OHA: 183

B. **Components addressed**

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

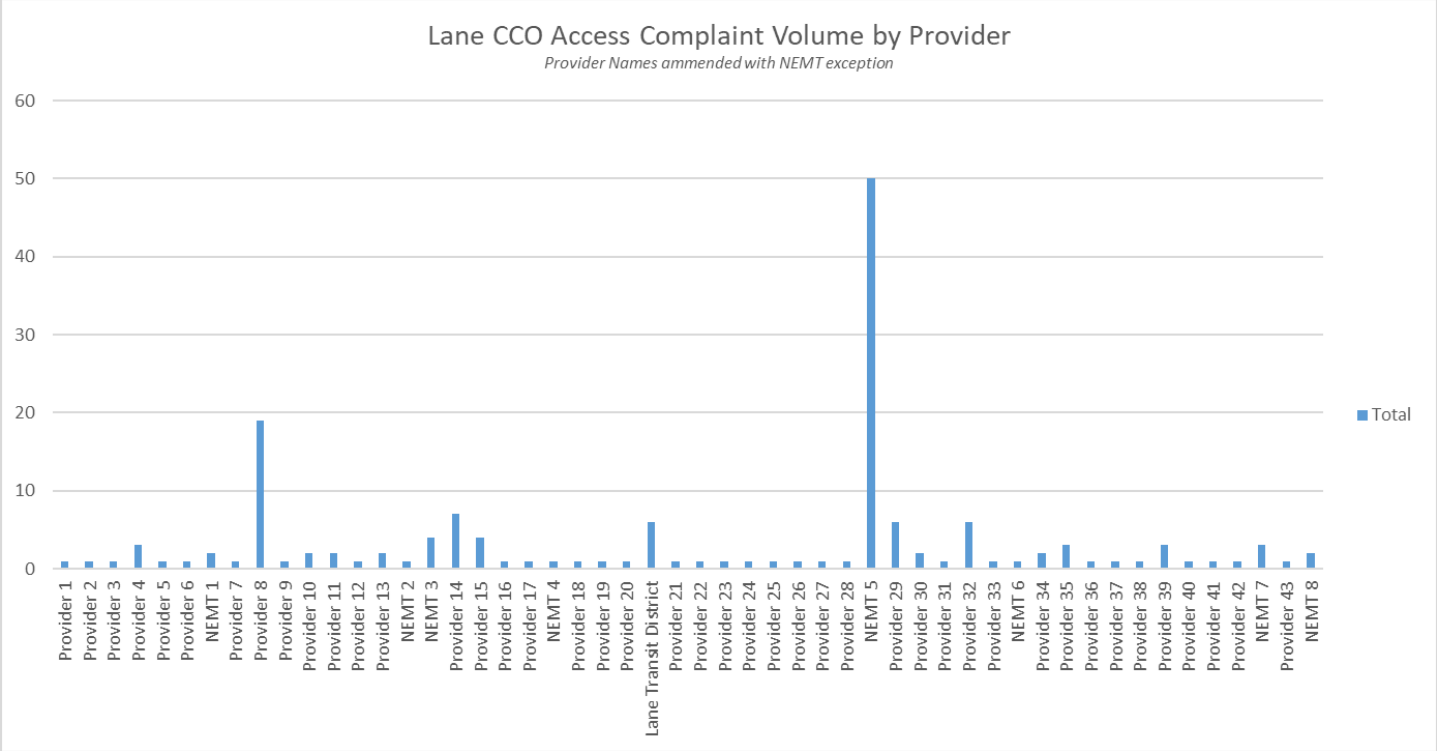
C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

PacificSource Community Solutions (PCS) Grievances and Appeals department (G&A) receives and processes member complaints pertaining to any expression of dissatisfaction. We log and categorize these grievances into six different categories based upon the root cause of the complaint. On a monthly basis, we analyze complaints related to the access to care category for any specific trends, including those complaints related to transportation. Time, distance, and practitioner–to-member ratios do not apply to Non-Emergent Medical Transportation (NEMT). As such, we evaluate and analyze NEMT provider adequacy monthly. This evaluation includes monitoring monthly and quarterly reports received from the NEMT brokerages, reports created by PCS, and monitoring of Grievance data. These data identify any capacity denials, the reasons for the denials, average ridership, rides per member per month, complaints regarding availability, appeals related to denials, and various additional data points. If we identify any deficiencies, they are addressed immediately and may result in a corrective action plan with the brokerage.

In addition to tracking member complaints, PCS supports Access: Quality and adequacy of services by monitoring compliance with established standards through access surveys and site visit checklists. If PCS recognizes a concerning trend through the access survey or receives three or more complaints concerning a particular provider or facility, the Provider Network Department conducts a site visit. PCS did not perform any site visits due to the COVID-19 pandemic, but alternatively reached out via phone and or email to investigate with the provider. Results from these visits help identify opportunities for improvement and corrective actions, if necessary.

In 2021, PCS compiled access data from all monitoring systems into one report to identify gaps and trends related to the quality and adequacy of services. We hired additional staff and partnered with a third party to help support data monitoring and deployment strategies to measure services' quality and adequacy. G&A partnered with PCS' Access to Care department to share data on access-to-care grievances and discuss opportunities through a monthly Oregon Access to Care Committee. In 2021, PCS identified a trend of access to care complaints regarding the transportation brokerage in the PCS – Lane (LN) CCO region. Trend data is shown in the following table and graph.

PCS – LN CCO Complaint Volume By Category 2021 Quarter 1 - 4				
	Q1(2021)	**Q2(2021)**	**Q3(2021)**	**Q4(2021)**
Average Enrollment	72,799	76,021	78,490	80,719
Access to Care	81	98	161	142
Interaction with Provider/Plan	144	126	195	128
Consumer Rights	28	51	44	66
Quality of Care	30	41	47	45
Quality of Service	26	39	30	12
Client Billing	5	15	6	16
Total Grievances	**314**	**370**	**483**	**409**
Rate per 1000 members	**4.31**	**4.87**	**6.15**	**5.07**



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

This TQS project is the same for all PCS' CCO regions, except for region-specific data throughout the report.

In 2020, PCS successfully established a standardized tool for monitoring internal grievance and appeal data from PCS and all subcontractors performing complaint resolution. This process allows PCS to evaluate delegated functions and review for appropriateness of response to an appeal or grievance, the timeliness of responding to member complaints, and whether PCS and its subcontractor followed the proper appeals and grievances processes and criteria. These data gathered in 2020 helped us identify a trend of grievances related to member interactions with dental providers. In

response, PCS utilized these enhanced data to provide a grievance report to our Dental Care Organizations (DCOs). We then conducted quarterly meetings with the DCOs to review grievance trends and discuss potential interventions. These meetings led to proactive outreach mechanisms, including written communication about programs, available providers, and a potential text messaging system.

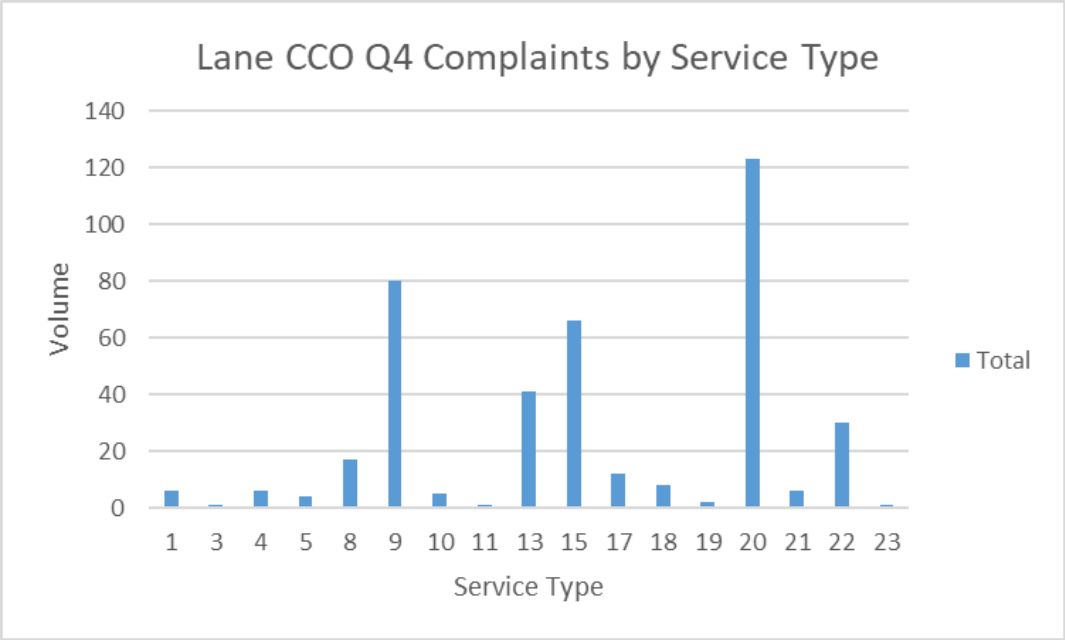
Results from the 2020 Grievance Report showed that NEMT had the highest complaint rate among PCS' subcontractors. In response, the 2021 project pivoted to focus on increasing NEMT collaboration and mitigation strategies to reduce complaints across all categories. While PCS continued quarterly discussions with dental subcontractors, PCS initiated similar meetings with NEMT subcontractors. The first quarterly meeting with NEMT subcontractors resulted in the creation of a root cause analysis of late-pickup occurrences. PCS focused subsequent discussions on the unpredictability created by COVID-19 surges, such as but not limited to driver capacity, unplanned appointment cancelations, or the overall reduced appointment utilization and subsequent lower ride utilization. The interventions from this collaboration resulted in a mutually agreed-upon incentive metric for the NEMT brokerage that measured the rate of grievances and incentivized the NEMT brokerage to focus on improvements strategies.

In 2021, PCS – LN saw an average complaint rate of 3 complaints per 1,000 members, a 73% reduction in total complaints per 1,000 members from the previous year. However, COVID-19 surges in 2021 also led to decreased care utilization and canceled services, which may have skewed the reduction in complaints.

	Q1(2021)	Q2(2021)	Q3(2021)	Q4(2021)
Total Grievances	314	370	483	409
Rate per 1000 members	4.31	4.87	6.15	5.07

E. **Brief narrative description**:

In 2021, PCS met its goal to reduce the overall rate of member grievances from 4.57 per 1,000 members to 4 per 1,000. We achieved this through targeted interventions aimed at NEMT member pickups and member communications. However, while PCS saw an improvement in the overall rate of complaints, a high number of complaints were related to transportation dissatisfaction that affected access to care (see data below).



SERVICE TYPE: Column D in the Grievance Log must have a Service type code.	
1) Durable Medical Equipment (DME)	12) Alcohol & Drug/Substance Use Disorder (SUD)
2) Occupational Therapy (OT)	13) Specialty Care
3) Physical Therapy (PT)	14) Long Term Care (LTC)
4) Hospital	15) Primary Care Provider (PCP)
5) Emergency Room (ER)	16) Outpatient
6) Ambulance/Medical Transportation	17) Other
7) Residential Rehabilitation	18) Diagnostic Studies
8) Pharmacy	19) Imaging
9) Dental	20) NEMT
10) Mental Health	21) Vision
11) Pain Management	22) CCO/ Plan
	23) Chiropractic
	24) Acupuncture

In 2022, this project will work to reduce grievance rates related to NEMT and improve access to care by engaging with the NEMT brokerage to address service dissatisfaction. Furthermore, PCS will expand on this collaboration by utilizing member survey results to identify opportunities to increase member awareness of free ride services. PCS will work with the NEMT brokerage to establish benchmark goals for survey responses to questions asking if the member is aware of free rides. Increased member awareness will positively impact member access to appointments and increase ride utilization. This project will use data to identify trends, implement interventions to alleviate the barriers to care based on those trends, and ultimately improve access to appointments.

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

Activity 1 description: PCS will work with the NEMT subcontractors to improve complaint rates specific to NEMT. This activity will further improve the members' satisfaction and access to services.

☐ Short term or ☒ Long term

Monitoring measure 1.1	PCS will work with NEMT subcontractors to improve complaint rates			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Complaints related to NEMT services through Q3 of 2021 average 33% of total complaint volume.	Annual average of complaints related to NEMT services less than 22% of total complaint volume.	12/2022	Annual average of complaints related to NEMT services less than 17% of total complaint volume.	12/2023
No interventions are in place to improve member satisfaction with NEMT driver interactions.	Develop two interventions to improve member satisfaction with NEMT driver interactions.	06/2022	Implement interventions to improve member satisfaction with NEMT driver interactions.	12/2022

Activity 2 description: To improve access to services, PCS will share member survey data related to NEMT services with the NEMT brokerages. This survey asks if members know about the free transportation services available to them. The goal of this activity will be to reduce response rates of "no" to this question through strategies aimed at increasing member knowledge of NEMT services.

☐ Short term or ☒ Long term

Monitoring measure 2.1	PCS will work with NEMT subcontractors to establish strategies and projects addressing member awareness of free ride services.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
2021 survey data currently at 37.9% responding "NO" to awareness of free rides available to them.	Reduce the response rate of "NO" to the awareness of free rides to 35%.	12/2022	Reduce the response rate of "NO" to the awareness of free rides to 25%.	12/2023
No interventions are in place to increase the awareness of free ride services.	Meet with NEMT brokerages and agree to two interventions to improve the awareness of free ride services.	06/2022	Interventions are put in place to increase the awareness of free ride services.	12/2022

A. **Project short title**: Project 6: Diabetes: Inter-professional Care Collaboration between Primary Care and Dental Providers

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

If continued, insert unique project ID from OHA: 184

B. **Components addressed**

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

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

In 2020 and 2021, the COVID-19 pandemic significantly impacted the dental care delivery system. This evolving landscape spurred some progress with teledentistry but continued to impede PacificSource Community Solution's (PCS) Oral Health Integration initiatives to increase dental visits for diabetic members. In recognition of these challenges, the Oregon Health Authority (OHA) retrospectively suspended the CCO Quality Incentive Measure (QIM) improvement targets for 2020 and rebased benchmarks and improvement targets for 2021. Although efforts to increase dental care for diabetic members fell significantly short of the original target, PCS-Lane (LN) is exceeding the rebased 2021 target of 17.3%.

CCO	MEASURE	NUM	DEN	RATE	Target	DIFF
Lane	Oral Evaluation - Diabetic	821	3,583	22.9%	17.3%	5.6

Despite ongoing challenges, PCS-LN continued scoping opportunities for co-location and teledentistry partnerships. As a result, Capitol Dental signed a memorandum of understanding (MOU) for a co-location partnership with G Street Integrated Health, which will begin once staffing shortages for expanded functions dental hygienists resolve. In addition, PCS-LN successfully facilitated a partnership with Advantage Dental and Capitol Dental to strategize a plan for oral health integration with behavioral health providers. While these co-locations do not specifically serve diabetic members, they serve as important interprofessional clinical innovations. In the future, we hope this initiative will extend across the four PCS CCO regions and improve oral health for members with behavioral health conditions.

In support of Oral Health Integration, PCS-LN scoped potential platforms for health information exchange (HIE) and health information technology (HIT). As a result, PCS created a collaborative workgroup with DCOs and Unite Us, a community information exchange platform used for social determinants of health screening and referrals. This group successfully designed a pilot to expand the platform's functionality to support provider-to-provider closed-loop referrals. Moving forward, we are hopeful this pilot will be successful, given Unite Us' broad provider use across Oregon.

Last year, PCS-LN also shared informational materials on co-location, Oral Health Integration, topical fluoride varnish, and member-facing materials with provider groups. These initiatives helped providers educate their patients on the connection between oral health and diabetes, and also assisted members in getting dental care. Accomplishments from these efforts include:

- 100% of PCS-LN contracted physical health partners completed topical fluoride varnish and oral health assessment technical assistance training.
- Three Lane County clinics began using the dental visit "prescription" pads, a tool used to encourage patients with diabetes to seek dental care.

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

This TQS project is the same for all PCS' CCO regions, except for region-specific data throughout the report and in the monitoring measures.

In 2020, PCS - LN chose *Diabetes: Inter-professional Care Collaboration between Primary Care and Dental Providers* as its Oral Health Integration TQS project due to the high prevalence of diabetes and its impact on members' health in Lane County. Data presented in the 2019 Lane County Community Health Assessment showed that 8.5% of Lane County adults have diabetes, and rates of childhood diabetes in this region continue to rise. Additionally, research has shown that preventing or correcting oral diseases is an integral part of optimal diabetes management.

As part of this project, PCS created the *Dental Care for Diabetics* report and deployed it to participating physical health providers. This report provided primary care physicians (PCPs) information on their panel's rate of dental visits, including periodontal or prophylaxis visits, which enabled them to integrate oral health into their patients' overall care. PCS-LN also leveraged value-based payment (VBP) strategies, dashboards, and monthly monitoring to increase the percentage of diabetic members who received a comprehensive or periodontal exam. However, COVID-19 led to several dental clinic closures, which impeded progress towards increasing dental exams for people with diabetes. Despite this, PCS-LN continued working on resuming care through teledentistry and co-location. In addition, PCS-LN created and deployed a dental integration activities log, which provided a baseline for current state diabetes co-location efforts.

In 2021, PCS-LN continued scoping possible HIE and HIT platforms. While PCS successfully adopted Reliance's Community Health Record platform in the Columbia Gorge and Central Oregon, both regions have shown underutilization of the eReferrals platform. Given these challenges, PCS-LN pivoted to researching Unite Us as an alternative platform to meet this need. This tool can help identify and address social determinants of health (SDOH) needs and potentially serve as a provider-to-provider referral platform. Moving forward, we are hopeful about provider-to-provider clinical referral possibilities with Unite Us and its broad provider use across Oregon. The vendor is currently piloting this functionality, and we are encouraged by this use-case, given PCS' investment in Unite Us across its four CCO regions.

E. **Brief narrative description**:

To implement and improve Oral Health Integration, PCS-LN will continue using a VBP model to incentivize the delivery of dental care to members with diabetes. This work aligns with the QIM addressing oral evaluations for diabetic members. It also aides the 2021 TQS strategy to use VBPs to incentivize DCOs to achieve the rebased performance improvement targets and, ultimately, the region's performance benchmark on this measure. The VBP strategy, in combination with monthly monitoring of measure dashboards and gap lists, will help drive continued progress.

PCS-LN will also continue promoting the establishment and expansion of co-located teledentistry programs within physical health clinics to increase dental care utilization in the diabetic population. We will continue facilitating regular conversations with DCOs, sharing resources and analytics, hosting discussions to encourage integration and co-location with physical health providers, and connecting interested physical health providers with DCOs to explore further options when needed.

Finally, PCS-LN will continue promoting the adoption of community HIE and HIT systems to enable interprofessional collaboration and care coordination between physical and dental providers. Given the provider-to-provider referral potentials of the Unite Us platform and the prospect of a singular solution across our regions, we will focus our attention on that future functionality assuming pilot efforts prove successful. If we learn that provider-to-provider referrals are

not an appropriate fit for the Unite Us platform, PCS-LN will research and evaluate other options to best support provider-to-provider communication.

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

Activity 1 description: PCS will leverage VBP strategies, dashboards, and monthly monitoring to increase the percentage of diabetic members who receive a comprehensive or periodontal exam during the measurement period.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Monitoring will occur via a dashboard that displays year-to-date performance on diabetic members with dental visits. This dashboard (accompanied by a gap list) will be refreshed monthly and shared with each DCO.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
The CCO estimated baseline for the PCS-LN region.	The CCO meets the CCO improvement target set by the OHA.	12/2022	The CCO meets the CCO benchmark set by the OHA.	12/2023

Activity 2 description: Promote dental care delivery to the diabetic population via teledentistry, co-located with physical health provider clinics.

☐ Short term or ☒ Long term

Monitoring measure 2.1	PCS – LN will track DCO implementation of co-located teledentistry programs in each region. We will monitor improvements to the baseline to track growth in teledentistry activities and partnerships.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
CCO baseline for the region overall: 0 co-located teledentistry programs serving the diabetic population.	1 or more co-located teledentistry programs are serving the diabetic population.	12/2022	Two or more co-located teledentistry programs are serving the diabetic population.	12/2023

Activity 3 description: Encourage all three DCO partners to adopt the Unite Us platform. Participate with efforts to pilot expanded Unite Us platform referral functionality to include provider-to-provider referral capability. Depending on pilot effort outcomes, suitability to meet needs, and deployment timelines, facilitate awareness of expanded functionality by arranging demonstrations (as needed) of the referral capabilities with DCOs and other interested providers.

☐ Short term or ☒ Long term

Monitoring measure 3.1	PCS – LN will work to expand the adoption of the Unite Us platform from two DCOs to all three DCOs.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**

Two DCOs have adopted the Unite Us SDoH platform	Three DCOs have adopted the Unite Us SDoH platform.	12/2022	Three DCOs have adopted the Unite Us SDoH platform.	12/2022

A. **Project short title**: Project 7: Connect Oregon

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

If continued, insert unique project ID from OHA: 385

B. **Components addressed**

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

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

In 2021, PacificSource Community Solutions – Lane CCO (PCS – LN) built upon existing community engagement work to improve Health Equity: Cultural Responsiveness and Social Determinants of Health & Equity (SDOH-E). In fall 2019 and winter 2020, we conducted targeted listening sessions, one-on-one interviews, and public forums to inform this work. Participants included OHP members, health care providers, social service providers, local health departments, and community members. Attendees represented various populations that have historically experienced health inequities based on their race, ethnicity, language, disability, age, sex, gender identity, sexual orientation, social class, and the intersections among these communities. The feedback from these listening sessions informed our Community Information Exchange (CIE) planning, including the need to increase access to culturally and linguistically responsive resources.

PCS – LN partners with the Lane Community Health Council (LCHC) to ensure local community governance is rooted in the unique assets and needs of the communities that span Lane County from the coast to the cascades. PCS – LN and the LCHC work to engage in a broad countywide collaboration called Live Healthy Lane to conduct the Community Health Assessment (CHA) and implement the Community Health Improvement Plan (CHP), which drives the SDOH-E efforts for PCS – LN. In addition, PCS – LN engages in many community-based efforts to advance SDOH-E needs in Lane County. These efforts include: the Lane County Poverty and Homelessness Board, the South Lane be Your Best Community Collaboration, All Hazards Sheltering Task Force, 100% Health Coalition, Early Learning Alliance Pediatric Advisory Council, Community Vaccination Collaborative, NAACP Health Committee, Lane Equity Coalition, and the Advocacy and Outreach Workers of Lane County.

In addition, Community Advisory Council (CAC) feedback is another channel of member and community feedback that informs this work. PCS – LN's Community Health Coordinator (CHC) serves as a liaison between the CAC and CIE planning team. When SDOH-E concerns arise in CAC meetings, the CHC brings this knowledge to our CIE planning to inform priority resources and communities.

Utilization of a CIE platform builds closed loop referral pathways between healthcare and many other sectors that affect SDOH-E. This project supports goals and strategies within the Lane County shared Community CHP to ensure community members are more easily able to connect with resources for things like food, housing, child care. As a broad group of community stakeholders of OHP members and member advocates identified specific actions, the development of an "information exchange for health and social service needs" emerged as a priority in the CHP - the implementation of a CIE platform supports all of these efforts with both healthcare providers and community-based organization (CBOs) having the option to join the network.

In 2020, PCS invested in the Unite Us CIE platform. In 2021, PCS joined the statewide Connect Oregon network, including onboarding to the Unite Us platform. This allowed PCS to expand its focus to address Social Determinants of Health-Equity (SDOH-E) at the community level by strengthening connections and collaboration between healthcare providers and CBOs that provide resources to our members. The network is available at no cost to CBOs. PCS invested in unlimited licenses for CCO contracted providers to join the network and platform. While the network is statewide, the network growth strategy is regional to allow for close work among local partners to develop a robust network. PCS – Lane, the LCHC, and Kaiser Permanente joined Unite Us to form the Local Network Implementation Advisory Board. Together, the Board developed an extensive list of local resources to invite to the platform and collaborate on outreach. In 2021, the Board identified 196 organizations; 50 have joined the network.

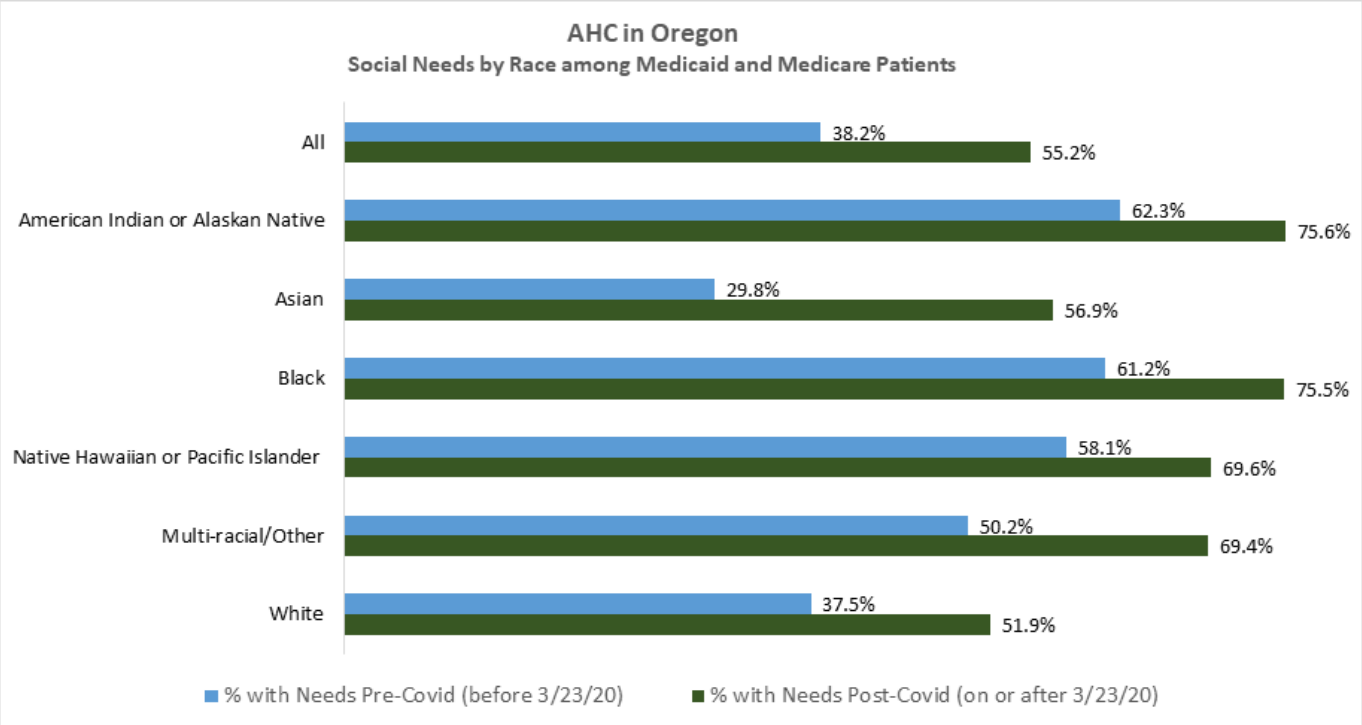
Pre-Onboarded Stages		
Lifecycle	**Definition**	**# orgs in region**
Cold Lead	Targeted organization in the pipeline with at least one contact. Typically, an organization that has never heard of Unite Us or the network.	**98**
Qualified Lead	Customer or community engagement priority organizations OR designated interest via form submission, email, or attendance at community events	**31**
Engaged	Organization is actively exploring adoption of the Unite Us Platform	**14**
Cultivated	Organization submits the Partner Registration Form	**1**
On Hold	Temporarily removed from the pipeline due to technical or operational constraints	**2**

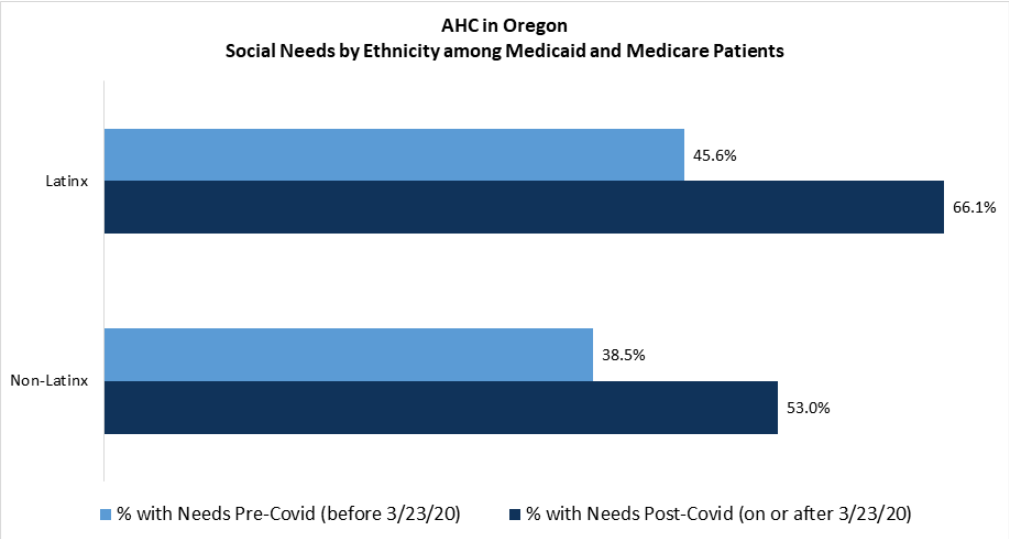
Post-Onboarded Stages		
Lifecycle	**Definition**	**# orgs in region**
Onboarded	Organization is live on the platform, but users have not yet sent and/or received a referral	**18**
Active	Organization has sent and/or received (and taken action on) at least one referral in the last three months	**27**
Dormant	Organization was previously Active but has not sent and/or received (and taken action on) at least one referral in the last three months	**5**
At Risk	Organization has open referrals and hasn't responded to outreach; ability to receive referrals has been turned off	**0**
Paused	Dormant or At Risk organization that has asked not to be contacted for a specific period of time	**0**
Inactive	Previously active organization cannot participate in the network and becomes fully inactive.	**0**

PCS continued its collaboration with the Oregon Rural Practice-based Research Network (ORPRN) and worked with Unite Us to integrate the CMS Accountable Health Communities (AHC) social needs assessment into the Unite Us platform. In addition, we invited AHC participating providers to join the network. In April 2021, PCS – LN Care Management (CM) teams received training and onboarded to Unite Us to begin conducting AHC screenings and referrals in the platform. PCS plans to begin accepting incoming referrals to the CM team on the Unite Us platform in 2022.

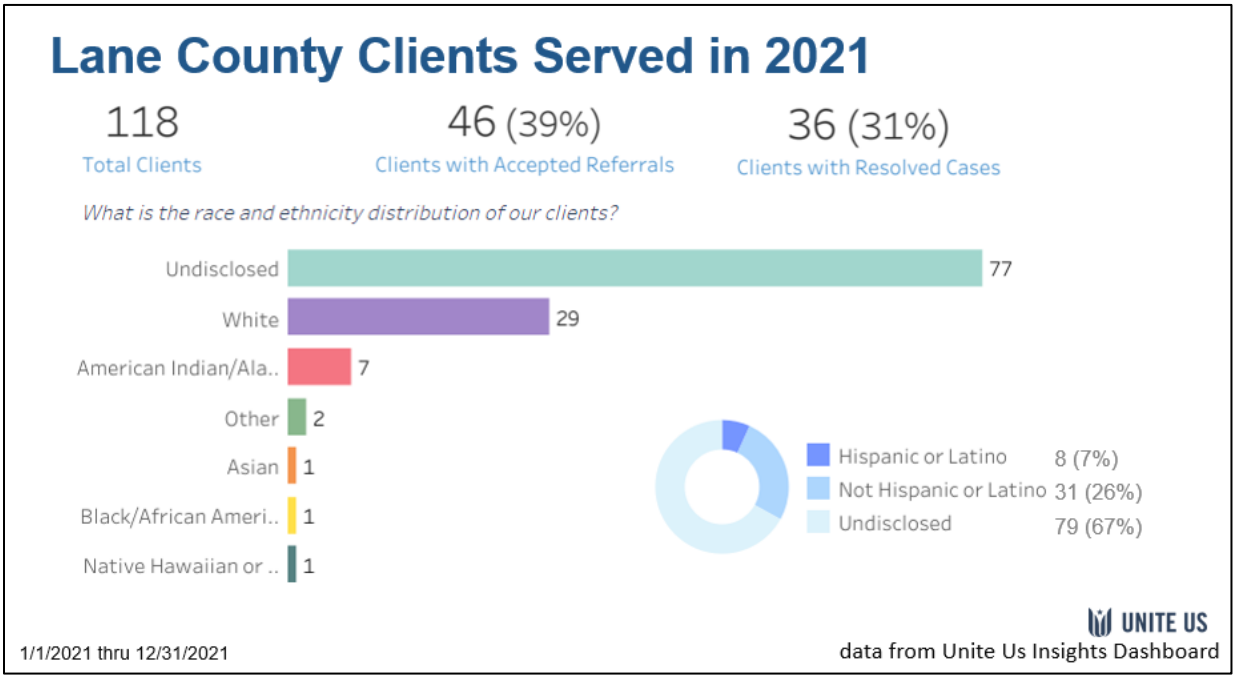
In addition, the PCS Flexible Services team joined the network to receive incoming referrals for flexible funds. Moving the process to the Unite Us platform allowed referrers to upload a completed form as a PDF attachment. This welcomed process enhancement eliminated the need to fax in referrals. It also allows for closed-loop referrals as the sender can see when a referral is accepted or rejected. Submitting via the Unite Us platform also allows the sender and Flexible Services Team to both track progress and outcomes to serve the needs of our members better. In 2022, PCS plans to enhance this process by embedding the flexible funds form in the platform. This would remove barriers by allowing senders to complete the form using fillable boxes rather than uploading a PDF.

The AHC project provides a statewide lens to see trends in health-related social need disparities to inform Health Equity: Cultural Responsiveness and SDOH-E planning across all of PCS's CCO regions. The AHC Study screened 25,000 Oregonians and provided several insights into Medicaid and Medicare members' unmet health-related social needs. Medicaid members' social needs have increased since the pandemic. Prior to the pandemic, 47.3% of Medicaid members reported social needs. Since the pandemic, that has increased to 62.6%. When combined, Medicaid and Medicare members also have higher percentages of social needs since the onset of the pandemic. Prior to the pandemic, 38.2% had an unmet social need, and since COVID-19, social needs have increased to 55.2%. Data also indicates that social needs have increased among all racial and ethnic groups, with a notable increase of 27.1% for Asian members, 20.5% for Latinx members, and 19.2% for Multi-racial and other Medicaid and Medicare member populations. Notably, all non-white racial groups have higher social needs rates compared to white Medicaid and Medicare members. Latinx members also have a higher rate of social needs compared to non-Latinx members. When digging further into social needs, Black, Indigenous, and People of Color (BIPOC) members reported houselessness at a rate of 7.5%, food insecurity at 50.9%, and transportation needs at 28.1% (see AHC data graphs below).





The social needs data speaks to how we can impact health inequities by addressing disparities for BIPOC individuals. It starts with accurate data collection of race, ethnicity, language, disability (REALD), and sexual orientation and gender identity (SOGI) data on the Unite Us platform, in addition to tracking clients served and responding to gaps by inviting organizations that specialize in supporting specific cultural or linguistic populations to join the network. In 2021, of the 118 Lane County community members supported via Connect Oregon, 65% (77) do not have their race and 67% (79) do not have their ethnicity captured in the platform. This missing data creates barriers to tracking inequities in access to services. An immediate need is to improve demographic data collection.



Given the current gap in demographic data, PCS - LN focused our 2021 Health Equity Cultural Responsiveness work on identifying community resources and providers that support specific cultural and linguistic groups and prioritizing these organizations for outreach and onboarding. This includes prioritization of resources that support individuals with communication and accessibility needs. PCS - LN then tracked referrals to and from these priority organizations. By

nature of their work, this likely increases the number of BIPOC community members served via the Connect Oregon network.

2021 was a strong year for initial network development. However, building a robust referral network is a multi-year effort. PCS - LN and the Local Network Implementation Advisory Board will build upon our 2021 successes in 2022 by inviting additional provider and CBO partners to join the network. The focus will also turn to the health of the existing network to track utilization of the network to screen and refer members to social need resources.

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

This TQS project is the same for most PSC' CCO regions except for region-specific data throughout the report and in the Monitoring Measures. However, the strategy for implementing this project in the PCS – Columbia Gorge CCO region varies slightly.

In 2021, PCS – LN made progress to meet our targets for network development and growth. Building the Connect Oregon network to better serve member's SDOH-E needs in the PCS – LN region was a collaborative effort with various community partners. In addition to the Local Implementation Advisory Board, Kaiser Permanente's Community-Clinic Integration Initiative (CCI) grantees guided this work. Grant recipients include: White Bird Clinic, Centro Latino Americano, Food for Lane County, and nine other CBOs from the Mid-Willamette Valley. In addition, the Lane Rural Advisory Committee (RAC), comprised of PCS - LN members and social service agencies, provided guidance to inform 2022 activities such as priority outreach in rural Lane County.

PCS – LN, Unite Us, and the LCHC hosted multiple intro and demo sessions to prospective Connect Oregon network partners. Effort kicked off in November 2020 at an LCHC Clinical Advisory Panel (CAP) meeting. We held the next event in December 2020 with key providers and CBOs. Interested organizations met with Unite Us individually or attended a more in-depth introduction and demo session. In November 2021, PCS – LN held its annual Community Conversation meeting where providers and community partners learned about key PCS - LN efforts, including Connect Oregon. Approximately 95 individuals attended.

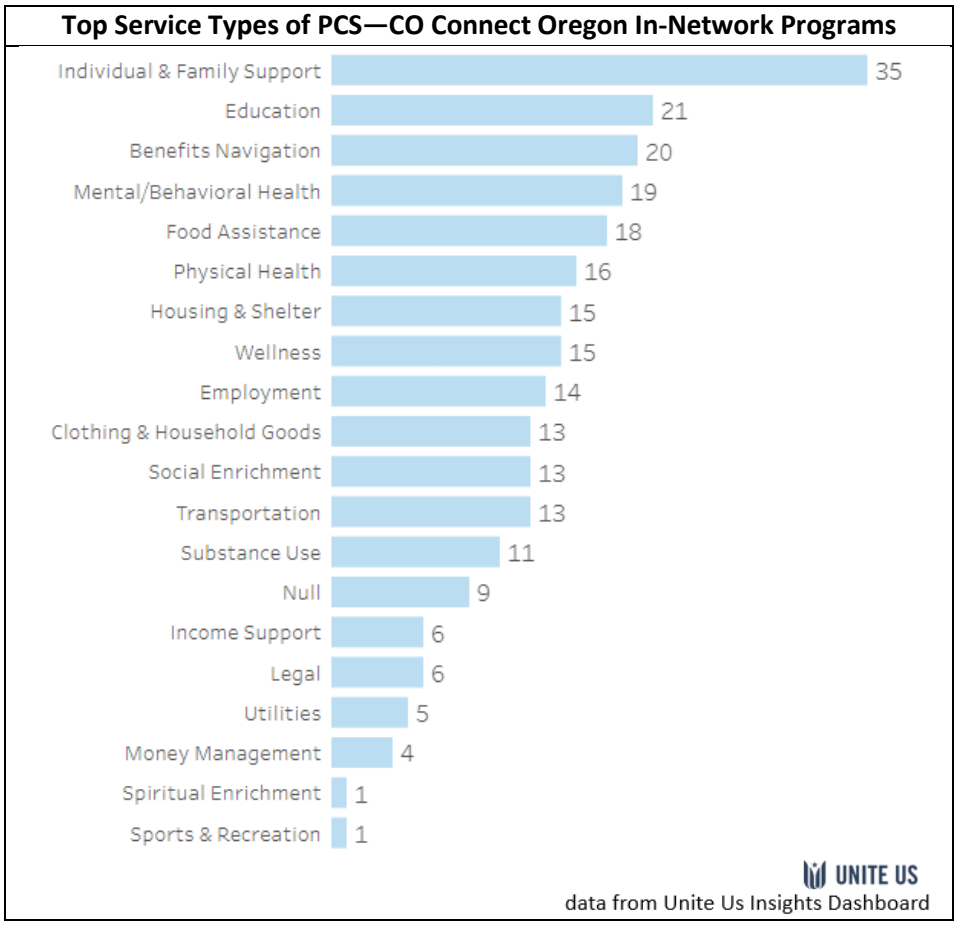
Unite Us, PCS - LN, and the LCHC also developed a list of priority contracted health care providers to join the network in wave one. This list consists of 29 key providers, including Federally Qualified Health Centers (FQHCs), other primary care providers, behavioral health providers, and Dental Care Organizations (DCOs).

PCS—LN Contract Health Care Provider Engagement Status		
Qualified Lead	Contact identified as a priority.	4
Engaged	Attended onboarding session, partner readiness, 1:1 exploratory session	10
Cultivated	Provider has submitted their Partner Registration Form.	0
Onboarded	Active	12
On hold	Pausing outreach; will resume at a future time.	3

In 2021, PCS – LN exceeded our target to onboard CBOs and made significant progress on our provider partner target. Sixteen PCS – LN providers and 34 CBOs have joined the Connect Oregon network. In 2021, the top sending providers included the PCS – LN CM team, Community Health Centers of Lane County, and FOOD for Lane County. The top receiving CBOs include White Bird Clinic, FOOD for Lane County, and The Arc of Lane County. In total, 120 individuals in Lane County received support through Connect Oregon, with 139 referrals sent on their behalf.

Measure	As of 12/31/2021	Goal By 12/31/21
CBOs in network	34	28
Healthcare provider groups in network	16	21

In addition to network growth, PCS - LN and Unite Us have been tracking network health. There are several key indicators to track. One is to look at the platform's diversity of social needs resources. When we look at the Connect Oregon in network program service types in the PCS – LN region, we see an opportunity to onboard more community resources in key social need sectors such as legal services and utility assistance. Prioritizing outreach to CBOs and other social needs providers will be a focal area in 2022.



In 2021, PCS - LN also focused efforts on Health Equity: Cultural Responsiveness by prioritizing network partners that serve the social needs of cultural and linguistic members, with priority on organizations that support the Latinx community. A Local Network Implementation Advisory group formed and included PCS – LN, the LCHC, Unite Us, and other key partners to develop a list of community partners to invite to join the network. Members of this advisory group held presentations and discussions with various community groups to seek their feedback on priority partners.

In 2020, two network partners in the PCS – LN region met these criteria, one specializing in supporting Latinx community members and one specializing in supporting Black/African American community members. In 2021, seven new organizations joined the network that supports populations with various cultural and linguistic needs, including those with a focus on supporting Latinx, transgender, and Black/African American community members. However, only eight referrals were sent or received from these nine organizations. This speaks to the need to better support network partners to utilize the platform.

Measure	As of 12/31/21	Goal By 12/31/21
# of Connect Oregon partners that support cultural and linguistic needs	9	N/A
# of referrals to/from organizations that support cultural and linguistic needs	8	20

E. **Brief narrative description**:

In 2022, PCS - LN will continue its SDOH-E efforts by inviting additional providers and CBO partners to join Connect Oregon. As we move into wave two of provider onboarding, PCS will also begin wider promotion of Connect Oregon with all eligible providers in our CCO regions while continuing high-touch engagement with key providers. PCS Provider Service and Population Health teams will promote Connect Oregon through multiple channels including site visits and provider training, and invite providers to attend a Unite Us Community Information Session. PCS - LN and Unite Us will also collaborate with community partners to provide five regional learning and engagement opportunities for providers and CBOs in 2022.

In addition to network growth, PCS - LN will also track and support current network partners. PCS - LN will also collaborate with Unite Us to invite partners to attend new user orientations, partner spotlight events, community of practice events and lunch-and-learns.

2022 Events for Prospective and Active Connect Oregon Partners			
Event Name	**Cadence**	**Regional or Statewide**	**Purpose**
Community Information Sessions	2x per month	Statewide	Interested partners learn more about Unite Us, the Connect Oregon network, and see a demo of the software.
New User Orientations	1x per month	Statewide	User Adoption: Help users to log in, become familiar with the platform and partners, and prepare for sending and receiving referrals.
Partner Spotlight Events	1-2 per year per region	Regional	Utilization: A networking event for regional partners to learn more about organizations actively seeking referrals on Connect Oregon.

Community of Practice	TBD	Statewide w/ regional breakouts	Utilization: A networking event for all Connect Oregon users to receive updates, get to know one another, and share stories and best practices.
Lunch-and-Learn	As needed	Statewide	Utilization: Specific focus area training sessions that address data driven opportunities for improving user and client success on Unite Us.

Health Equity: Cultural Responsiveness efforts will continue to focus on access and support for members with cultural and linguistic needs. PCS - LN will continue to prioritize onboarding organizations that support a specific cultural and linguistic population and track referrals to and from these organizations, with the aim of 50% of key cultural and linguistic supporting organizations to maintain active referral traffic by Q4 2022. We will track this data on a quarterly basis to identify opportunities for technical assistance and support.

Unite Us offers a health equity dashboard to track utilization by race, ethnicity, age, and gender. System enhancements are underway to add language as well. However, this dashboard is only as strong as the demographic data collected with member interactions. Currently, Connect Oregon only has 35% and 33% of Lane County's individuals' race and ethnicity data, respectively. Long term, PCS will explore the feasibility of developing internal dashboards to track referral activity by REALD and SOGI data. In the short term, PCS will focus on increasing PCS internal user demographic field fill rate to 50% by Q4 2022. Priority will be on completing race and ethnicity information while always maintaining the option for a member to decline.

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

Activity 1 description Social Determinants of Health & Equity: PCS - LN will continue to work with community partners to expand a regional CIE network of providers, CCO CM staff, local health departments, and CBOs. Connect Oregon will allow closed-loop referrals across sectors to meet the SDOH-E needs of CCO members.

☒ Short term or ☐ Long term

Monitoring measure 1.1	PCS will monitor CIE network growth of CBO and provider partners through the Connect Oregon dashboard and tableau reporting. By Q4 2022, PCS - LN and Unite Us will provide five regional learning sessions and onboard 10 additional CBOs and 10 additional providers.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
2021: 34 Lane CBOs and 16 providers are in the Connect Oregon network.	PCS - LN and Unite Us will collaborate with community partners to provide 5 regional learning and engagement opportunities in 2022.	12/2022	An additional 10 CBOs will join the network. An additional 10 providers will join the network	12/2022

Activity 2 description: **Health Equity: Cultural Responsiveness.** PCS - LN will identify community resources that support members with cultural and linguistic needs and invite them to join the Connect Oregon network. PCS - LN will monitor

the network utilization of these organizations by tracking referral traffic and offering technical assistance and support as needed.

☒ Short term or ☐ Long term

Monitoring measure 2.1	PCS will monitor onboarding and utilization of key cultural and linguistic supportive network partners through the Connect Oregon dashboard and tableau reporting. By Q4 2022, 50% of key cultural and linguistic supportive partners have maintained an active status in the network.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
9 Connect Oregon network partners in Lane County support a specific cultural and linguistic population. These organizations have sent or received eight referrals.	Establish additional partnerships with organizations that serve the social needs of cultural and linguistic members. Four additional organizations will join the network that support members' cultural and linguistic needs.	12/2022	Each quarter, PCS - LN will track the active referral status of key network partners that support members with cultural and/or linguistic needs. By Q4 2022, 50% of these identified organizations have maintained an active status in the network.	12/2022

Monitoring measure 2.2	PCS - LN will monitor PCS - LN internal user utilization through the Connect Oregon dashboard and tableau reporting. By Q4 2022, PCS - LN internal race and ethnicity fill rate will be 50%			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
The Unite Us platform has not captured Race data for 65% of clients served in the PCS – LN region. The platform has not captured Ethnicity data for 67% of clients. PCS - LN internal field fill rate: Race—25% Ethnicity—23%	PCS - LN will track the race and ethnicity field fill rate quarterly for PCS - LN internal users and offer technical assistance and support as needed.	12/2022	PCS - LN internal race and ethnicity field fill rate will increase to 50% by Q4 2022.	12/2022

A. **Project short title**: Project 8: Assessing and Impacting Social Isolation for Members with Special Health Care Needs

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

If continued, insert unique project ID from OHA: N/A

B. **Components addressed**

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

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

In PacificSource Community Solutions – Lane (PCS – LN) CCO, 31.4% of our membership (24,129 members) meet the criteria for having Special Health Care Needs (SHCN). The PCS Care Management (CM) team offers all members with SHCN a health risk assessment (HRA) at several intervals in the continuum of care coordination. All members with SHCN receive multiple opportunities to complete HRAs within the first 90 days of their enrollment on the Dual Eligible Special Needs Plan (D-SNP) and after triggering events, which are indicators of health status changes. The HRA, while optional for members to complete, identifies existing physical, behavioral, oral, and social needs. The responses members provide in their HRAs inform the development of the Individualized Care Plan (ICP). PCS CM teams develop each member's ICP through collaboration with their Individualized Care Team (ICT). ICT participants will vary according to a member's specific needs and may include external participants such as specialty providers and community service providers, in addition to PCS CM teams, the member, and any other individual the member would like to be involved in their care. The ICT aims to improve member care through ongoing coordination across systems, levels, settings, and episodes of care. This includes scheduling Interdisciplinary Team (IDT) meetings and routine revisions to the care plan.

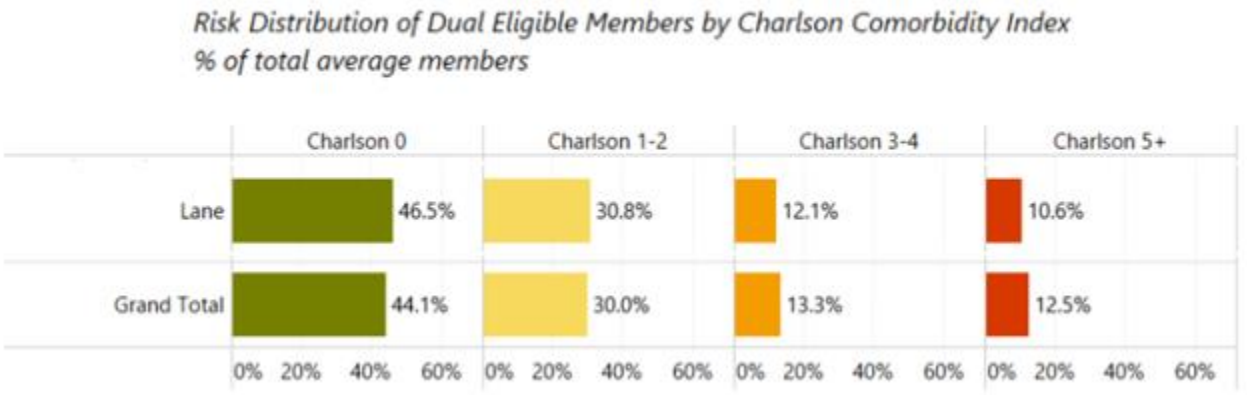
In 2020 and 2021, PCS conducted a population health assessment on its Full Benefit Dual Eligible (FBDE) members to prepare for the new 2022 D-SNP. We anticipated that our existing FBDE members would enroll in our new D-SNP; therefore, the curated data from our population health assessment helped inform our Model of Care (MOC) by providing visibility to the unique needs and characteristics of our FBDE members. This population health assessment described our SHCN-FBDE members' unique needs through demographics, condition prevalence, care gaps, and healthcare utilization patterns. Our average FBDE member is 65 years old, living with at least one chronic health condition, is more likely to have a disability or behavioral health condition, and has more emergency department (ED) visits. Overall, our findings support the need to develop unique strategies to improve health outcomes among this vulnerable population.

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

This TQS project is the same for all PCS' CCO Dual-Care regions, except for region-specific data throughout the report.

The majority of FBDE members aged 65 and older live with one or more chronic conditions and their health-related risks continue to increase with age. The Charlson Comorbidity Index (CCI) is a summary measure that uses age and 19 chronic comorbidities to predict members' mortality risk in 12 months. Higher CCI scores indicate members have more chronic

conditions and higher resource needs. When comparing the distribution of the FBDE Medicare population to the non-dual eligible Medicare population, we found that FBDE members are about 70% more likely to fall into the highest category of a CCI, scoring five or higher. We use CCI scores to improve the quality of members' care coordination by understanding each SHCN member's unique medical complexities and risk factors.



The CCI quantifies the most prevalent conditions affecting PCS FBDE members. Conditions with the highest prevalence rates among our FBDE members include depression, diabetes or pre-diabetes, severe and persistent mental illness (SPMI), asthma, chronic obstructive pulmonary disease, substance use, coronary artery disease, congestive heart failure, and chronic kidney disease. Furthermore, one in two FBDE members managing a chronic condition will also struggle with depression, serious and persistent mental illness (SPMI), or a substance use disorder. Analysis of CCI scores and condition prevalence demonstrates greater medical complexity of and care coordination needs for our FBDE SHCN members.

Average Condition Prevalence of Dual Eligible PacificSource Medicaid or Medicare by Region

	Central Oregon - Crook, Deschutes, Jefferson, Klamath	Columbia Gorge - Hood River & Wasco	Lane
Depression	27.4%	9.6%	15.5%
Diabetes	10.3%	4.2%	5.9%
Severe and Persistent Mental Illness (SPMI)	9.1%	3.6%	6.2%
SPMI Not Including Depression	4.8%	2.4%	4.0%
Pre-Diabetes	7.9%	1.9%	2.0%
Asthma	3.1%	0.8%	2.4%
Chronic Obstructive Pulmonary Disease	3.3%	1.1%	1.4%
Substance Abuse	3.3%	1.0%	1.4%
Coronary Artery Disease	2.3%	1.4%	0.8%
Congestive Heart Failure	2.4%	1.2%	1.2%
Chronic Kidney Disease	1.9%	0.6%	1.2%

A systematic literature review illustrated associations between loneliness and many prevalent chronic conditions in PCS FBDE members. Loneliness significantly increased older adults' odds of death from cardiovascular-related problems and was cited as one of the ten most predominant characteristics in adults with coronary artery disease.[4] The study further

[4] Petitte, Trisha et al. "A Systematic Review of Loneliness and Common Chronic Physical Conditions in Adults." The open psychology journal vol. 8,Suppl 2 (2015): 113-132. doi:10.2174/1874350101508010113

states that some chronic diseases also increase the risk for loneliness, namely peripheral vascular disease, heart disease, lung disease, and arthritis. Finally, older adults who experience loneliness have significantly higher rates of hypertension; greater diastolic blood pressure reactivity when experiencing stress, face doubled odds of mortality from circulatory system ailments, and increased frequency of dyspnea after heart failure.[5]

Social determinants of health (SDOH) such as income, education, employment, community, safety, and other family and social supports influence a member's daily life, influencing overall health and wellbeing. Whether perceived or actual, loneliness has recently emerged as a recognized SDOH. Research published by the National Academies of Sciences (2020) shows that older adults are more likely to experience loneliness and social isolation, increasing their risk of detrimental health outcomes.[6] Social isolation and loneliness affect the health and quality of life of adults who are 50 and older, particularly among those who identify as being low-income, underserved, and vulnerable. Several research studies evidence a significant association between loneliness and frequency of hospital visits, establishing loneliness as a meaningful predictor of ED utilization.[7] Furthermore, social isolation and loneliness are risk factors for depression and may exacerbate pre-existing comorbidity-related challenges.[8] Finally, social isolation increases the risk for functional decline and mortality on a par with factors such as smoking, obesity, and lack of physical activity.[9] Targeting loneliness in CM interventions may be preventative for our FBDE members who are 65 and older living with multiple chronic health conditions.

According to the National Institute on Aging, lonely older adults are, on average, less healthy, with more frequent hospital admissions and longer inpatient stays.[10] This aligns with our population health assessment findings where, comparatively, FBDE members' ED visits and inpatient admissions are more than double than that of our non-dual membership. In addition to the higher number of inpatient admissions amongst FBDE members, the rate of plan all-cause readmissions (as measured using HEDIS specifications) is consistently higher than that of non-dual eligible members. There is a significant association between loneliness and ED visits, hospital readmissions, and longer inpatient stays. Therefore, loneliness is a meaningful predictor of future ED utilization. CM strategies targeting loneliness for FBDE SHCN members may be an effective preventative measure to reduce ED visits, length of inpatient stays, and the likelihood of readmissions.

[5] Petitte, Trisha et al. "A Systematic Review of Loneliness and Common Chronic Physical Conditions in Adults." The open psychology journal vol. 8,Suppl 2 (2015): 113-132. doi:10.2174/1874350101508010113

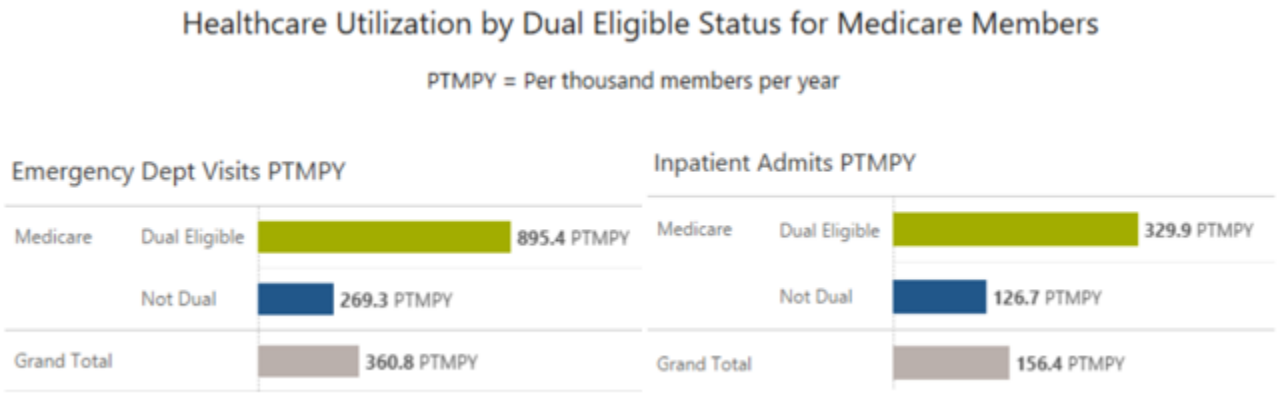
[6] "Social isolation and loneliness in older adults; opportunities for the health care system," *The National Academies Press,* https://doi.org/10.17226/25663.

[7] Geller J, Janson P, McGovern E, Valdini A. Loneliness as a predictor of hospital emergency department use. *The Journal of family practice*. 1999;48(10):801-4.

[8] Cacioppo, J. T., Hawkley, L. C., & Thisted, R. A. (2010). Perceived social isolation makes me sad: 5-year cross-lagged analyses of loneliness and depressive symptomatology in the Chicago Health, Aging, and Social Relations Study. Psychology and Aging, 25(2), 453–463. https://doi.org/10.1037/a0017216

[9] Amy Freedman, Jennifer Nicolle, "Social Isolation and Loneliness: the New Geriatric Giants: Approach for Primary Care," *PubMed* 66 (2020): 176-182, https://pubmed.ncbi.nlm.nih.gov/32165464/

[10] "Social isolation, loneliness in older people pose health risks," National Institute on Aging, April 2019, https://www.nia.nih.gov/news/social-isolation-loneliness-older-people-pose-health-risks



COVID-19 may have intensified the effects and magnitude of pre-existing social isolation, disconnectedness, and associated mental health issues. Across all age groups, the protective measures and recommendations designed to prevent COVID-19 all incorporate varying degrees of social distancing and isolation. Older adults are aware that they face greater morbidity and mortality risk from COVID-19. This heightened awareness may make older adults more diligent and vigilant about protective measures against the virus, which simultaneously further limits social interactions and connectivity. This heightened distress associated with COVID-19 emphasized the need for innovative approaches to increase social support for older adults with SHCN.

E. **Brief narrative description**:

This project will serve the FBDE SHCN population, specifically targeting members who are 65 and older with CCI scores of two or above, with active enrollment in PacificSource Dual Care (D-SNP) plans. PCS will establish a baseline measurement of ED utilization for FBDE SHCN members using data collected within our Hospital Event Notification (HEN) system in 2021. CM teams will use the HEN system to monitor monthly ED utilization for all D-SNP members with SHCN. PCS will assign our D-SNP members with SHCN into comparison cohorts by the type of intervention they receive. Members who enroll and engage with CM and Papa Pals will form Cohort A. PCS will assign members who do not engage in Papa Pals in Cohort B. Establishing intervention-based cohorts will facilitate ongoing monitoring and evaluation for the purposes of this TQS.

CM teams will use members' CCI scores as an indicator of risk to drive care coordination quality improvement through early intervention. CM teams will stratify all D-SNP members with SHCN using CCI scores, systematically prioritizing members with the highest CCI scores for immediate intervention. CM teams will initiate outreach to members to facilitate their completion of HRAs, create ICTs, develop ICPs, and encourage enrollment with Papa Pals. CM teams provide all D-SNP members with SHCN individualized support, tailoring ICP interventions to their unique health goals and care preferences. CM will track and monitor completion of the ICP for all D-SNP members with SHCN and are ultimately responsible for coordinating members' benefits, monitoring progress toward goals, and maintaining records within our database for reporting purposes.

For members who engage with PCS CM teams, we may deploy a combination of intervention strategies, including referral(s) to physical or mental health providers, education on disease process, strengthening communication between healthcare providers, increasing support during periods of care transitions, and facilitating enrollment with Papa Pals. Papa Pals provides curated companion support to members, including reminders for healthcare appointments, essential transportation, safety checks, reminders about care gaps or treatment recommendations, companionship or group activities, and assistance with Instrumental Activities of Daily Living (IADL). A recent Papa Pals study shows that 69% of participants who participated in the program felt less lonely post-intervention and 39% reported not feeling lonely at

all.[11] All D-SNP members with SHCN will receive education from PCS on the Papa Pals program via telephonic outreach and mailings. CM will encourage members to enroll with Papa Pals and offer support navigating the enrollment process. To ensure members receive care aligned with their personal preferences, visits with Papa Pals may occur virtually or in person. Papa Pals screen members for loneliness at multiple intervals using the UCLA 3-item loneliness scale. CM will monitor members' scores on the loneliness assessment to track changes in self-reported isolation and social connectedness.

PCS will track and monitor care plan completion, loneliness assessment scores, Papa Pal visits, and ED utilization for members who engage in CM and enroll with Papa Pals (Cohort A). For members who do not enroll with Papa Pals (Cohort B), PCS will track and monitor care plan completion and ED utilization. PCS will use the data collected for each cohort to compare interventions and evaluate the overall effectiveness of the CM and Papa Pals intervention in reducing ED utilization for D-SNP members with SHCN.

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

Activity 1 description: Identify all D-SNP members with SHCN and establish a baseline measurement of 2021 ED utilization. Create comparison cohorts segmenting members who enroll with Papa Pals from those who do not. Monitor and track 2022 ED utilization for both cohorts to determine the effect of loneliness interventions on overall ED utilization.

☒ Short term or ☐ Long term

Monitoring measure 1.1	Establish a baseline measurement of estimated ED utilization for D-SNP members with SHCN using 2021 FBDE SHCN member data. Decrease overall ED utilization for D-SNP SHCN members by ≥2%.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
PCS does not have a baseline measurement of ED utilization for D-SNP SHCN members.	Establish an estimated baseline measurement of ED utilization for D-SNP SHCN members using 2021 FBDE SHCN member data.	06/2022	Track the total ED visits by month for 100% of D-SNP members. Target ≥2% reduction in ED utilization compared to the 2021 baseline year.	12/2022
Monitoring measure 1.2	Establish cohorts within Collective to compare the efficacy of loneliness interventions in reducing ED utilization. Monitor member ED utilization on a monthly basis.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
PCS does not monitor members' ED utilization segmented by Papa Pals enrollment status.	Establish comparison cohorts in Collective for D-SNP SHCN members. Segment member cohorts by Papa	12/2022	Monitor cohorts in Collective for D-SNP SHCN members monthly to determine intervention efficacy.	12/2022

[11] "Combating Senior Loneliness and Social Isolation," Papa, July 2021, https://global-uploads.webflow.com/5a6e91077bd20a0001852e86/61708b3a5d7d7223002097f2_Papa_2.pdf

	Pals enrollment status to compare intervention effects on ED utilization.			

Activity 2 description: PCS Care Managers will facilitate member enrollment and engagement with Papa Pals. Increase member enrollment with Papa Pals by 1% each quarter. Members who enroll and engage with Papa Pals receive loneliness assessments at several intervals. Increase loneliness assessment completion by 1% each quarter. Track 100% of loneliness assessment scores and monitor scores for changes in members' self-reported loneliness.

☒ Short term or ☐ Long term

Monitoring measure 2.1	100% of D-SNP SHCN members will receive opportunities to enroll with Papa Pals. Prioritize Papa Pals referrals for members with CCI scores of 2 or more. Track all member enrollments with Papa Pals, targeting a 1% enrollment increase each quarter. Track loneliness scale assessment scores to monitor changes in self-reported loneliness.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No D-SNP SHCN members have enrolled with Papa Pals.	Increase member enrollment with Papa Pals, prioritizing referrals for high-risk members using CCI scores.	12/2022	Track member enrollment with Papa Pals. Increase member enrollment with Papa Pals by at least 1% per quarter.	12/2022
Monitoring measure 2.2	Track UCLA Loneliness Scale assessment scores to monitor improvements in self-reported loneliness or changes in health outcomes for members who enroll and engage with Papa Pals. Monitor assessment scores for changes in self-reported loneliness.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
PCS does not screen D-SNP members with SHCN for loneliness. No members have completed the UCLA Loneliness Scale assessment.	Monitor member completion of the UCLA Loneliness Scale and establish a baseline.	12/2022	Track the total number of members who complete the UCLA Loneliness Scale. CM will monitor 100% of member assessment scores for changes in members' self-reported loneliness.	12/2022

Activity 3 description: Improve health outcomes for D-SNP members with SHCN through CM interventions. All D-SNP members with SHCN will receive an ICP. Monitor and track visit information for 100% of members who enroll with Papa Pals. Compare and evaluate intervention efficacy in reducing members' ED utilization.

☐ Short term or ☒ Long term

Monitoring measure 3.1	Monitor and track member visits with Papa Pals and CM care plans to evaluate the efficacy of loneliness interventions on reducing ED admissions.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Members who do not engage in CM do not receive an ICP.	100% of D-SNP members with SHCN will receive an ICP.	12/2022	Track the ICP completion for 100% of D-SNP members with SHCN.	12/2022
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
Papa Pals is a new benefit in 2022; therefore, visit information is not available.	PCS will track and monitor all Papa Pals visit information.	12/2022	CM will track the total number of visits and intervention information for 100% of members who enroll with Papa Pals.	12/2022

A. **Project short title**: Project 9: Improving Health Outcomes of Chronically Unhoused Members with Diabetes

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

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

B. **Components addressed**

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

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

Currently, the PacificSource Community Solutions (PCS) Care Management (CM) team provides outreach to all members that meet the definition of having Special Health Care Needs (SHCN) and again when a retriggering event takes place. In the PCS Lane CCO (PCS – LN), 31.4% of our membership (24,129 members) meet the criteria for SHCN.

In addition to outreach, we also receive referrals from members themselves, providers, and community partners. When the PCS CM team of Member Support Specialists and Clinicians works with a member, it screens for Social Determinants of Health (SDOH) and chronic conditions. When we identify a member experiencing homelessness, our workflows include referrals through the Connect Oregon platform to local housing agencies, follow-up with any community partner that the team may be working with on housing, and scheduling of interdisciplinary team meetings (IDTs) to bring providers and SDOH staff together to create a shared care plan for the member. We frequently utilize Flexible Funding to support members with housing and other SDOH needs.

For members with SHCN who elect to engage in CM services, we provide a full health assessment, development of a care plan, and goal setting, and we work with both the member and providers to ensure comprehensive and coordinated care across all systems. This includes scheduling IDT meetings and routine revisions to the care plan. For members who do not participate in telephonic Care Management, we continue to coordinate and collaborate with the member's current providers (primary care, specialists, behavioral health, and acute care settings) to ensure access, facilitate transitions, and strategize means of supporting the member through direct providers.

PCS Care Coordinators provide clinical support and advocacy to our members with complex needs, with a focus on members with SHCN. They help to reduce SDOH and address barriers to care. Typically, they work as a team of a Clinician and a Member Support Specialist, creating an individualized plan of care for each member through assessments and conversations with the member and their broader healthcare team. These Care Coordination Teams collaborate with community providers and partners to assist in coordinating appropriate and timely care for our members while keeping the members' health needs at the forefront. PCS works with an interactive voice system vendor ("Eliza") to conduct initial outreach to all of our prioritized population members, which includes all members identified as having SHCN. If a member agrees to engage, Eliza will provide a warm transfer to the Medicaid Care Management team, offer to leave a message for a callback, or offer Intensive Care Coordination services.

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

This TQS project is the same for all PCS' CCO regions, except for region-specific data throughout the report.

Homelessness in the United States is a critical challenge for healthcare systems in promoting basic health and well-being. Despite progress in reducing the number of homeless persons in the US, there has been a steady increase in homeless persons across the US since 2016, with an estimated 580,466 people experiencing homelessness in America.[12] Oregon's homeless population lies in stark contrast with a much higher percentage of homeless persons than states on the East Coast and Midwest, according to the National Alliance to End Homelessness. The US Department of Housing and Urban Development's (HUD) Annual Homeless Assessment Report (AHAR), a report providing estimates of the nation's homeless population, estimated 14,655 Oregonians experienced homelessness (35 in every 10,000 people) in 2020. Of this overall population, a subset of 4,339 individuals identified as "chronically homeless."[13] Chronic homelessness describes persons who have experienced homelessness for at least a year or repeated homelessness while also experiencing a disabling condition such as substance use disorder, serious mental illness, or disabling physical condition.

In addition to barriers and burdens caused by homelessness (e.g., food insecurity, safety issues, transportation, poverty), many homeless persons also contend with chronic health conditions and the inability to access routine health care and consequently rely upon emergency room care to treat both complex and routine medical issues. Access and routine care are more complex for those living with severe mental health-related conditions (e.g., bipolar disorder or schizophrenia, for example) as these persons grapple both with health-related issues and often untreated and persistent symptoms of mental illness. Persons with serious mental illness, or those meeting criteria for Severe and Persistent Mental Illness (SPMI), have been overrepresented in Oregon's homeless population, making up an estimated 14% of the homeless population in Oregon in 2017, with many of those representing the Chronically Homeless.[14]

Through the CCO 2.0 focus on members with SHCN and challenges from the COVID-19 pandemic, PCS CM teams have found that SPMI coupled with homelessness are the primary drivers in our most complex cases. Our teams have found that members experiencing both SPMI and homelessness are less likely to engage in CM, are more likely to lack access to technology, and have unique needs and barriers related to managing their chronic conditions. One specific population that has been particularly challenging to engage is members with poorly controlled diabetes who are also experiencing homelessness. Our CM teams have observed unhoused members with diabetes who have had significant negative outcomes, including amputations, permanent disability, and death while living on the streets. The stories of these member experiences sparked our passion for improving how we take care of one of our most vulnerable and at-risk member populations. Knowing which members are homeless is a particular challenge as our data has been limited primarily to claims-based Z codes, which providers use inconsistently in documentation.

In traditional health care settings, patients with diabetes are encouraged to assume a more dominant role in the self-management of the disease. They learn practical means of managing their conditions such as diet, exercise, monitoring blood glucose, and the administration of medications or insulin.[15] However, those experiencing chronic homelessness face obstacles in self-management not commonly experienced by housed persons with the same condition. This includes other SDOH such as lack of social and familial support, inability to store medications safely and securely, and food instability which can adversely affect a person's ability to adhere to treatment plans (e.g., eating a nutrient-rich diet, exercise, adequate sleep, daily blood glucose testing and self-administration of medications). As noted, rates of persons identified as chronically homeless are high across most of Oregon. Determining how many members experience both homelessness and poorly controlled diabetes in our CCOs has been difficult. However, one of the OHA Quality Incentive

[12] National Alliance to End Homelessness, "State of Homelessness: 2021 Edition," National Alliance to End Homelessness, accessed January 10, 2022, https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness-2021/.
[13] Meghan Henry et al., "The 2020 Annual Homeless Assessment Report (AHAR) to Congress. Part 1: Point-in-time estimates of homelessness," The US Department of Housing and Urban Development, Office of Community Planning and Development, accessed on January 10, 2022, https://www.huduser.gov/portal/sites/default/files/pdf/2020-AHAR-Part-1.pdf (2021).
[14] Megan Bolton, "2017 Point-in-Time estimates of Homelessness in Oregon," Oregon Housing and Community Services, (2017): 1-6, https://www.nhipdata.org/local/upload/file/2017-Point-in-Time-Estimates-Homelessness-Oregon.pdf.
[15] Janice Constance & Joanne Lusher, "Diabetes Management Interventions for Homeless Adults: A Systematic Review," *International Journal of Public* Health 65, no. 9 (2020): 1773-1783, accessed November 7, 2021, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7716851/.

Metrics (QIMs) provides data regarding diabetes control in our CCO regions, which helps to inform the importance of working with this specific population. The *2020 CCO Metrics Performance Report*, published in October 2021 by the Oregon Health Authority, indicates that for the PCS – LN CCO, 23.7% of members aged 18-75 with diabetes had an A1C score <9.0% during the measurement period.

Identification of members who meet the criteria for SPMI is readily available. As of Q3 2021, the number of members (including children and adults) who meet the criteria for SPMI was 9,695 members within the PCS – LN CCO.

Challenges exist in the identification of CCO members who are chronically homeless and experience SMPI conditions. In 2021, PCS worked closely with Collective Medical Technology (CMT) to add a flag in charts for members listed with the Homeless Management Information Systems (HMIS), which is used to collect and track data related to people experiencing homelessness. The PCS – LN CCO now has access to this flag in CMT to identify members experiencing homelessness; however, due to challenges related to COVID vaccine prioritization, this flag has not been activated statewide. PCS has also worked to integrate additional data streams into internal algorithms to help flag whether a member has any indicators of housing insecurity, including data from member addresses, Connect Oregon data, and Z-coded claims.

E. **Brief narrative description**:

The target cohort for intervention is chronically homeless CCO members who fall into the SPMI prioritized population and have an A1C score above 9%. However, due to the limited availability of specific member-level data that indicates whether a member is chronically unhoused, we may expand the population to members with an indicator of housing insecurity and a condition grouper flag for diabetes. The first year of this project will include building a comprehensive plan, including developing tools for potential screening and data collection of eligible CCO members (those who have indicators of housing insecurity and diabetes), in partnership with Patient-Centered Primary Care Home (PCPCH) clinics per CCO region. Data collection efforts may include screening tools, member outreach, and care coordination to determine whether a member is experiencing chronic homelessness, uncontrolled diabetes, and SPMI. In future years of project implementation, we plan to marry this data with REALD and SOGI data to further track trends and development interventions to reduce health disparities. PCS will use this information to enhance person-centered interventions to improve health outcomes and well-being.

We also intend to collaborate internally and externally with our partners to capture necessary data. We will focus our efforts on those CCO members accessing primary care services within a PCPCH setting and known to the medical programs as experiencing homelessness. We will build relationships with PCPCH providers as part of this project implementation, and we will work with the PCPCH to align staffing, survey available resources within the PCPCH and CCO regions, and survey staff to explore the needs and challenges within each region.

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

Activity 1 description: Our initial effort will be to build partnerships within our service regions. PCS will focus on identifying PCP clinics that support the chronically unhoused population. We will work together to identify members and build workflows to ensure proper utilization of services and ensure members are well wrapped in care coordination to address their SDOH needs as well as coordinate their healthcare needs.

☐ Short term or ☒ Long term

Monitoring measure 1.1	Establish partnerships with stakeholders, referrals, and workflow processes.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
PCS is not currently coordinating with PCPCH stakeholders who support the	PCS will identify at least one clinic stakeholder serving the unhoused	06/2022	PCS and clinic will establish a fully formed partnership with defined project	12/2022

unhoused population.	population and establish a partnership.		roles, regularly scheduled meetings, and a plan for 2023.	
PCS has no identified referral and workflow process between CCO and PCP clinics.	Establish a comprehensive plan, referral process, and workflows for implementation.	12/2022	PCS will have fully implemented referral and workflow processes in place with PCP clinics.	12/2023
No staffing plan for PCS or PCP clinics to implement the project exists.	Identify one person per CCO and PCP clinic as the primary coordinator for implementation.	6/2022	Both PCS and PCP clinics will have identified staff engaged in project implementation.	12/2022

Activity 2 description: This activity intends to develop data streams that will allow us to identify chronically unhoused members as well as monitor their utilization and medication adherence. Understanding who our chronically unhoused population is and pairing that with a medication adherence baseline and ED utilization baseline among the chronically unhoused population will allow us to implement focused interventions in 2023 to improve members' health outcomes. Identifying this population is difficult due to the complexity and barriers experienced by the chronically unhoused, so it is vital PCS builds the data infrastructure needed to monitor this population. Reliable data will allow us to better facilitate referrals to a PCP and reduce the inappropriate use of the ED for unmanaged diabetes through improved care coordination. We will utilize HIE tools, including the Collective Medical Platform, as well as claims data to complete these activities.

☐ Short term or ☒ Long term

Monitoring measure 2.1	Develop a process for data collection and a mechanism to report population data.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
PCS has internal algorithms to determine if a CCO member has housing insecurity and a diagnosis of diabetes, but we have not developed utilization reporting on these members.	Develop reporting for internal teams to better understand and assess the needs and utilization patterns of members with housing insecurity, SPMI, and diabetes.	12/2022	Develop reporting for internal teams to better understand and assess the needs and utilization patterns of members with housing insecurity, SPMI, and diabetes.	12/2022
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
PCS has no identified process for tracking claims data to monitor medication adherence for unhoused members or members with housing insecurity.	Develop reporting to identify utilization data for unhoused or members with housing insecurity, including medication adherence and	12/2022	Fully implement a reporting system to track claims data in conjunction with homelessness and housing insecurity algorithms; ability to	12/2023

	engagement in primary care.		monitor medication adherence.	
Baseline or current state	**Target/future state**	**Target met by (12/2022)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
PCS does not currently have a process to cross-reference both housing status and ED utilization baseline data.	Develop reporting method to evaluate baseline ED utilization for unhoused members; baseline established.	12/2022	Fully implement reporting systems that will allow us to cross-reference baseline ED utilization and track over time.	12/2023

A. **Project short title**: Project 10: Implementation of the Medicaid Efficiency and Performance Program: Asthma Episode of Care

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

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

B. **Components addressed**

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

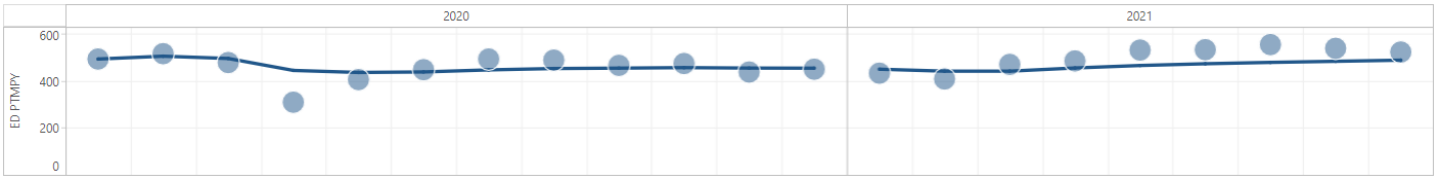
C. **Component prior year assessment:** Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

The PacificSource Community Solutions (PCS) Utilization Review (UR) Program is an integrated and comprehensive system that evaluates the medical necessity, appropriateness, and efficacy of health care services, whether physical, behavioral health, or oral health-related. The UR Program reviews requests for care and services according to PacificSource approved or endorsed policies and procedures and the member's health benefits, in compliance with federal and state regulatory agencies and industry accrediting standards.

PCS uses multiple methods to detect over- and under-utilization of services, including analyzing experience reports and dashboards, convening committees for review, analyzing appeals and grievances, and analyzing UR Program data. PCS reviews reporting in several forums, including the Health Council and through an internal Cost of Care Committee, which includes our Medical Directors and line of business vice presidents. In addition, PCS reviews under- and over-utilization through various quality committees with external providers. Our CCO Quality Incentive Measure (QIM) Team also monitors for over- and under-utilization of services by evaluating monthly utilization data and target graphs to determine where to focus provider outreach. Lastly, each year, the Medicaid Medical Director and representatives from critical departments meet to review data from the previous year regarding utilization, costs, and decision status. This data helps to inform which services should require a preapproval.

One area of focus for the UR Program is Emergency Department (ED) utilization over time. As shown in the excerpt from the ED Utilization Dashboard below, the PCS-Lane (LN) region began to see an upward trend in ED utilization in 2021, following the rapid decline during the onset of the COVID-19 pandemic. As a result of this data, we worked with our regional provider partners to collaboratively address access to care concerns that may have increased the likelihood of our members seeking care in the ED. This is one example of how PCS leverages internal analytics tools to affect utilization.

PCS – LN ED Visit Count Per Thousand Members Per Year (PTMPY)
Line: Rolling 12 mo. rate; Circle: Point-in-time rate



In addition to PCS' ongoing utilization monitoring, in 2020 the Oregon Health Authority (OHA) challenged CCOs to leverage the Medicaid Efficiency and Performance Program (MEPP) tool to identify actionable opportunity areas to implement meaningful interventions. In that year, OHA selected three episodes as recommended initial focus areas: Asthma, Diabetes, and Substance Use Disorder (SUD). Analyzing areas of over and underutilization, in addition to episode of care costs available in the MEPP tool including variation in Adverse Actionable Event (AAE) costs, guided our MEPP team in developing interventions to positively impact health outcomes and reduce avoidable health care utilization (including ED utilization) over time. PCS implemented a MEPP focused on asthma with an action plan submitted in 2020 and interventions spanning 2020-2021. PCS is discontinuing this MEPP project in 2022 as we designed short-term interventions, including a one-time educational mailing campaign for members with asthma (please see attachment nine (ATTM 9) for the complete final MEPP closeout report).

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

This TQS project is the same for all PCS' CCO regions, except for region-specific data throughout the report.

For 2022, the PCS MEPP Steering Group convened to explore the data available in the MEPP dashboard, including AAE costs by episode of care, episode subtypes, procedure codes, Diagnosis Related Group (DRG) codes, and diagnoses codes. After reviewing the data, PCS adopted asthma as one of three of its episodes of focus. The Steering Group chose this episode of care based on its significant contributions to state-wide costs, broad impacts on Oregon's population, and alignment with state policies. To improve quality and episode of care costs, PCS will continue to engage internal workgroups for this episode type to oversee and implement action plans for intervention strategies specific to this chronic condition. MEPP workgroups include Medical Directors, Clinical Quality Coordinators, Healthcare Data Analysts, and subject matter experts (SMEs) related to each episode.

The MEPP: Asthma Workgroup examined the available MEPP Dashboards for meaningful insights to inform the overall implementation strategy outlined in the 2022 MEPP Project Proposal for PCS- LN. The following information provides a subset of the reviewed data elements.

PCS-LN MEPP Dashboard Excerpt
CCO Dashboard CY18-20, Episode Drilldown Dashboard (accessed 1/26/2022)

Episode Description
(Click to Filter)

Episo..	Typical	AAE
Substance ..	$7,755,919	$2,932,022
Diabetes	$4,689,348	$2,485,273
Depression ..	$14,311,888	$1,908,208
Asthma	$3,950,508	$1,590,482
Hypertensi..	$3,101,354	$1,233,212
Schizophre..	$2,209,886	$966,436
Bipolar Dis..	$2,382,987	$959,492
Heart Failure	$1,003,624	$792,649
Chronic Obs..	$1,472,724	$736,247
Low Back P..	$3,513,263	$592,547
Trauma & S..	$7,387,935	$446,964
Arrhythmia..	$821,309	$378,743

The PCS-LN MEPP data shows that asthma contributed over $5.5 million of total costs for CY18-CY20, with almost $1.6 million of these costs designated as AAE in the MEPP tool. This means that 28.7% of asthma episode costs were AAE, which is higher than the 21.5% of overall CCO costs determined to be AAE according to the "3. Provider Comparison" report. In addition, asthma is one of the most prevalent conditions among our pediatric membership, which is an important group to include in our strategic MEPP interventions. (Note that for this data excerpt of the MEPP Dashboard, we set all filters to active and selected a lower enrollment gap filter threshold to 45 days).

Within the MEPP Dashboard Episode Drilldown, ED utilization (codes 99284 and 99285) are among the highest AAE costs. Medication adherence among members with asthma is an important factor to avoid more costly healthcare utilization (such as ED utilization), as well as improve health outcomes. As part of its project development, the MEPP: Asthma Workgroup reviewed pharmacy denials data and discovered a significant amount of denied pharmacy claims for asthma maintenance inhalers. The data showed that many members who received a denial never received an alternative maintenance inhaler to help with their chronic condition. About 15% of these members had subsequent ED, Urgent Care, or Inpatient Admits with asthma-related primary or secondary diagnoses. This data points to the denial of claims for maintenance inhalers as an area of opportunity to reduce increased ED and Urgent Care visits associated with asthma.

Cost Benefit Analysis

The MEPP dashboard identifies over $1,590,000 AAE costs for asthma episodes in the PCS-LN region for the CY18-20 time period when costs are "split" among different episodes. There are over $3,000,000 AAE costs for asthma episodes when looking at "unsplit" costs (i.e., fully attributing costs to the asthma episode even when multiple episodes are identified). This means significant savings are associated with improving episodes of care for our members with asthma.

Diving into a more detailed level of AAE costs, some of the top procedure codes are 99284 and 99285 for ED visits. Additional expenses for ED utilization are reflected for codes 99281, 99282, and 99283. There were $520,957 AAE costs for these ED procedure codes identified in the MEPP dashboard. When looking at AAE costs by DRG code, there was $46,460 in AAE cost for code 203, "bronchitis and asthma without complications." This data indicates that costly hospital utilization is a driver of AAE costs for this episode. Annualizing the cost of these targeted codes leads to an estimated potential savings opportunity of up to $190,000.

There are currently no anticipated additional direct expenses due to the project activities identified for implementation. We plan to use existing staffing, resources, and communication channels to execute the project plan. Therefore, we expect the project's potential savings to exceed the anticipated costs.

Performance Measurement Strategy

Measure Name	Asthma maintenance inhaler pharmacy denials PTMPY (additional information in Section F. Monitoring Measure 3.1)
Numerator	Number of distinct pharmacy denials for relevant asthma maintenance inhaler prescriptions among members diagnosed with asthma
Denominator	Medical member month exposure for members with a diagnosis of asthma
Performance Period	1/1/2022 to 12/31/2022
Baseline Period	1/1/2021 to 12/31/2021
Population	CCO members diagnosed with asthma and enrolled during the measurement period
Definition of Success	The project aims to reduce pharmacy inhaler denials PTMPY by at least 25% between the baseline and performance period.
Data Source	Internal PCS Caremark pharmacy denials data, internal PCS "Member Insight" member profile with condition algorithm flags for asthma diagnoses

Measure Name	Asthma-related emergency department utilization (additional information in Section F. Monitoring Measure Monitoring Metric 3.2)
Numerator	Number of emergency department visits for reasons related to asthma (primary or secondary diagnosis code beginning with J4) for members diagnosed with asthma
Denominator	Medical member month exposure for members with a diagnosis of asthma
Performance Period	1/1/2022 to 12/31/2022
Baseline Period	1/1/2021 to 12/31/2021
Population	CCO members diagnosed with asthma and enrolled during the measurement period
Definition of Success	The project aims to reduce asthma-related ED utilization PTMPY by 5% between the baseline and performance period.
Data Source	Internal claims data and PCS "Member Insight" member profile with condition algorithm flags for asthma diagnoses

Intersections with Health Equity

It is unclear if this project will impact health equity outcomes, but we will continue to consider this vital element as our project progresses. Translated member materials will be available for prevalent languages in the region, helping to ensure that we are meeting our membership's linguistic needs in this process.

E. **Brief narrative description**:

In 2022, the PCS-LN Asthma MEPP Project will address the underutilization of maintenance inhalers by Medicaid members with asthma. The project team will expand the pharmacy formulary to include more low-cost inhalers and inform providers of the covered benefit changes to achieve this improvement. This project intends to improve medication adherence and lower avoidable utilization of in-patient, urgent care, and ED visits related to asthma. In addition, we aim to increase proper inhaler use by offering educational materials to our provider partners. By helping our members improve the control of their asthma through education and medication adherence, this project will positively impact the quality of care associated with the chronic condition.

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

Activity 1 description: PCS will expand the pharmacy formulary to cover lower-cost inhalers to reduce pharmacy denials.

☒ Short term or ☐ Long term

Monitoring measure 1.1	Expand pharmacy formulary			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
PCS does not currently offer lower-cost inhalers.	PCS expands the pharmacy formulary to include lower-cost inhalers.	06/2022	PCS expands the pharmacy formulary to include lower-cost inhalers.	06/2022

Activity 2 description: PCS will inform all contracted providers of the covered benefit changes to remove barriers associated with physicians prescribing non-covered inhalers. Additionally, PCS will disseminate educational materials to providers on proper inhaler use to share with members.

☒ Short term or ☐ Long term

Monitoring measure 2.1	Inform contracted providers of covered benefit changes			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
PCS contracted providers are unaware of the formulary change.	PCS informs contracted providers of expanded formulary to include lower-cost inhalers.	06/2022	PCS informs contracted providers of expanded formulary to include lower-cost inhalers.	06/2022
Monitoring measure 2.2	Provide educational materials to providers to share with members			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
PCS does not have educational materials on proper inhaler use for providers to share with members who have asthma.	PCS creates materials on the proper use of inhalers to distribute to providers. Educational materials will be available in prevalent member languages.	12/2022	PCS creates materials on the proper use of inhalers to distribute to providers. Educational materials will be available in prevalent member languages.	12/2022

Activity 3 description: Reduce the avoidable utilization of in-patient, urgent care, and emergency department visits related to asthma by monitoring medication adherence.

☒ Short term or ☐ Long term

Monitoring measure 3.1	Asthma inhaler pharmacy denials per member per year			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
PCS has not calculated a baseline for the volume of asthma inhaler pharmacy denials PTMPY.	PCS develops and calculates a 2021 baseline for the volume of asthma inhaler pharmacy denials.	6/2022	Reduce the number of inhaler denials (controlled for changes in membership) by 25% between baseline and project year.	12/2022
Monitoring measure 3.2	Assess and monitor Emergency Department Utilization			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
PCS has not developed an ED utilization (for asthma) PTMPY baseline.	PCS develops an Emergency Department utilization (for reasons related to asthma) PTMPY baseline for 2021.	6/2022	Reduce Emergency Department utilization for reasons related to asthma PTMPY by 2% between the baseline and project period.	12/2022

A. Project short title: Project 11: Implementation of the Medicaid Efficiency and Performance Program: Diabetes and Depression

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

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

B. Components addressed

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

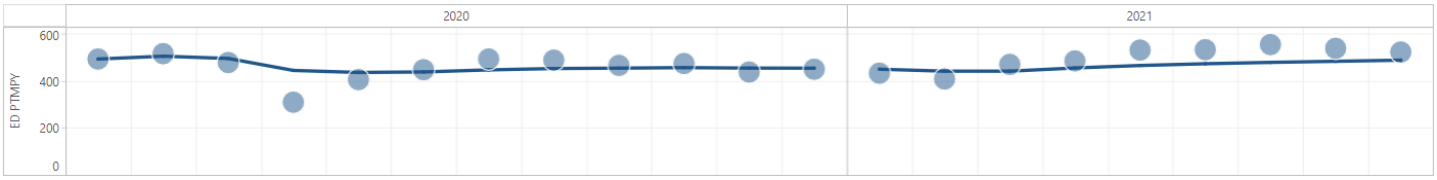
C. Component prior year assessment: Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

The PacificSource Community Solutions (PCS) Utilization Review (UR) Program is an integrated and comprehensive system that evaluates the medical necessity, appropriateness, and efficacy of health care services, whether physical, behavioral health, or oral health-related. The UR Program reviews requests for care and services according to PacificSource approved or endorsed policies and procedures and the member's health benefits, in compliance with federal and state regulatory agencies and industry accrediting standards.

PCS uses multiple methods to detect over- and under-utilization of services, including analyzing experience reports and dashboards, convening committees for review, analyzing appeals and grievances, and analyzing UR data. PCS reviews reporting in several forums, including the Health Council and through an internal Cost of Care Committee, which includes our Medical Directors and line of business vice presidents. In addition, PCS reviews under- and over-utilization through various quality committees with external providers. Our CCO Quality Incentive Measure (QIM) Team also monitors for over- and under-utilization of services by evaluating monthly utilization data and target graphs to determine where to focus their provider outreach. Lastly, each year the Medicaid Medical Director and representatives from critical departments meet to review data from the previous year regarding utilization, costs, and decision status. This data helps to inform which services should require a preapproval.

One area of focus for the UR Program is Emergency Department (ED) utilization over time. As shown in the excerpt from the ED Utilization Dashboard below, the PCS-Lane (LN) region began to see an upward trend in ED utilization in 2021, following the rapid decline during the onset of the COVID-19 pandemic. As a result of this data, we worked with our regional provider partners to collaboratively address access to care concerns that may have increased the likelihood of our members seeking care in the ED. This is one example of how PCS leverages internal analytics tools to affect utilization.

PCS-LN ED Visit Count Per Thousand Members Per Year (PTMPY)
Line: Rolling 12 mo. rate; Circle: Point-in-time rate



In addition to PCS' ongoing utilization monitoring, in 2020 the Oregon Health Authority (OHA) challenged CCOs to leverage the Medicaid Efficiency and Performance Program (MEPP) tool to identify actionable opportunity areas to implement meaningful interventions. In that year, OHA selected three episodes as recommended initial focus areas: Asthma, Diabetes, and Substance Use Disorder (SUD). Analyzing areas of over- and under-utilization, in addition to episode of care costs available in the MEPP tool, including variation in Adverse Actionable Event (AAE) costs, guided our MEPP team in developing interventions to positively impact health outcomes and reduce avoidable health care utilization (including ED utilization) over time. PCS implemented a MEPP focused on diabetes with an action plan submitted in 2020 and interventions spanning 2020-2021. PCS continues to offer providers materials designed for the MEPP: Diabetes Project; however, we plan to discontinue this MEPP project in 2022 and identify new interventions for implementation in 2022 (please see attachment ten (ATTM 10) for the complete final MEPP closeout report).

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

This TQS project is the same for all PCS' CCO regions, except for region-specific data throughout the report.

For 2022, the PCS MEPP Steering Group convened to explore the data available in the MEPP Dashboards, including AAE costs by episodes of care, episode subtypes, procedure codes, Diagnosis Related Group (DRG) codes, and diagnoses codes. After reviewing the data, PCS adopted the intersection of diabetes and depression as one of three of its episodes of focus. The group chose these episodes of care based on their significant contributions to state-wide costs, broad impacts on Oregon's population, and alignment with state policies. To improve quality and episode of care costs, PCS will continue to engage internal workgroups for these episode types to oversee and implement action plans for intervention strategies specific to these chronic conditions. MEPP Workgroups include Medical Directors, Clinical Quality Coordinators, Healthcare Data Analysts, and subject matter experts (SMEs) related to each episode.

The MEPP: Diabetes and Depression Workgroup examined the available MEPP Dashboards to gain meaningful insights to inform the overall implementation strategy outlined in the 2022 MEPP Project Proposal for the PCS-LN region. The following information provides a subset of the reviewed data elements.

PCS-LN MEPP Dashboard Excerpt
CCO Dashboard CY18-20, Episode Drilldown Dashboard (accessed 1/26/2022)

Episode Description
(Click to Filter)

Episo..	Typical	AAE
Substance ..	$7,755,919	$2,932,022
Diabetes	$4,689,348	$2,485,273
Depression ..	$14,311,888	$1,908,208
Asthma	$3,950,508	$1,590,482
Hypertensi..	$3,101,354	$1,233,212
Schizophre..	$2,209,886	$966,436
Bipolar Dis..	$2,382,987	$959,492
Heart Failure	$1,003,624	$792,649
Chronic Obs..	$1,472,724	$736,247
Low Back P..	$3,513,263	$592,547
Trauma & S..	$7,387,935	$446,964
Arrhythmia..	$821,309	$378,743

In the MEPP dashboard, depression and diabetes episodes are among the top three highest AAE cost episodes in the PCS – LN CCO region for CY18-CY20. Working at the intersection of these two conditions could help reduce costs in both episodes while improving the well-being of a population that includes some of our most medically complex members. Depression and diabetes are comorbid conditions that exacerbate and worsen symptoms of the other, leading to poor health outcomes and increased healthcare utilization. Proper management of this high-risk population could help to reduce the $2.5M AAE costs associated with diabetes and $1.9 AAE costs associated with depression and anxiety in the MEPP tool. Note that for these figures, all filters were active and the lower enrollment gap filter threshold set to 45 days.

Expansion of Behavioral Health Integration Provider Incentive Programs (BHI Program) will help drive healthcare transformation by financially supporting participating provider groups to make steps towards fully integrated behavioral health in primary care settings. Involving multidisciplinary teams in the care for members with diabetes and depression could help lower symptoms of depression, increase healthy lifestyle behaviors, and improve glycemic control of our members—enhancing their quality of life and improving long-term costs.

PCS has been working with Patient-Centered Primary Care Homes (PCPCHs) to support interventions for members with depression and diabetes. In 2021, PCS began gathering data from PCPCH clinics regarding this population and their utilization of integrated behavioral health. PCS will offer and track attendance at Learning Collaboratives for PCPCH clinics that are part of the BHI Program to support efforts to improve the behavioral health of this population. Additionally, PCS will continue to gather data from PCPCH clinics to help support program evaluation. PCS will develop and monitor behavioral health utilization among members with diabetes and depression for participating provider groups according to available claims data. Over time, the member population served will experience improved well-being and higher engagement in their care. This project intends to increase team-based care for members with diabetes and depression, which can help mitigate improper ED utilization and other long-term complications of depression and diabetes (i.e., kidney failure, ketoacidosis, and poor medication adherence). To better understand the impacts of this work, PCS will also enhance reporting tools for ED utilization to allow for easier monitoring of over-utilization among members with diabetes and depression diagnoses. In 2022, the MEPP team will enhance current reporting tools, monitor the metric to understand any areas of opportunity to drive further MEPP strategies and develop a baseline of ED utilization in this specific population.

Cost-Benefit Analysis

The MEPP Dashboard identifies over $3,864,000 AAE costs for diabetes episodes in the PCS-LN region for the CY18-20 time period (when costs are “unsplit” among different episodes). Internal data show that 37.7% of members with a diabetes diagnosis also have a diagnosis of depression. Currently, about 60.1% of our members with diabetes and depression have an active assignment with a participating BHI PCPCH clinic. Therefore, working with our provider partners at the intersection of these two episodes of care, we hope to make a meaningful impact to the well-being of a significant portion of members with diabetes.

Diving into a more detailed level of AAE costs, some of the top procedure codes are 99284 and 99285 for ED visits. Additional expenses for ED utilization are reflected for codes 99281, 99282, and 99283. There were $328,213 “unsplit” AAE costs for these ED procedure codes identified in the MEPP dashboard. When looking at AAE costs by DRG code, there were $45,411 in AAE costs for code 639, “diabetes w/o cc/mcc.” This data emphasize that costly hospital utilization is a driver of AAE costs for the diabetes episode. Annualizing the cost of these targeted codes and assuming that our intervention population includes about 22.6% of members with a diabetes episode (the subset with a diagnosis of depression and assigned to a BHI partner) leads to an estimated potential savings opportunity of up to $28,000.

There are currently no anticipated additional direct expenses due to the project activities identified for implementation. PCS has already launched the Behavioral Health Integration Value Based Payment (VBP) Program and funding. This year we are emphasizing the impact of this program’s effort more explicitly on our members living with diabetes. We plan to use existing staffing, consulting resources, and communication channels to execute the project plan. Therefore, we anticipate the project’s potential savings to exceed the anticipated costs.

Performance Measurement Strategy

Measure Name	Behavioral health reach in target population among participating BHI provider groups (more detail in Monitoring Metric 1.1 below)
Numerator	Number of members with diagnoses of depression and diabetes assigned to a BHI PCPCH with a behavioral health visit in the performance period
Denominator	Number of members with diagnoses of depression and diabetes assigned to a BHI PCPCH
Performance Period	1/1/2022 to 12/31/2022
Baseline Period	1/1/2021 to 12/31/2021
Population	CCO members with diabetes and depression diagnoses assigned to a BHI PCPCH
Definition of Success	The target for the measurement period will be assessed by 2022 Q3 when the baseline reporting is available.
Data Source	Internal claims data, PCS "Member Insight" member profile with condition algorithm flags for diabetes and depression, internal BHI participant rosters

Measure Name	ED Visits PTMPY among members with diabetes and depression
Numerator	Number of ED visits for members with both diabetes and depression diagnoses
Denominator	CCO membership exposure of members with both diabetes and depression (to calculate a ED visit PTMPY rate).
Performance Period	1/1/2022 to 12/31/2022
Baseline Period	1/1/2021 to 12/31/2021
Population	CCO members with diabetes and depression diagnoses
Definition of Success	PCS modifies current reporting to support easier monitoring and develops baseline
Data Source	Internal claims data, member enrollment data, internal disease algorithm flags for diabetes and depression available in member insight data access layer

Measure Name	Implementation of Learning Collaboratives
Numerator	Number of Learning Collaboratives that took place to support behavioral health integration in the treatment of comorbid diabetes & depression in integrated primary care settings
Denominator	Number of Learning Collaboratives scheduled to support behavioral health integration in the treatment of comorbid diabetes & depression in integrated primary care settings
Performance Period	1/1/2022 to 12/31/2022
Baseline Period	1/1/2021 to 12/31/2021
Population	PCPCHs participating in the BHI Program
Definition of Success	Provide two Learning Collaboratives specific to supporting BHI in the treatment of comorbid diabetes & depression in integrated primary care settings
Data Source	Internal review to ensure Learning Collaboratives take place.

Intersections With Health Equity

The overall impact on health equity outcomes is unclear at this time. There are challenges to evaluating these impacts due to the small population size of those with depression and diabetes and being able to make any definitive conclusions about disparities due to statistically insignificant sample sizes. We risk exposing protected health information due to these low sample sizes. Health equity will remain a focal point when evaluating program implementation, but we may not be able to measure disparities in a statistically valid way. When we look at our overall member population, current internal data suggest that our PCPCH groups participating in the BHI Program excel at offering culturally and linguistically appropriate care to many member groups such as our Hispanic/Latinx members and members requiring an interpreter. Through team-based care for members with diabetes within our PCPCHs, we have historically seen strong engagement among key populations such as our Hispanic/Latinx membership, and hope to continue to move health equity in behavioral health forward.

E. Brief narrative description:

In 2022, the PCS- LN Depression and Diabetes MEPP Project will focus on Medicaid members aged 12 years or older who have diagnoses of both diabetes and depression. This project aims to improve the utilization of behavioral health services for the target population to reduce long-term complications and potentially avoidable utilization of costly health care services. The project will achieve this by conducting Learning Collaboratives specific to the sub-population identified with diabetes and depression. A licensed clinical psychologist will conduct these Collaboratives to educate providers implementing evidenced-based practices of treating and improving quality outcomes related to this specific co-occurring health condition. Providers will be encouraged to identify this subpopulation among their overall patient population and offer BH services when appropriate. These collaboratives will be completed by end of 2022.

F. Activities and monitoring for performance improvement:

Activity 1 description: Monitor the utilization of behavioral health services among members with diabetes and depression.

☒ Short term or ☐ Long term

Monitoring measure 1.1	Behavioral health program reach in target population among participating BHI provider groups.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
PCS does not track or report the percent of members with diabetes and depression who have had a BH visit in the last 12 months among participating BHI provider groups.	PCS will develop internal reporting to examine BH utilization in 2021 for members with diabetes and depression among providers participating in the BHI Program.	06/2022	PCS will develop a population reach target based on the baseline.	09/2022
Monitoring measure 1.2	ED Visits PTMPY among members with diabetes and depression.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
PCS currently reports ED utilization among members with diabetes and	PCS enhances reporting of ED utilization among members with	06/2022	PCS monitors ED utilization among members with diabetes and	12/2022

depression, but reporting needs modification to make the metric easier to access for MEPP project leaders.	diabetes and depression to allow for easier monitoring and access.		depression to set baseline utilization and identify potential opportunities to include in MEPP strategic planning.	

Activity 2 description: PCS will solicit information regarding the priority subpopulation of members with diabetes and depression from clinics participating in the VBP program.

☒ Short term or ☐ Long term

Monitoring measure 2.1	Collection of reporting from participating clinics that prioritize Behavioral Health Clinician (BHC) involvement for patients with diabetes and depression as their targeted priority subpopulation.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
PCS does not currently require reporting on BHC involvement on the priority subpopulation of members with diabetes and depression, as this is a new component of the BHI Program for 2022.	Develop a survey to capture quarterly reporting from participating clinics.	3/2022	Identify any barriers to reporting on subpopulation and provide technical assistant (TA) to clinics if challenges arise.	12/2022

Activity 3 description: Improve the utilization of behavioral health services by providing Learning Collaboratives focused on providing behavioral health services to patients with depression and diabetes at a primary care home.

☒ Short term or ☐ Long term

Monitoring measure 3.1	Learning Collaborative Development and Attendance.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
PCS does not offer peer-to-peer Learning Collaboratives for team-based BHI in the treatment of comorbid depression and diabetes.	PCS will develop materials specific to behavioral health treatment of comorbid depression and diabetes in integrated primary care settings.	6/2022	PCS will offer two Learning Collaboratives to support BHI in the treatment of comorbid diabetes & depression in integrated primary care settings.	12/2022

A. Project short title: Project 12: Implementation of the Medicaid Efficiency and Performance Program: Substance Use Disorder Episode

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

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

B. Components addressed

a. Component 1: Utilization review
b. Component 2 (if applicable): Choose an item.
c. Component 3 (if applicable): Choose an item.
d. Does this include aspects of health information technology? ☒ Yes ☐ No
e. If this project addresses social determinants of health & equity, which domain(s) does it address?
   ☐ Economic stability ☐ Education
   ☐ Neighborhood and build environment ☐ Social and community health
f. If this project addresses CLAS standards, which standard does it primarily address? Choose an item.

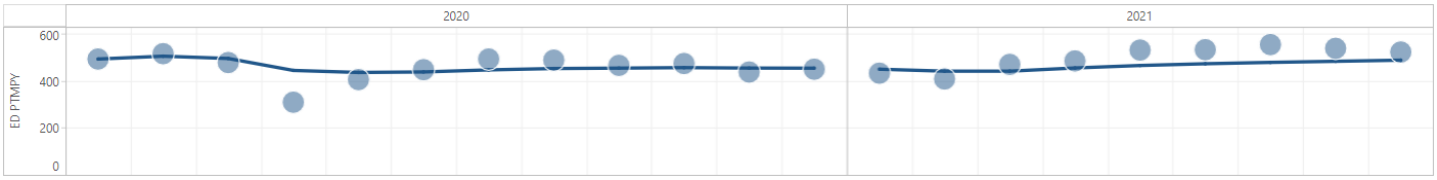
C. Component prior year assessment: Include calendar year assessment(s) for the component(s) selected with CCO- or region-specific data.

The PacificSource Community Solutions (PCS) Utilization Review (UR) Program is an integrated and comprehensive system that evaluates the medical necessity, appropriateness, and efficacy of health care services, whether physical, behavioral health, or oral health-related. The UR Program reviews requests for care and services according to PacificSource approved or endorsed policies and procedures and the member's health benefits, in compliance with federal and state regulatory agencies and industry accrediting standards.

PCS uses multiple methods to detect over- and under-utilization of services, including analyzing experience reports and dashboards, convening committees for review, analyzing appeals and grievances, and analyzing UR data. PCS reviews reporting in several forums, including the Health Council and through an internal Cost of Care Committee, which includes our Medical Directors and line of business vice presidents. In addition, PCS reviews over- and under-utilization through various quality committees with external providers. Our CCO Quality Incentive Measure (QIM) Team also monitors for under- and over-utilization of services by evaluating monthly utilization data and target graphs to determine where to focus their provider outreach. Lastly, each year the Medicaid Medical Director and representatives from critical departments meet to review data from the previous year regarding utilization, costs, and decision status. This data helps to inform which services should require a preapproval.

One area of focus for the UR Program is Emergency Department (ED) utilization over time. As shown in the excerpt from the ED Utilization Dashboard below, the PCS-Lane (LN) region began to see an upward trend in ED utilization in 2021, following the rapid decline during the onset of the COVID-19 pandemic. As a result of this data, we worked with our regional provider partners to collaboratively address access to care concerns that may have increased the likelihood of our members seeking care in the ED. This is one example of how PCS leverages internal analytics tools to affect utilization.

PCS – LN ED Visit Count Per Thousand Members Per Year (PTMPY)
Line: Rolling 12 mo. rate; Circle: Point-in-time rate



In addition to PCS' ongoing utilization monitoring, in 2020, the Oregon Health Authority (OHA) challenged CCOs to leverage the Medicaid Efficiency and Performance Program (MEPP) tool to identify actionable opportunity areas to implement meaningful interventions. In that year, OHA selected three episodes as recommended initial focus areas: Asthma, Diabetes, and Substance Use Disorder (SUD). Analyzing areas of over- and under-utilization, in addition to episode of care costs available in the MEPP tool, including variation in adverse actionable event (AAE) costs, guided our MEPP team in developing interventions to positively impact health outcomes and reduce avoidable health care utilization (including ED utilization) over time. PCS implemented a MEPP focused on SUD with an action plan submitted in 2020 and interventions spanning 2020-2021. PCS is discontinuing this MEPP project in 2022 as we designed short-term interventions, including a one-time educational webinar for providers (please see attachment eleven "ATTM 11" for the final MEPP closeout report).

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

This TQS project is the same for all PCS' CCO regions, except for region-specific data throughout the report.

For 2022, the PCS MEPP Steering Group convened to explore the data available in the MEPP dashboard, including AAE costs by episodes of care, episode subtypes, procedure codes, Diagnosis Related Group (DRG) codes, and diagnoses codes. After reviewing the data, PCS adopted SUD as one of three of its episodes of focus. The group chose this episode of care based on their significant contributions to state-wide costs, broad impacts on Oregon's population, and alignment with state policies. To improve quality and episode of care costs, PCS will continue to engage internal workgroups for each episode type to oversee and implement action plans for intervention strategies specific to each chronic condition. These workgroups include Medical Directors, Clinical Quality Coordinators, Healthcare Data Analysts, and subject matter experts (SMEs) related to each episode.

The MEPP: Substance Use Disorder (SUD) Workgroup examined the available MEPP Dashboards to gain meaningful insights to inform the overall implementation strategy outlined in the 2022 MEPP Project Proposal for the PCS-LN region. The table below shows that the SUD episode type has the highest AAE costs of any episode in the region. These high AAE costs, in addition to OHA's indicated interest in interventions for the SUD episode of care, led us to pursue strategies to improve care coordination for our members with SUD.

PCS – LN MEPP Dashboard Excerpt

CCO Dashboard CY18-20, Episode Drilldown Dashboard (accessed 1/26/2022)

Episode Description
(Click to Filter)

Episo..	Typical	AAE
Substance ..	$7,755,919	$2,932,022
Diabetes	$4,689,348	$2,485,273
Depression ..	$14,311,888	$1,908,208
Asthma	$3,950,508	$1,590,482
Hypertensi..	$3,101,354	$1,233,212
Schizophre..	$2,209,886	$966,436
Bipolar Dis..	$2,382,987	$959,492
Heart Failure	$1,003,624	$792,649
Chronic Obs..	$1,472,724	$736,247
Low Back P..	$3,513,263	$592,547
Trauma & S..	$7,387,935	$446,964
Arrhythmia..	$821,309	$378,743

Providing services for those with SUD may require referrals and lengthy coordination among providers. Barriers to accessing care could be due to patient eligibility, provider or patient knowledge, lack of referral resources and capacity, and issues with communication between the referral source and patient.[16] These barriers are more complex if the SUD provider is outside of the region where the patient and their provider reside.

After considering the high percentage of AAE costs associated with SUD, the MEPP: SUD Workgroup identified improved care coordination for SUD services as an actionable intervention strategy. This work aims to improve the utilization of appropriate SUD treatment services to reduce AAE costs associated with SUD. In developing this strategy, the MEPP: SUD Workgroup coordinated with the Behavioral Health Population Health (BHPH) team to develop a comprehensive SUD Technical Assistance (TA) Toolkit to clarify the roles and responsibilities for providers in coordinating and providing services for PCS members as they access various American Society of Addiction Medicine (ASAM) levels of care throughout Oregon. Education and training may help bridge the gap in substance use treatment and increase the ability of a provider to detect SUD and appropriately refer to treatment.[17] We intend for the SUD TA Toolkit to identify gaps or barriers in referral and coordination processes between SUD providers and agencies and how they impact PCS members. Through improved care coordination and education on appropriate treatment referral resources, this project aims to increase SUD treatment of our CCO members and decrease the high amount of AAE costs in hospital settings demonstrated in the MEPP tool in DRG codes 897 (Alcohol/Drug abuse or dependence w/o rehabilitation therapy w/o MCC) and CPT codes 99285 and 99284 for ED services.

Throughout the project, MEPP project leaders will be monitoring the Initiation and Engagement of Substance Use Disorder Treatment (NQF 0004) Quality Incentive Measure (QIM) to understand potential impacts of the project to actual rates of SUD treatment for our CCO members. Current QIM reporting allows internal project leaders to understand performance both at the CCO and the provider group level, which will help support programmatic outreach strategies. In addition, PCS will modify current reporting to allow project leaders to monitor ED utilization for SUD among CCO members aged 13 and older. This monitoring measure will help PCS project leaders understand baseline utilization and look for opportunities to drive MEPP strategies directed at lowering the costs of the SUD episode.

Cost-Benefit Analysis

The MEPP Dashboard identifies over $2,932,000 AAE costs for SUD episodes in the PCS-LN region for the CY18-20 time period when costs are “split” among different episodes. There are over $5,438,593 AAE costs for SUD episodes when looking at “unsplit” costs (i.e., fully attributing costs to the SUD episode even when we identify multiple episodes). This project partners with regional PCPCH Provider Groups with at least 50% of the assigned CCO membership, which means

[16] Abdalla, S. (2018). Eligibility, communication issues barriers to substance use disorder treatment. Boston University School of Public Health. Retrieved from https://www.bu.edu/sph/news/articles/2018/eligibility-communication-issues-barriers-to-substance-use-disorder-treatment/).

[17] Blevins, C. E., Rawat, N., & Stein, M. D. (2018). Gaps in the Substance Use Disorder Treatment Referral Process: Provider Perceptions. Journal of addiction medicine, 12(4), 273–277. https://doi.org/10.1097/ADM.0000000000000400

that there are significant savings associated with working with our PCPCH Provider Groups to improve episodes of care for our members with SUD.

Diving into a more detailed level of AAE costs, the top procedure codes in terms of costs are 99284 and 99285 for ED visits. Additional expenses for ED utilization are present for codes 99281, 99282, and 99283. There were $1,124,754 "unsplit" AAE costs for these ED procedure codes identified in the MEPP Dashboard. When looking at AAE costs by DRG code, there were $205,774 in AAE costs for code 897, "alcohol or drug abuse or dependence w/o rehabilitation therapy or MCC" and $91,045 in AAE costs for code 918 "poisoning and toxic effects of drugs w/o MCC." This data underline that costly hospital utilization is a driver of AAE costs for the SUD episode. Annualizing the cost of these targeted codes (and assuming a population reach of 50%) leads to an estimated potential savings opportunity of up to $237,000.

There are currently no anticipated additional direct expenses due to the project activities identified for implementation. We plan to use existing staffing, provider partnerships, and communication channels to execute the project plan. Therefore, we expect the project's potential savings to exceed the anticipated costs.

Performance Measurement Strategy

Measure Name	Offer TA to a number of PCS paneled PCPCH Provider Groups serving at least 50% of CCO members
Numerator	Number of PCPCH Provider Groups given SUD resources and TA support
Denominator	Number of PCPCH Provider Groups with the most attributed members and reaching at least 50% of CCO membership assignment
Performance Period	1/1/2022 to 12/31/2022
Baseline Period	Baseline is not applicable for this measure
Population	CCO members with SUD assigned to applicable partner PCPCH Provider Groups
Definition of Success	The project aims to offer SUD treatment resources and TA to the number of PCPCH Provider Groups in the CCO region that reaches at least 50% of CCO membership.
Data Source	Internal roster of BHI participating provider groups, attendance records from the learning collaboratives.

Measure Name	Initiation and Engagement of Substance Use Disorder Treatment (NQF 0004)
Numerator	Definition will be consistent with the numerator specified in the 2022 CCO Incentive Measure Specification Sheet as part of the Quality Incentive Metric program
Denominator	Definition will be consistent with the denominator specified in the 2022 CCO Incentive Measure Specification Sheet as part of the Quality Incentive Metric program
Performance Period	1/1/2022 to 12/31/2022
Baseline Period	1/1/2021 to 12/31/2021
Population	Definition will be consistent with the population specified in 2022 CCO Incentive Measure Specification Sheet as part of the Quality Incentive Metric program
Definition of Success	PCS meets or exceeds the OHA 2022 CCO Quality Incentive Metric target for Initiation and Engagement of Substance Use Disorder Treatment.
Data Source	Internal quality incentive metric monitoring data

Measure Name	Emergency Department Utilization for Substance Use Disorder
Numerator	Emergency department (ED) visits for members 13 years of age and older with a principal diagnosis of alcohol or other drug (AOD) abuse or dependence.
Denominator	CCO member exposure of members aged 13 years of age and older (to calculate a visit PTMPY rate).
Performance Period	1/1/2022 to 12/31/2022
Baseline Period	1/1/2021 to 12/31/2021
Population	Adult CCO members aged 13 and older.
Definition of Success	PCS modifies current reporting to support easier monitoring and develops baseline.
Data Source	Internal HEDIS data sources, claims data, and member enrollment data.

Intersections with Health Equity

Disparities exist in the treatment and coordination of care for members with primary health care needs than members with a SUD diagnosis. The SUD TA Toolkit will increase alignment and integration to ensure members and their providers can receive the same standard and experience of care for SUD services they would for the primary care referral process. It also aims to decrease the stigma of seeking SUD services, diagnosis, referral, and treatment of substance use by supporting education and resources of the process. Therefore, this project intends to improve health equity for members with a substance use disorder.

The overall impact of the SUD TA Toolkit on other health equity outcomes is unclear at this time. However, health equity continues to be a critical perspective as we design and implement interventions. For example, PacificSource's Diversity, Equity, and Inclusion (DEI) team will review the SUD TA Toolkit to ensure that we are following Culturally and Linguistically Appropriate Services best practices when applicable. The TA Toolkit will also offer information to providers on how to access interpreter vendor services to help ensure that we are meeting our members' linguistic needs. Additionally, one key audience of this SUD TA Toolkit is our PCPCH Provider Groups. Internal data suggests that these groups excel at engaging and offering culturally and linguistically appropriate care to many member groups, such as our Hispanic/Latinx members and members requiring an interpreter. Through boosting education and resources within our PCPCH Provider Groups where we have seen strong engagement, we hope to continue to move health equity in behavioral health forward.

E. Brief narrative description:

In 2022, the PCS-LN SUD MEPP project will work to reduce AAE and costs associated with SUD by working with PCPCH Provider Groups in coordinating and providing services to adult PCS members as they access various ASAM levels of care throughout Oregon. The BHPH team will distribute the SUD TA Toolkit to providers to help identify gaps or barriers in referral and coordination processes between SUD providers and agencies to ensure adult PCS members receive the appropriate level of care and achieve their treatment goals. Additionally, the BHPH team will provide TA to support providers in streamlining the referral to appropriate services process, as well as coordination of services for the member upon entering and exiting treatment to ensure successful reintegration into their community, which includes transportation, housing supports, and follow up supports.

F. Activities and monitoring for performance improvement:

Activity 1 description: PCS will develop content based on the ASAM criteria for the SUD TA Toolkit and develop internal policies and procedures outlining the process for each level within the toolkit.

☒ Short term or ☐ Long term

Monitoring measure 1.1	Develop policies and procedures outlining the process for each level within the toolkit.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No SUD Toolkit and related policies and procedures exist to provide TA to providers.	PCS will develop the SUD Toolkit based on ASAM criteria to share with providers.	10/2022	PCS will develop a policy and procedures outlining the process for each level/tool within the SUD Toolkit.	10/2022

Activity 2 description: PCS will solicit necessary internal approvals on the SUD Toolkit and related materials to share with providers.

☒ Short term or ☐ Long term

Monitoring measure 2.1	PCS will submit the SUD Toolkit to PCS' Marketing and Communications Department for approval.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
No SUD Toolkit exists. Once completed, PCS will need to gain approval of any materials we share with providers.	PCS develops the SUD Toolkit and submits it to PCS' Marketing and Communications Department for approval.	11/2022	PCS' Marketing and Communications Department approves the SUD Toolkit.	11/2022

Activity 3 description: PCS will improve adult members' access to various ASAM levels of care by providing TA to paneled PCPCH Provider Groups, in addition to monitoring program effectiveness by tracking PCS' Quality Incentive Metric for Initiation and Engagement of Substance Use Disorder Treatment.

☒ Short term or ☐ Long term

Monitoring measure 3.1	Offer TA to PCS paneled PCPCH Provider Groups serving at least 50% of adult CCO members.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
PCS does not provide specific TA to SUD providers on ASAM criteria to improve care coordination.	PCS will offer SUD TA Toolkit to PCPCH Provider Groups with a 50% adult population reach within CCO membership.	12/2022	PCS will offer SUD TA Toolkit to PCPCH Provider Groups with a 50% adult population reach within CCO membership.	12/2022
Monitoring measure 3.2	Initiation and Engagement of Substance Use Disorder Treatment			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
PCS currently tracks Initiation and Engagement of	PCS meets or exceeds the OHA 2022 CCO Quality	12/2022	PCS meets or exceeds the OHA 2022 CCO Quality	12/2022

Substance Use Disorder Treatment as part of our Quality Incentive Metric Program.	Incentive Metric target for Initiation and Engagement of Substance Use Disorder Treatment.		Incentive Metric target for Initiation and Engagement of Substance Use Disorder Treatment.	
Monitoring measure 3.3	ED utilization with a principal diagnosis of SUD abuse or dependence among members 13 years of age and older.			
Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
PCS currently reports ED utilization for SUD, but reporting needs modification to make the metric easier to access for MEPP project leaders.	PCS enhances reporting of ED utilization for SUD to allow for easier monitoring and access.	6/2022	PCS monitors ED utilization for SUD to set baseline utilization and identify potential opportunities to include in MEPP strategic planning.	12/2022

Section 2: Discontinued Project(s) Closeout

(Complete Section 2 by repeating parts A through D until all discontinued projects have been addressed)

A. Project short title: Improving Access to Care and Monitoring
B. Project unique ID (as provided by OHA): 180
C. Criteria for project discontinuation: CCO's and/or organizations' resources must be reprioritized and shifted to other bodies of work
D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words):

In late 2020, PCS launched a healthcare access survey to monitor member accessibility. Each month, PCS mails out 4,000 surveys to members who have had a recent appointment with a physical, behavioral, oral healthcare provider or a traditional health worker (THW). Response rates are lower than anticipated despite increasing the sample size in mid-2021. However, the work is still meaningful as we can collect direct member feedback and work with individuals to resolve barriers to care. For example, we are still able to work directly with members who request an interpreter/translation help and provide education to members who indicate they are unaware of Non-Emergent Medical Transportation services.

PCS decided to discontinue the Access to Care and Monitoring project, given the challenges of gaining statistically significant data from surveys. Without meaningful data, PCS could not identify actionable improvement opportunities to increase members' access to care. In addition, PCS fully completed and adopted the project's site visit initiative to centralize visit information into one system. For these reasons, we decided to reprioritize project resources to serve new access initiatives. Regardless of discontinuing this TQS, PCS will continue efforts to improve access data, including contracting with a vendor in 2022 to increase response rates in our Provider Access to Care Survey and adding additional language translations to our member access to care surveys.

Section 2: Discontinued Project(s) Closeout

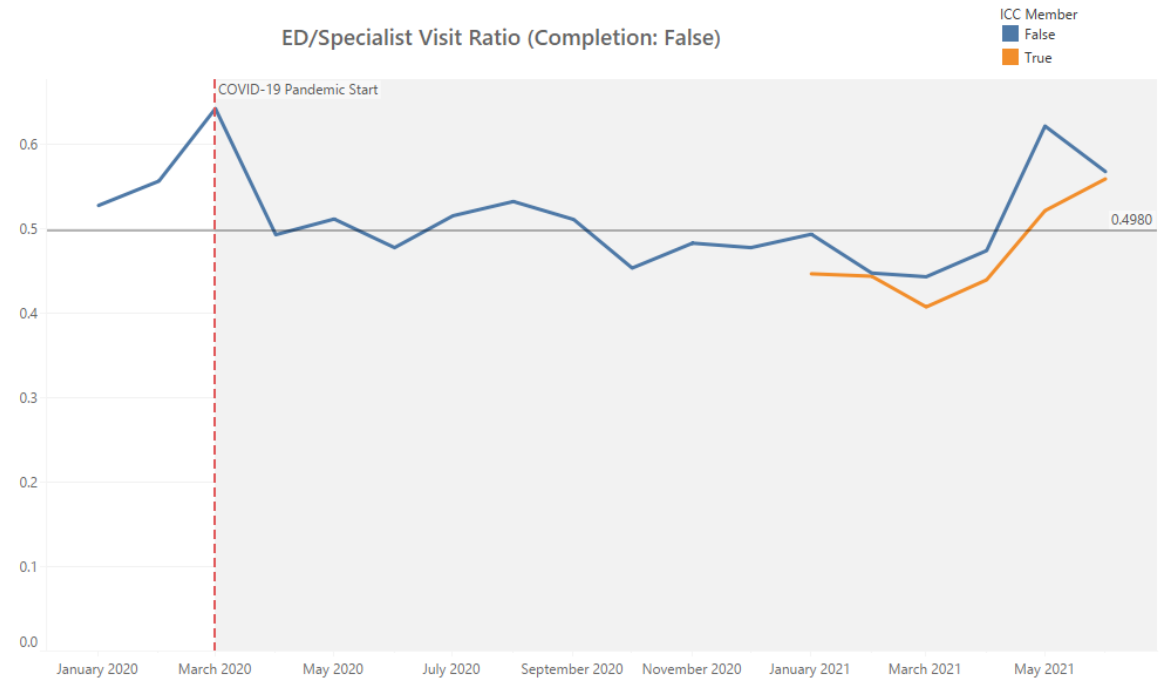
(Complete Section 2 by repeating parts A through D until all discontinued projects have been addressed)

A. Project short title: Utilization of Direct Access to Care
B. Project unique ID (as provided by OHA): 186
C. Criteria for project discontinuation: CCO's and/or organizations' resources must be reprioritized and shifted to other bodies of work
D. Reason(s) for project discontinuation in support of the selected criteria above (max 250 words):

The initial goal of the Utilization Review TQS project was to monitor the utilization of specialty healthcare services by Intensive Care Coordination (ICC) members and observe if the use of specialty care seemed to affect the use of emergency care for these members. Unfortunately, the COVID-19 severely impacted the utilization of healthcare services, which drastically slowed down after March 2020.

Below is a visualization of the emergency department to Specialist visit ratios over time, a metric we hoped to use to monitor the use of specialty and emergency care for our ICC and non-ICC members. We can see that within the CCO region, healthcare utilization decreased enormously after the beginning of the pandemic, and the inability to establish a baseline for utilization made measuring progress in this project challenging, if not impossible. After further consideration and evaluation of the feedback provided by OHA, PCS decided to retire this project and reprioritize resources to a project that will have a more significant impact on our membership and measurable data support with achievable outcomes.

PCS – Lane CCO:



CCO Member Rights

State(s):	LOB(s):
☐ *Idaho* ☐ *Montana* ☒ *Oregon* ☐ *Washington* ☐ *Other:*	☐ *Commercial* ☐ *Medicare* ☒ *Medicaid*

Government Medicaid Policy

Purpose:

To describe how providers, members, and potential members are educated about PacificSource Community Solutions (PSCS) CCO members' rights, to discuss the methods PSCS uses to ensure that members and potential members are aware of their rights, and to monitor to ensure that providers are complying with member or potential members' rights.

Procedure:

Individuals enrolled in the Oregon Health Plan are afforded certain rights under Exhibit B of the CCO contract, OAR 410-141-3590, and as well as civil rights afforded under Title VI of the Civil Rights Act of 1975 as implemented by regulations at 45 CFR part 91, The Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, Titles II and III of the Americans with Disabilities Act and section 1557 of the Patient Protection and Affordable Care Act and ORS Chapter 659 A. Under its contract with the Oregon Health Authority (OHA), PSCS is responsible for communicating these rights to contracted providers and monitoring these providers to ensure their compliance.

Member Rights

Members shall have the following rights:

- The CCO shall require and cause it's Participating Providers to require, that members are treated with dignity and respect with due considerations for his or her dignity and privacy, and the same as non-members or other patients who receive services equivalent to Covered Services;
- To be treated by Participating Providers the same as other people seeking health care benefits to which they are entitled, and to be encouraged to work with the member's care team, including providers and community resources appropriate to the member's needs.
- To choose a health care professional from available Participating Providers and Facilities to the extent possible and appropriate and to change those choices as permitted in the CCO's administrative policies. For a member in a Service Area serviced by only one PHP, any limitation the CCO imposes on his or her freedom to change between PCPs or to obtain services from Non-Participating Providers if the service or type of provider is not available with the CCO's Provider Network may be no more restrictive that the limitation on Disenrollment under Exhibit B, Part 3, Section 6b.
- To refer oneself directly to Behavioral Health, Chemical Dependency or Family Planning Services without getting a referral from a PCP or other Participating Provider;

- To have a friend, family member, member representative or advocate present during appointments and at other times as needed within clinical guidelines;
- To be actively involved in the development of his/her treatment plan if Covered Services are to be provided and to have family involved in such treatment planning;
- To be given information about his/her condition and Covered and Non-Covered Services to allow an informed decision about proposed treatment(s);
- To consent to treatment or refuse services, and be told the consequences of that decision, except for court ordered services;
- To receive written materials describing rights, responsibilities, benefits available, how to access services, and what to do in an emergency;
- PSCS will develop and provide written information, materials and educational programs and have a mechanism to help members and potential members understand the requirements and benefits of the Plan consistent with the requirements of OAR 410-141-3580 and 410-141-3590.
- To have written materials explained in a manner that is understandable to the member and be educated about the coordinated care approach being used in the community and how to navigate the coordinated health care system;
- To receive culturally and linguistically appropriate services and supports, in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities and regardless of gender, sexual orientation or gender identity in a manner that meets the members unique needs and in locations as geographically close to where members reside or seek services as possible, and choice of providers within the delivery system network that are, if available, offered in non-traditional settings that are accessible to families, diverse communities, and underserved populations;
- To receive oversight, care coordination and transition and planning management from their CCO within the targeted population of Division to ensure culturally and linguistically appropriate community based care is provided in a way that serves them in as natural and integrated an environment as possible and that minimizes the use of institutional care;
- To receive necessary and reasonable services to diagnose the presenting condition;
- To receive integrated person-centered care and services designed to provide choice independence and dignity and that meet generally accepted standards of practice and are medically appropriate;
- To have a consistent and stable relationship with a care team that is responsible for comprehensive care management;
- To receive assistance in navigating the health care delivery system and in accessing community and social support services and statewide resources including, but not limited to, the use of certified or qualified health care interpreters, certified traditional health workers including, community health workers, peer wellness specialists, peer support specialists, doulas and personal health navigators who are part of the member's care team to provide cultural and linguistic assistance appropriate to the member's need to access appropriate services and participate in processes affecting the member's care and services;
- To obtain covered preventive services;
- To have access to urgent and emergent services 24 hours a day, 7 days a week without prior authorization;
- To receive referrals to specialty practitioners for medically appropriate covered coordinated care services in the manner provided in the CCO's referral policy;
- PSCS will ensure that each member has access to Covered Services which at least equals access available to other persons served by the CCO.
- To have a Clinical Record maintained which documents conditions, services received, and referrals made;
- To have the right to request and receive a copy of one's own Health Record, unless restricted in accordance with ORS 179.505 or other applicable law, and to request that the records be amended or corrected as specified in 45 CFR Part 164.To transfer a copy of his/her Clinical Record to another Provider;

- PSCS requires its Participating Providers to require that members receive information on available treatment options and alternatives presented in a manner appropriate to the member's condition, preferred language and ability to understand.
- To participate in decisions regarding his or her health care, including the right to refuse treatment and has the opportunity to execute a statement of wishes for treatment, including the right to accept or refuse medical, surgical, chemical dependency or behavioral health treatment and the right to execute directives and powers of attorney for health care established under ORS 127.505 to 127.660 and the OBRA 1990 – Patient Self-determination Act; ;
- The CCO shall ensure and cause it's Participating Providers to ensure that each member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the CCO, its staff, Subcontractors, Participating Providers or OHA, treat the member. The CCO shall not discriminate in any way against members when those members exercise their rights under the OHP;
- To receive written notices before a denial of, or change in, a benefit or service level is made, unless such notice is not required by federal or state regulations;
- To be able to make a complaint or appeal with the CCO and receive a response;
- To request a contested case hearing;
- To receive Certified or Qualified Health Care Interpreter services free of charge whether a Potential member or a member of the CCO. This service applies to all non-English languages, not just those that OHA identifies as prevalent. The CCO will notify its members and potential members that oral interpretation is available free of charge for any language and that written information is available in prevalent non-English languages in the Service Area(s) as specified in 42 CFR 438.10(d)(4). PSCS will also notify its members on how to access oral interpretation and written translation services;
- To receive a notice of an appointment cancellation in a timely manner;
- To receive a second opinion from a qualified Health Care Professional within the Provider Network, or have the Plan arrange for member to obtain a qualified Health Care Professional from outside the Provider Network, at no cost to the member.
- To report a complaint of discrimination by contacting the Plan, OHA, the Bureau of Labor and Industries (BOLI) or the Office of Civil Rights (OCR) and that they are aware of their civil rights under Title VI of the Civil Rights Act and ORS Chapter 659A;
- To receive notice of Plan's nondiscrimination policy and process to report a complaint of discrimination on the basis of race, color, national origin, religion, sex, sexual orientation, marital status, age, or disability in accordance with all applicable laws including Title VI of the Civil Rights Act and ORS Chapter 659A
- To receive equal access for males or females identified under 18 years of age to appropriate facilities, services and treatment under the current CCO Contract, consistent with OHA obligations under ORS 417.270;
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliations as specified in federal regulations on the use of restraints and seclusion.
- To only be responsible for cost sharing authorized under this Contract in accordance with 42 CFR 447.50 through 42 CFR 447.60 and with the General Rules.
- PSCS will notify members of their responsibility for paying a Co-Payment for some services as specified in OAR 410-120-1230;
- PSCS will furnish to each of its members the information specified in 42 CFR 438.10(f)(2)-(3) and 42CFR 438.10(g), if applicable, as specified in the CFR within 30 days after PSCS receives notice of the member's enrollment from OHA or for members who are Fully Dial Eligible, within the time period required by Medicare. PSCS will notify all members of their right to request and obtain the information described in this section at least once a year.
- To utilize electronic methods of communications upon request and if available; PSCS will utilize electronic communications for purposes described in the subsection above only if:
    - The recipient has requested or approved electronic transmittal;
    - The identical information is available in written form upon request;

- The information does not constitute a direct member notice related to an adverse Action or any portion of a Grievance, Appeals, Contested Case Hearings or any other member rights or member protection process;
- Language and alternative format accommodations are available; and
- All HIPAA requirements are satisfied with respect to personal information.

Residential Services Rights

In addition to the rights listed above, every individual receiving residential services has the following rights:

- To a safe, secure and clean living environment;
- To a humane service environment that has:
  - Reasonable protection from harm;
  - Reasonable privacy;
  - Daily access to fresh air and the outdoors;
  - To keep and use personal clothing and belongings;
  - To have enough private, secure storage space;
  - To express sexual orientation;
  - Gender identity and presentation;
  - To get to and participate in social, religious and community activities;
  - To private and uncensored communications by mail, telephone and visitation, subject to the following restrictions:
    - This right may be restricted only if the provider documents in the individual's record that there is a court order that says something else, or
    - That in the absence of this restriction, significant physical or clinical harm will result to the individual or others. (The nature of the harm must be specified in reasonable detail. Any restriction of the right to communicate must be no broader than necessary to prevent harm) and,
    - The individual and his or her guardian, if applicable, must be given specific written notice of each restriction of the individual's right to private and uncensored communication.
  - The provider must make sure that correspondence:
    - Can be conveniently received and mailed;
    - That telephones are reasonable able to use and allow for confidential communication. (Reasonable times for the use of telephones and visits may be established in writing by the provider.)
    - That space is available for visits;
    - To have access to and get available applicable educational services in the most integrated setting in the community;
    - To communicate privately with public or private rights protection programs or rights advocates, clergy, and legal or medical professionals;
  - To participate regularly in indoor and outdoor recreation;
  - To not be required to perform labor;
  - To have enough food and shelter;
  - To a reasonable accommodation if, due to a disability, the housing and services are not sufficiently accessible.

Provider Communication

Each contracted provider has access to our Provider Manual on the company website. If a provider cannot access the website, a printed copy of the manual can be supplied upon request. Member rights and the provider's responsibilities to comply with these rights are outlined in the Provider Manual. The Provider Manual encompasses all services rendered under PSCS, including physical health, behavioral health, oral health, and Non-Emergent Medical Transportation.

The Provider Network department will communicate these rights annually via the Provider Bulletin. The Provider Network Department is also responsible for developing, executing, and tracking an annual provider training plan in consultation with internal departments and experts, community governance partners, and other stakeholders. The plan will provide contracted providers with adequate opportunity for training, from PSCSor another source, in practices that support member rights and optimal care, including the following:

- cultural responsiveness,
- implicit bias,
- language access,
- trauma-informed practices such as Foundations of Trauma Informed Care,
- tools and interventions that promote healing from trauma and support resiliency,
- screening for Adverse Childhood Experiences,
- screening for medical or behavioral health conditions,
- screening for the adequacy of member's social and material supports,
- patient and family engagement,
- shared decision-making,
- use of the Prescription Drug Monitoring Program database,
- opiate prescribing guidelines,
- buprenorphine waiver eligibility,
- overdose reversal,
- accurate data reporting on utilization and capacity,
- motivational interviewing,
- program specific training (e.g. Wraparound Fidelity Index Short Form for agencies providing Wraparound services, use of HIT for providers)

Staff Communication

All PSCS staff will be trained on member rights during the onboarding process. Additionally this will be added to our internal annual training that is required to be completed by all PSCS employees. PSCS staff have continual access to company policies through the intranet on the PS Web. In addition, staff are informed of policy creation or updates through email and/or team meetings.

In addition to Enterprise-level programs for education such as tuition reimbursement and annual training related to Compliance and Security topics, the Human Resources Department is responsible for developing, executing, and tracking an annual staff training plan in consultation with internal departments and experts, community governance partners, and other stakeholders. The plan will provide staff with adequate opportunity for training in skills and knowledge that support member rights and optimal care as relevant to each staff member's role, including the following:

- cultural responsiveness,
- implicit bias,
- language access,
- trauma-informed practices such as Foundations of Trauma Informed Care,
- tools and interventions that promote healing from trauma and support resiliency,
- screening for Adverse Childhood Experiences,
- screening for medical or behavioral health conditions,
- screening for the adequacy of member's social and material supports,
- patient and family engagement,

- shared decision-making,
- motivational interviewing,

Enrollee Communication

PSCS notifies members of their rights upon each enrollment segment with the CCO, unless they were previously enrolled in the CCO within the last 6 months. PSCS sends the member the PSCS Member Handbook, which includes the member rights. The member rights are also available on the PSCS website at https://communitysolutions.pacificsource.com/Member, which can be accessed 24 hours a day, 7 days a week. If a member cannot access the website, a printed copy of the member rights can be supplied upon request. In addition, PSCS conducts a Verification of Services Survey on one percent of claims that are adjudicated. Included in this survey are questions pertaining to member rights. The responses to these questions are reviewed and any issues identified are addressed.

Provider Monitoring and Corrective Action

PSCS will educate, oversee, and monitor providers to ensure they are complying with the rights and responsibilities listed above. The monitoring process will be conducted through an annual Provider Member Rights Survey. Results from the survey will analyzed, delinquent providers outlined from the results of the survey will be contacted for education. Education will be provided within Provider Network by the Service department. Additional monitoring will occur through the Grievance and Appeals process. Any complaint received that is regarding a possible violation of a member's rights will be logged and tracked as a member rights grievance. These complaints will be reviewed by the Clinical Quality and Utilization Management (CQUM) Committee on a monthly basis. If a provider is found to have violated a member's rights, the CQUM Committee will determine appropriate corrective action.

Appendix

Policy Number: [Policy Number]

Effective: 7/1/2019 **Next review:** 7/1/2022

Policy type: Government

Author(s): Jane Hannabach

Depts: Provider Network, Claims, Health Services, Grievance and Appeals

Applicable regulation(s): OAR 410-141-3590: OAR 410-141-3320

External entities affected: [External Entities Affected]

Approved by

Modification History

Date	Modified By	Reviewed By	Modifications
06/21/21	Jane Hannabach		No changes Annual Review
06/19/20	Jane Hannabach		Correction of OAR numbers
03/24/20	Jane Hannabach		Update per new OAR
7/8/2019	R. Hanson J. Hannabach T. Anderson K. Dillon S. Ohrtman T. Townsend	David Stenstrom MD Mike Franz, MD	Updated policy language with minor edits per CCO 2020
3/22/2019	Jane Hannabach & Tara Anderson	Lindsey Hopper, Jessica Sayers, Tara Anderson	Revised language to update per CCO 2020 contract
2/19/18	Sara Ohrtman	Jane Hannabach, Sara Ohrtman	Corrected to CQUM Committee
01/12/2017	Jessica Sayers	Lindsey Hopper, Sara Ohrtman, Jane Hannabach	Added communication language required for compliance.
1/6/2016	Debbie Smith/Jennifer Brown	Jennifer Brown	Updated language consistent with regulations.
10/12/2015	Lisa Zent	Jennifer Brown	Updated all language consistent with OAR 410-141-3320
02/06/2015	Michelle Cochran	Lisa Zent	Minor language updates

Medicaid Grievance and Appeals System – Member Information and Education Requirements

State(s):	LOB(s):
☐ *Idaho* ☐ *Montana* ☒ *Oregon* ☐ *Washington* ☐ *Other:*	☐ *Commercial* ☐ *Medicare* ☒ *Medicaid* ☐ *PSA*

Government Policy

This Policy outlines the requirements and actions of PacificSource Community Solutions member materials, information and education requirements in line with Oregon Administrative Rules (OAR) 410-141-3875 through 410-141-3915, 410-141-3525, 410-141-3751 through 410-141-3915, 410-120-1860, 137-003-0501 through 137-003-0700, 410-141-3915, 410-141-3500, 410-141-3885.

This policy is subject to approval by the Oregon Health Authority (OHA) and must be submitted annually, as directed by the OHA, or anytime thereafter upon a significant change.

Procedure: Member Information and Education Requirements

In accordance with the CCO contract with the State, PacificSource is required to utilize a member handbook approved by the state that:

- Includes the enrollee's right to file grievances and appeals.
- Includes the requirements and timeframes for filing a grievance or appeal.
- Includes information on the availability of assistance in the filing process for grievances.
- Includes information on the availability of assistance in the filing process for appeals.
- Includes the enrollee's right to request a state fair hearing after the CCO has made a determination on an enrollee's appeal, which is adverse to the enrollee.
- Specifies that, when requested by the enrollee, benefits that the CCO seeks to reduce or terminate will continue if the enrollee files an appeal or a request for state fair hearing within the timeframes specified for filing, and that the enrollee may, consistent with state policy, be required to pay the cost of services furnished while the appeal or state fair hearing is pending if the final decision is adverse to the enrollee.

(1) CCOs may engage in activities for existing members related to outreach, health promotion, and health education. The Authority shall approve prior to distribution any written communication by the CCO or its subcontractors and providers that:

(a) Is intended solely for members; and

(b) Pertains to requirements for obtaining coordinated care services at service area sites or benefits.

(2) CCOs may communicate with providers, caseworkers, community agencies, and other interested parties for informational purposes or to enable care coordination, and address social determinants of

health or community health. The intent of these communications should be informational only for building community linkages to impact social determinants of health or member care coordination and not to entice or solicit membership. Communication methodologies may include but are not limited to brochures, pamphlets, newsletters, posters, fliers, websites, health fairs, or sponsorship of health-related events. CCOs shall address health literacy issues by preparing these documents at a low-literacy reading level, incorporating graphics and utilizing alternate formats.

(3) The creation of name recognition because of the CCO's health promotion or education activities may not constitute an attempt by the CCO to influence a client's enrollment.

(4) A CCO or its subcontractor's communications that express participation in or support for an CCO by its founding organizations or its subcontractors may not constitute an attempt to compel or entice a client's enrollment.

(5) The following may not constitute marketing or an attempt by the CCO to influence client enrollment:

(a) Communication to notify dual-eligible members of opportunities to align CCO provided benefits with a Medicare Advantage or Special Needs Plan;
(b) Improving coordination of care;
(c) Communicating with providers serving dual-eligible members about unique care coordination needs; or
(d) Streamlining communications to the dually-enrolled member to improve coordination of benefits.

(6) CCOs shall have a mechanism to help members understand the requirements and benefits of the CCO's integrated and coordinated care plan. The mechanisms developed shall be culturally and linguistically appropriate.

(7) CCOs shall have written procedures, criteria, and an ongoing process of member education and information sharing that includes member orientation, member handbook, and health education. CCOs shall update their educational material as they add coordinated services. Member education shall:

(a) Include information about the coordinated care approach and how to navigate the coordinated health care system, including how to access Exceptional Needs Care Coordination (ENCC) or Intensive Care Coordination (ICC) Services, and where applicable for dual-eligible individuals, the process for coordinating Medicaid and Medicare benefits;

(b) Clearly explain how members may receive assistance from advocates, including certified health care interpreters, community health workers, peer wellness specialists, and personal health navigators, and include information to members that interpreter services in any language required by the member, including American Sign Language, auxiliary aids and alternative format materials at provider offices are free to CCO members as stated in 42 CFR 438.10.

(8) Written member education materials shall:

(a) Ensure written materials, including provider directories, member handbooks, appeal and grievance notices, and all denial and termination notices are made available in the prevalent non-English languages in its particular service area;

(b) Be translated or include taglines in the prevalent non-English languages in the state as well as large print (font size 18) explaining the availability of written translation or oral interpretation to understand the information provided and the toll free and TTY/TDY telephone number of the CCO's member/customer service unit;

(c) Be made available in alternative formats upon request of the member at no cost. Auxiliary

aids and services must also be made available upon request of the member at no cost.

(d) Accommodate requests made by other sources such as members, family members, or caregivers for language accommodation, translating to the member's language needs as requested.

(9) Electronic versions of member materials, including provider directories, formularies, and handbooks shall be made available prominently on the CCO website in a form that can be electronically retained and printed, available in a machine readable file and format, and readily accessible, e.g., a PDF document posted on the plan website that meets language requirements of this section. For any required member education materials on the CCO website, the member is informed that the information is available in paper form without charge upon request, and the CCO shall provide it upon request within five business days.

(10) CCO provider directories shall include:

(a) The provider's name as well as any group affiliation;

(b) Street address;

(c) Telephone number;

(d) Website URL, as appropriate;

(e) Provider Specialty, as appropriate;

(f) Whether the provider will accept new members;

(g) Information about the provider's cultural and linguistic capabilities including:

(A) Availability of qualified or certified interpreters at no cost to members ensuring oral interpretation is available in all languages and American Sign Language per CFR §438.10;

(B) Availability of auxiliary aids and services for all members with disabilities upon request and at no cost; and

(C) Whether the provider has completed cultural competence training as required by ORS
413.450 and whether providers have verifiable language fluency in non-English (i.e., such as clinical training in a foreign country or clinical language testing);

(A) Whether the provider's office or facility is accessible and has accommodations for people with physical disabilities, including information on accessibility of providers' offices, exam rooms, restrooms, and equipment.

(h) The provider directory must include the information for each of the following provider types covered under the contract, as applicable to the CCO contract:

(A) Physicians, including specialists;

(B) Hospitals;

(C) Pharmacies;

(D) Behavioral health providers; including specifying substance use treatment providers;

(E) Dental providers.

(i) Information included in the provider directory must be updated at least monthly, and electronic provider directories must be updated no later than 30 days after the CCO receives updated provider information. Updated materials shall be available on the CCO website in a readily accessible and machine readable file, e.g., a PDF document posted on the plan website, per form upon request and other alternative format;

(j) Each CCO shall make available in electronic or paper form the following information about its formulary:

(A) Which medications are covered both generic and name brand;

(B) What tier each medication is on.

(11) Within 14 days or a reasonable timeframe of a CCO's receiving notice of a member's enrollment, CCOs shall mail a welcome packet to new members and to members returning to the CCO 12 months or more after previous enrollment. The packet shall include, at a minimum, a welcome letter, a member handbook, and information on how to access a provider directory, including a list of any in-network retail and mail-order pharmacies.

(12) For existing CCO members, a CCO shall notify members annually of the availability of a member handbook and provider directory and how to access those materials. CCOs shall send hard copies upon request within five days.

(13) CCOs shall facilitate materials as follows:

(a) Translate the following written materials into the prevalent non-English languages served by the CCO:

(A) Welcome Packets that include welcome letters and member handbooks; and

(B) Notices of medical benefit changes.

(b) Information on disability access, alternate format and language statement inserts with:

(A) Communications regarding member enrollment; and

(B) Notice of Adverse Benefit Determination to deny, reduce, or stop a benefit, and Verification of Services Letter.

(c) Accommodate requests of the member to translate written materials into prevalent non-English languages served by the CCO. Written and spoken language preferences are indicated on the Oregon Health Plan application form and reported to plans in 834 enrollment updates. CCOs shall honor requests made by other sources such as members, family members, or caregivers for language accommodation, translating to the member's language needs as requested;

(d) Make oral interpretation services available free of charge to each potential member and member. This applies to all non-English languages and American Sign Language, not just prevalent non-English languages.

(14) CCOs must notify enrollees:

(a) That oral interpretation is available free of charge for any language, including American Sign Language, and written information is available in prevalent non-English languages and alternate formats that include but are not limited to audio recording, close-captioned videos, large type (18 font), and braille; and

(b) The process for requesting and accessing interpreters or auxiliary aids and alternative formats, including where appropriate how to contact specific providers responsible through sub-contracts to ensure provision of language and disability access;

(c) Language access services also applies to family members and caregivers with hearing impairments or limited English proficiency who need to understand the member's condition and care.

(15) A CCO shall electronically provide to the Authority for approval each version of the printed welcome packet that includes a welcome letter, member handbook, and information on how to access a provider directory. At a minimum, the member handbook shall contain the following:

(a) Revision date;

(b) Tag lines in English and other prevalent non-English languages, as defined in this rule, spoken by populations of members. The tag lines shall be located at the beginning of the document for the ease of the member and describe how members may access free sign and oral interpreters, as well as translations and materials in other formats. Alternate formats may include but are not limited to readily accessible formatted materials, audio recordings, close-captioned videos, large (18 point) type, and braille;

(c) CCO's office location, mailing address, web address, office hours, and telephone numbers including TTY;
(d) Availability and access to coordinated care services through a patient-centered primary care home or other primary care team with the member as a partner in care management. Explain how to choose a PCP, how to make an appointment, and how to change PCPs, and the CCO's policy on changing PCPs;

(e) How to access information on contracted providers currently accepting new members and any restrictions on the member's freedom of choice among participating providers;

(f) Which participating or non-participating provider services the member may self-refer;

(g) Policies on referrals for specialty care, including prior authorization requirements and how to request a referral;

(h) Explanation of Intensive Care Coordination (ICC) services or Exceptional Needs Care Coordination (ENCC) and how members with the following special health care needs may access these care coordination services: Members who are aged, blind, disabled or who have complex medical needs, high health needs, multiple chronic conditions, mental illness, chemical dependency, or receive additional Authority Medicaid-funded long-term care or long-term services and supports;

(i) Information about the coordinated care approach, how to navigate the coordinated care health care system as applicable to dual-eligible individuals, the process for coordinating Medicaid and Medicare benefits;

(j) How and where members are to access urgent care services and advice, including how to access these services and advice when away from home;

(k) How and when members are to use emergency services, both locally and when away from home, including examples of emergencies;

(l) Information on contracted hospitals in the member's service area;

(m) Information on post-stabilization care after a member is stabilized in order to maintain, improve, or resolve the member's condition;

(n) Information on the CCO's grievance and appeals processes and the Authority's contested case hearing procedures, including:

(A) Information about assistance in filling out forms and completing the grievance process available from the CCO to the member as outlined in OAR 410-141-3875;

(B) Information about the member's right to continued benefits during the grievance process as provided in OAR 410-141- 3240.

(o) Information on the member's rights and responsibilities, including the availability of the OHP Ombudsman;

(p) Information on charges for non-covered services, and the member's possible responsibility for charges if they go outside of the CCO network for non-emergent care; including information specific to deductibles, copays and coinsurance for dually-enrolled qualified Medicare beneficiaries;

(q) Information about when providers may bill clients for services and what to do if they receive a bill, including information specific to payment responsibilities for dually-enrolled qualified Medicare beneficiaries;

(r) The transitional procedures for new members to obtain prescriptions, supplies, and other necessary items and services in the first month of enrollment if they are unable to meet with a PCP or PCD, other prescribing provider, or obtain new orders during that period; including specific communications for members who are becoming new Medicare enrollees;

(s) Information on advance directive policies including:

(A) Member rights under federal and Oregon law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;

(B) The CCO's policies for implementation of those rights, including a statement of any limitation regarding the implementation of advanced directives as a matter of conscience.

(t) Whether or not the CCO uses provider contracts including alternative payment methodologies or incentives;

(u) The member's right to request and obtain copies of their clinical records, whether they may be charged a reasonable copying fee, and that they may request the record be amended or corrected;

(v) How and when members are to obtain ambulance services;

(w) Resources for help with transportation to appointments with providers and scheduling process for use of non-emergency medical transportation (NEMT) services;

(x) Explanation of the covered and non-covered coordinated care services in sufficient detail to ensure that members understand the benefits to which they are entitled;

(y) How to access in-network retail and mail-order pharmacies;

(z) How members are to obtain prescriptions including information on the process for obtaining non- formulary and over-the-counter drugs;

(aa) The CCO's confidentiality policy;

(bb) How and where members may access any benefits that are available under OHP

but are not covered under the CCO's contract, including any cost sharing;

(cc) When and how members may voluntarily and involuntarily disenroll from CCOs and change CCOs;

(dd) CCOs shall, at a minimum, annually review their member handbook for accuracy and update it with new and corrected information to reflect OHP program changes and the CCO's internal changes. If changes affect the member's ability to use services or benefits, the CCO shall offer the updated member handbook to all members;

(ee) The "Oregon Health Plan Client Handbook" is in addition to the CCO's member handbook, and a CCO may not use it to substitute for any component of the CCO's member handbook.

(16) Member health education shall include:

(a) Information on specific health care procedures, instruction in self-management of health care, promotion and maintenance of optimal health care status, patient selfcare, and disease and accident prevention. CCO providers or other individuals or programs approved by the CCO may provide health education. CCOs shall make every effort to provide health education in a culturally sensitive and linguistically appropriate manner in order to communicate most effectively with individuals from non- dominant cultures;
(b) Information specifying that CCOs may not prohibit or otherwise restrict a provider acting within the lawful scope of practice from advising or advocating on behalf of a member who is his or her patient for the following:

(A) The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

(B) Any information the member needs to decide among all relevant treatment options;

(C) The risks, benefits, and consequences of treatment or non-treatment.

(c) CCOs shall ensure development and maintenance of an individualized health educational plan for members whom their provider has identified as requiring specific educational intervention. The Authority may assist in developing materials that address specifically identified health education problems to the population in need;

(d) Explanation of Intensive Care Coordination (ICC) services or Exceptional Needs Care Coordination (ENCC) and how to access this care coordination through outreach to members with special health care needs including those who are aged, blind, or disabled, or who have complex medical needs or high health care needs, multiple chronic conditions, mental illness, chemical dependency, or receive additional Authority Medicaid-funded long-term care or long-term services and supports;

(e) The appropriate use of the delivery system, including proactive and effective education of members on how to access emergency services and urgent care services appropriately;

(f) CCOs shall provide written notice to affected members of any significant changes in program or service sites that affect the member's ability to access care or services from CCO's participating providers. The CCO shall provide, translated as appropriate, the notice at least 30 days before the effective date of that change, or as soon as possible if the participating provider has not given the CCO sufficient notification to meet the 30-day notice requirement. The Authority shall review and approve the materials within two working days.

(17) Informational materials that CCOs develop for members shall meet the language requirements identified in this rule and be culturally and linguistically sensitive to members with disabilities or

reading limitations, including members whose primary language is not English as previously outlined in this rule.

(18) CCOs shall provide an identification card to members unless waived by the Authority that contains simple, readable, and usable information on how to access care in an urgent or emergency situation. The cards are solely for the convenience of the CCO, members, and providers.

Appendix

Policy Number: [Policy Number]

Effective: 1/1/2021 **Next review:** 7/1/2022

Policy type: Government

Author(s):

Depts: [Dept]

Applicable regulation(s): [Applicable Regulations(s)]

External entities affected: [External Entities Affected]

Approved by:

Modification History

Date	Modified By	Reviewed By	Modifications
2/17/2021	Jessica Waltman		Annual Review and carve out from single policy
05/25/2021	JoEl Adams		Revisions following OHA PnP review
08/12/2021	JoEl Adams		Received OHA PnP approval dated 08/09/2021.

Medicaid Grievance and Appeal System – Notice of Adverse Benefit Determination

State(s):	LOB(s):
☐ *Idaho* ☐ *Montana* ☒ *Oregon* ☐ *Washington* ☐ *Other:*	☐ *Commercial* ☐ *Medicare* ☒ *Medicaid* ☐ *PSA*

Government Policy

This policy outlines the requirements and actions of how PacificSource Community Solutions will accept, process and issue notice of adverse benefit determinations in line with Oregon Administrative Rules 410-141-3515, 410-141-3520, 410-141-3820, 410-141-3830, 410-141-3835, 410-141-3875 – 410-141-3895.

This policy is subject to approval by the Oregon Health Authority (OHA) and must be submitted annually as directed by OHA, or anytime thereafter upon a significant change.

Definitions

Adverse benefit determination means any of the following:

1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit;

2) The reduction, suspension or termination of a previously authorized service;

3) The denial, in whole or in part, of payment for a service. This excludes any claim that is not a clean claim. Clean claim means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

4) The failure to provide services in a timely manner pursuant to 410-141-3515;

5) The MCE's failure to act within the timeframes provided in 410-141-3875 through 410-141-3895 regarding the standard resolution of grievances and appeals;

6) For a resident of a rural area with only one MCE, the denial of a member's request to exercise their legal right under §438.52(b)(2)(ii) to obtain services outside the network; or

7) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance and other member financial liabilities.

Adverse Benefit Determination

(1) When PacificSource has made an adverse benefit determination, PacificSource shall notify the requesting provider and give the member and the member's representative a written notice of adverse benefit determination. The notice shall:

(a) PacificSource must use an Oregon Health Authority (OHA) approved form unless the member is dually eligible member of affiliated Medicare and Medicaid plans, in which case the CMS Integrated Denial Notice may be used as long as it incorporates required information fields in Oregon's NOABD.

(b) Comply with the Authority's formatting and readability standards in OAR 410-141-3585 and 42 CFR § 438.10 and be written in language sufficiently clear that a layperson could understand the notice and make an informed decision about appealing and following the process for requesting an appeal. This includes translating a NOABD for those members who speak prevalent non-English languages. OHA defines "easily understood" as 6th grade reading level or lower using the Flesch-Kincaid readability scale and use of a minimum 12 point font or larger print (18 point). NOABD must include a language access tagline in 18 point font which explains:
1) The availability of written translation or oral interpretation to understand the information provided, how to request auxiliary aids and services for members who have limited English proficiency or a disability, as well as alternate formats at no cost, and
2) The toll-free and TTY/TDY telephone number of the MCE's member/customer service unit.
The NOABD includes a language access statement with the 24 translated languages in at least 12 point font.
A nondiscrimination policy is attached to each NOABD.

(c) For timing of notices, follow timelines required for the specific service authorization or type via oral and written mechanisms for any service request of the member or the member's provider outlined in OAR 410-141-3835 MCE Service Authorization or otherwise specified in this rule;

(d) Meet the content notice requirements specified in 42 CFR § 438.404 and in PacificSource's contract, including the following information:

(A) Date of the notice;
(B) PacificSource's name, address, and telephone number;
(C) Name of the member's Primary Care Practitioner (PCP), Primary Care Dentist (PCD), or behavioral health professional, as applicable;
(D) Member's name, address, and member ID number;
(E) Description and explanation of the service(s) requested or previously provided and explanation of the adverse benefit determination the MCE has made or intends to make, including whether the MCE is denying, terminating, suspending or reducing a service or payment for a service in whole or in part
(F) Date of the service or date service was requested by the provider or member;
(G) Name of the provider who performed or requested the service;
(H) Effective date of the adverse benefit determination if different from the date of the notice;
(I) Whether PacificSource considered other conditions such as co-morbidity factors if the service was below the funding line on the Prioritized List of Health Services and other services pursuant to 410-141-3820 and 410-141-3830;
(J) Clear and thorough explanation of the specific reasons for the adverse benefit

determination;
(K) A reference to the specific statutes and administrative rules to the highest level of specificity for each reason and specific circumstance identified in the ABD notice;
(L) The member's or the provider's right to file an appeal of PacificSource's adverse benefit determination with PacificSource, including information on exhausting PacificSource's one level of appeal, and the procedures to exercise that right;
(M) The member's or the provider's right to request a contested case hearing with the Authority only after PacificSource's Appeal Notice of Resolution or where PacificSource failed to meet appeal timelines in OAR 410-141-3890 and 410-141-3895, and the procedures to exercise that right;
(N) The circumstances under which an appeal process or contested case hearing can be expedited and how the member or the member's provider may request it;
(O) The member's right to have benefits continue pending resolution of the appeal or contested case hearing, how to request that benefits be continued, and the circumstances under which the member may be required to pay the cost of these services; and
(P) The member's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination including any processes, strategies, or evidentiary standards used by PacificSource in setting coverage limits or making the adverse benefit determination.
(Q) Provide copies of the following forms to members when it issues an NOABD:
1) The Health Systems Division Service Denial Appeal and Hearing Request form (OHP 3302) or approved facsimile (OHA preferred form); or
2) Hearing request form (MSC 443) and Notice of Hearing Rights (OHP 3030). .

(2) PacificSource shall provide copies of the following forms when PacificSource issues a Notice of Adverse Benefit Determination:
(a) Hearing request form (MSC 443) and Notice of Hearing Rights (OHP 3030); or
(b) The Health Systems Division Service Denial Appeal and Hearing Request form (OHP 3302) or approved facsimile.

(3) For requirements of notice of adverse benefit determinations that affect services previously authorized, PacificSource shall mail the notice at least ten10 days before the date the adverse benefit determination reduction, termination, or suspension takes effect, as referenced in 42 CFR 431.211.

(4) In 42 CFR §§ 431.213 and 431.214, exceptions related to advance notice include the following:

(a) PacificSource may mail the notice no later than the date of adverse benefit determination if:

(A) PacificSource has factual information confirming the death of the member;

(B) PacificSource receives notice that the services requested by the member stating are no longer desired or PacificSource is provided with information that requires termination or reduction in services and indicates that he understands that this must be the result of supplying that information;

(i) All notices sent by a member under this section shall be in writing, clearly indicate the member understands that the services previously requested will be terminated or reduced as a result of the notice and signed by the member;
(ii) All notices sent by PacificSource under this section shall be in writing and shall include a clear statement that advises the member what information was received and that such information required the termination or reduction in the services the member requested.

(C) PacificSource can verify that the member has been admitted to an institution where the member is no longer eligible for OHP services from PacificSource;

(D) PacificSource is unaware of the member's whereabouts and PacificSource receives returned mail directed to the member from the post office indicating no forwarding address and the Authority or Department has no other address;

(E) PacificSource verifies another state, territory, or commonwealth accepted the member for Medicaid services; or

(F) The member's PCP, PCD, or behavioral health professional prescribed a change in the level of health services.

(b) PacificSource must mail the notice five days before the adverse benefit determination when PacificSource:

(A) Has facts indicating that an adverse benefit determination should be taken because of probable fraud on part of the member; and

(B) PacificSource has verified those facts, whenever possible, through secondary resources.

(c) For denial of payment, the adverse benefit determination shall be mailed at the time of any adverse benefit determination that affects the claim.

(5) For standard authorization decisions for services not previously authorized and that deny or limit the amount, duration or scope of services, the MCE must notify the requesting provider and mail the NOABD to the member as expeditiously as the member's condition requires and in all cases no later than 14 calendar days following receipt of the request for services with a possible extension for MCE up to 14 additional days, if:

1) The member, member's representative or provider requests an extension; or
2) The MCE justifies to OHA upon request a need for additional information and how the extension is in the member's best interest. MCE must provide its justification to OHA, via Administrative Notice to the email address identified by OHA in its request, within five days of OHA's request.

(6) For cases in which a provider indicates, or the MCE determines, that following the standard authorization timeframe could seriously jeopardize the member's life or health or member's ability to attain, maintain or regain maximum function, the MCE must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service which period of time is determined by the time and date stamp on the receipt of the request.

(7) The MCE may extend the 72 hour expedited authorization decision time period up to 14 additional calendar days if:
1) The member or the provider requests an extension; or
2) If the MCE justifies to OHA upon request a need for additional information; and
3) How the extension is in the member's interest.
MCE must provide its justification for any request to OHA, via Administrative Notice, upon request.

(8) If the MCE meets the criteria to extend the 14 calendar day NOABD timeframe for expedited and standard authorization decisions that deny or limit services, it must:
1) Give the member written notice of the reason for the decision to extend the timeframe;
2) Make reasonable effort to give the member oral notice of the reason for the decision to extend

the timeframe;
3) Inform the member of the right to file a grievance if the member disagrees with that decision; and
4) Issue and carry out its determination as expeditiously as the member's health or mental health condition requires, but no later than the date the extension expires.

(9) For either standard or expedited service authorization decisions not reached within the timeframes specified in 438.210(d) [which constitutes a denial and is thus an adverse benefit determination], the MCE must mail the notice on the date that the timeframes expire.

(10) Within 60 days from the date on the notice: The member or provider may file an appeal; the member may request a Contested Case Hearing with the Authority after receiving notice that PacificSource's adverse benefit determination is upheld; or if PacificSource fails to adhere to the notice and timing requirements in 42 CFR 483.408, the Authority may consider PacificSource appeals process
exhausted.

Timing of NOABD for Outpatient Drugs

Service authorization decisions for outpatient drugs include a practitioner administered drug (PAD). When the MCE has made or intends to make an adverse benefit determination for an initial outpatient drug request and is in receipt of the MCE's standard information collection tools for prior authorization, within 24 hours, the MCE must issue a written NOA/NOABD to the member and telephonic or electronic notice to the prescribing practitioner, and when known to the MCE, the pharmacy if the drug is denied or partially approved.

If additional documentation needs to be requested from the prescribing practitioner in order to render a decision, this must not delay a decision to approve or deny the drug as expeditiously as the member's health requires and no later than 72 hours.

The 72-hour window for a coverage decision begins with the initial date and time stamp of a prior authorization request for a drug.

If the requested additional documentation is not received within 72 hours from the date and time stamp of the initial request for prior authorization, the MCE must issue a written NOABD to the member and telephonic or electronic notice to the prescribing practitioner, and when known to the MCE, the pharmacy.

Participating Providers and Subcontractors

PacificSource must cause its participating providers and subcontractors to comply with the Grievance and Appeal System requirements set forth.

PacificSource must provide to all participating providers and subcontractors, at the time they enter into a subcontract, written notification of procedures and timeframes for notices of adverse benefit determination, grievances, appeals, and contested case hearings as set forth in Exhibit I and must provide all of its participating providers and other subcontractors written notification of updates to these procedures and timeframes within five (5) business days after approval of such updates by OHA.

PacificSource must monitor and document the compliance of its subcontractors, including its provider network, with all adverse benefit determination requirements in accordance with applicable law and the applicable provisions of this contract and take and document any necessary corrective action.

Recordkeeping Requirements

PacificSource must retain and keep accessible all notices of adverse determination and any documentation, logs and other records for adverse benefit determinations whether in paper, electronic, or other form for a minimum of 10 years.

Appendix

Policy Number: [Policy Number]

Effective: 1/1/2021 **Next review:** 7/1/2022

Policy type: Government

Author(s):

Depts: [Dept]

Applicable regulation(s): 410-141-3515, 410-141-3520, 410-141-3820, 410-141-3830, 410-141-3835, 410-141-3875 through 410-141-3895

External entities affected: [External Entities Affected]

Approved by:

Modification History

Date	Modified By	Reviewed By	Modifications
2/17/2021	Jessica Waltman		Annual review and carve out to own policy
05/25/2021	JoEl Adams		Revisions following OHA PnP review
08/10/2021	JoEl Adams		Received OHA's official notice of PnP approval, dated 08/09/2021.

Medicaid Grievance and Appeals System – Grievances, Appeals and Hearings

State(s):	LOB(s):
☐ Idaho ☐ Montana ☒ Oregon ☐ Washington ☐ Other:	☐ Commercial ☐ Medicare ☒ Medicaid ☐ PSA

Government Policy

This Policy outlines the requirements and actions of how PacificSource Community Solutions will accept, process and respond to appeals, grievances, and contested hearings in line with Oregon Administrative Rules (OAR) 410-141-3875 through 410-141-3915, 410-141-3525, 410-141-3751 through 410-141-3915, 410-120-1860, 137-003-0501 through 137-003-0700, 410-141-3915, 410-141-3500, 410-141-3885.

This policy is subject to approval by the Oregon Health Authority (OHA) and must be submitted annually, as directed by OHA, or anytime thereafter upon a significant change.

Procedure: Grievances, Appeals and Hearings

(1) The following definitions apply for purposes of this rule and OAR 410-141-3835 through 410-141-3915:

(a) “Appeal” means a review by PacificSource, pursuant to OAR 410-141-3890 of an adverse benefit determination.
(b) “Adverse Benefit Determination” means, any of the following, consistent with 42 CFR § 438.400(b):

(A) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
(B) The reduction, suspension, or termination of a previously authorized service;
(C) The denial, in whole or in part, of payment for a service;
(D) The failure to provide services in a timely manner pursuant to 410-141-3515;
(E) PacificSource’s failure to act within the timeframes provided in these rules regarding the standard resolution of grievances and appeals;
(F) For a resident of a rural area with only one MCE, the denial of a member’s request to exercise their legal right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network; or

(G) The denial of a member’s request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

(c) “Contested Case Hearing” means a hearing before the Authority under the procedures of OAR 410-141-3900 and 410-120-1860;
(d) “Continuing benefits” means a continuation of benefits in the same manner and same amount while an appeal or contested case hearing is pending, pursuant to OAR 410-141-3910;
(e) “Grievance” means a member's expression of dissatisfaction to PacificSource or to a participating provider the Authority about any matter other than an adverse benefit determination, as defined in OAR 410-120-0000. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member’s rights regardless of whether remedial action is requested. A Grievance also includes a member’s right to dispute an extension of time proposed by PacificSource to make an authorization decision;
(f) “Member.” With respect to actions taken regarding grievances, appeals and contested case hearings, references to a “member” include, as appropriate, the member, the member’s representative, and the representative of a deceased member’s estate. With respect to PacificSource notification requirements, a separate notice must be sent to each individual who falls within this definition;
(g) “Notice of Adverse Benefit Determination” means the notice must meet all requirements found at 42 CFR 438.44

(2) PacificSource shall establish and have an Authority approved process and written procedures for compliance with grievance and appeals requirements that shall include the following:

(a) Member rights to file a grievance at any time for any matter other than an adverse benefit determination;
(b) Member rights to appeal and request an MCE review of an adverse benefit determination, including the ability of providers and authorized representatives to appeal on behalf of a member;
(c) Member rights to request a contested case hearing regarding a PacificSource adverse benefit determination once the plan has issued a written notice of appeal resolution under the Administrative Procedures Act;
(d) An explanation of how PacificSource shall accept, acknowledge receipt, process, and respond to
grievances, appeals, and contested case hearing requests within the required timeframes;
(e) Compliance with grievance and appeals requirements as part of state quality strategy and to enforce a consistent response to complaints of violations of consumer rights and protections;
(f) Specific to the appeals process, the policies shall:

(A) Consistent with confidentiality requirements, ensure PacificSource’s staff designated to receive appeals begins to obtain documentation of the facts concerning the appeal upon receipt;
(B) Provide the member a reasonable opportunity to present evidence and testimony and make legal and factual arguments in person as well as in writing:;
(C) PacificSource shall inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for both standard and expedited appeals;
(D) PacificSource shall provide the member the member’s case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by PacificSource (or at the direction of PacificSource) in connection with the appeal of the adverse benefit determination at no charge and sufficiently in advance of the standard resolution timeframe for appeals.; and

(E) Ensure documentation of appeals in an appeals log maintained by PacificSource that complies with OAR 410-141-3915 and is consistent with contractual requirements.

(3) PacificSource shall provide information to members regarding the following:

(a) An explanation of how PacificSource shall accept, process, and respond to grievances, appeals, and contested case hearing requests, including requests for expedited review of grievances and appeals;
(b) Member rights and responsibilities; and
(c) How to file for a hearing through the state's eligibility hearings unit related to the member's current eligibility with OHP.

(4) PacificSource shall adopt and maintain compliance with grievances and appeals process timelines in 42 CFR §§ 438.408(b)(1) and (2) and these rules.

(5) Upon receipt of a grievance or appeal, PacificSource shall:

(a) Within five business days, resolve or acknowledge receipt of the grievance or appeal to the member and the member's provider where indicated;
(b) Give the grievance or appeal to staff with the authority to act upon the matter;
(c) Obtain documentation of all relevant facts concerning the issues, including taking into account all comments, documents, records, and other information submitted by the member without regard to whether the information was submitted or considered in the initial adverse benefit determination or resolution of grievance;
(d) Ensure staff and any consulting experts making decisions on grievances and appeals are:

(A) Not involved in any previous level of review or decision making nor a subordinate of any such individual;
(B) Health care professionals with appropriate clinical expertise in treating the member's condition or disease, if the grievance or appeal involves clinical issues or if the member requests
an expedited review. Health care professionals shall make decisions for the following:

(i) An appeal of a denial that is based on lack of medically appropriate services or involves clinical issues;
(ii) A grievance regarding denial of expedited resolution of an appeal or involves clinical issues.

(C) Taking into account all comments, documents, records, and other information submitted by the member without regard to whether the information was submitted or considered in the initial adverse benefit determination;

(D) Not receiving incentivized compensation for utilization management activities by ensuring that individuals or entities who conduct utilization management activities are not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

(6) PacificSource shall analyze all grievances, appeals, and hearings in the context of quality improvement activity pursuant to OAR 410-141-3525 and 410-141-3875.

(7) PacificSource shall keep all health care information concerning a member's request confidential, consistent with appropriate use or disclosure as defined in 45 CFR 164.501, and include providing member assurance of confidentiality in all written, oral, and posted material in grievance and appeal processes.

(8) The following pertains to the release of a member's information:

(a) PacificSource and any provider whose authorizations, treatments, services, items, quality of care, or requests for payment are involved in the grievance, appeal, or hearing may use this information without the member's signed release for purposes of:

(A) Resolving the matter; or
(B) Maintaining the grievance or appeals log as specified in 42 CFR 438.416.

(a) If PacificSource needs to communicate with other individuals or entities not listed in subsection (a) to respond to the matter, PacificSource shall obtain the member's signed release and retain the release in the member's record.

(9) PacificSource shall provide members with any reasonable assistance in completing forms and taking other procedural steps related to filing grievances, appeals, or hearing requests. Reasonable assistance includes but is not limited to:

(a) Assistance from certified community health workers, peer wellness specialists, or personal health navigators to participate in processes affecting the member's care and services;
(b) Free interpreter services or other services to meet language access requirements where required in 42 CFR §438.10;
(c) Providing auxiliary aids and services upon request including but not limited to toll-free phone numbers that have adequate TTY/TTD and interpreter capabilities; and
(d) Reasonable accommodation or policy and procedure modifications as required by any disability of the member.

(10) PacificSource, its subcontractors, and its participating providers may not:

(a) Discourage a member from using any aspect of the grievance, appeal, or hearing process or take punitive action against a provider who requests an expedited resolution or supports a member's appeal;
(b) Encourage the withdrawal of a grievance, appeal, or hearing request already filed; or
(c) Use the filing or resolution of a grievance, appeal, or hearing request as a reason to retaliate against a member or to request member disenrollment. Moreover, must protect the anonymity of members utilizing any of the rights afforded in the Grievance system.

(11) In all MCE administrative offices and in those physical, behavioral, and oral health offices where PacificSource has delegated responsibilities for appeal, hearing request, or grievance involvement, PacificSource shall have the following forms available:

(a) OHP Complaint Form (OHP 3001);
(b) MCE appeal forms;
(c) Hearing request form (MSC 443) and Notice of Hearing Rights (OHP 3030); or
(d) The Health Systems Division Service Denial Appeal and Hearing Request form (OHP 3302) or approved facsimile.

(12) In all investigations or requests from the Department of Human Services Governor's Advocacy Office, the OHP Client Services Unit, the Authority's Ombudsperson or hearing representatives, PacificSource, and participating providers shall cooperate in ensuring access to all activities related to member appeals, hearing requests, and grievances including providing all requested written materials in required timeframes as expeditiously as the affected member's health condition requires.

(13) If at the member's request PacificSource continues or reinstates the member's benefits while the appeal or administrative hearing is pending, the benefits shall continue pending administrative hearing pursuant to OAR 410-141-3910.

(14) Adjudication of appeals in a member grievance and appeals process may not be delegated to a subcontractor. If PacificSource delegates any other portion of the grievance and appeal process to a subcontractor, PacificSource must, in addition to the general obligations established under OAR 410-141-3505, do the following:

(a) Ensure the subcontractor meets the requirements consistent with this rule and OAR 410-141-3715 through 410-141-3915;
(b) Monitor the subcontractor's performance on an ongoing basis;
(c) Perform a formal compliance review at least once a year to assess performance, deficiencies, or areas for improvement; and
(d) Ensure the subcontractor takes corrective action for any identified areas of deficiencies that need improvement.

CCO Grievance Process Requirements

(1) A member and, with the written consent of the member, a provider or an authorized representative may file a grievance at any time either orally or in writing, on behalf of a member. The grievance may be filed with PacificSource or the Authority. If the grievance is filed with the Authority, it shall be promptly forwarded to PacificSource.

(2) For standard resolution of a grievance, PacificSource shall resolve each grievance and provide notice of the disposition as expeditiously as the member's health condition requires. PacificSource shall:

(a) Within five business days from the date of PacificSource's receipt of the grievance, notify the member in their preferred language that a decision on the grievance has been made and what that decisions is; or

(b) Promptly, but in no event more than five business days after the date of PacificSource's receipt of the grievance, notify the member in their preferred language that there shall be a delay in PacificSource's decision of up to 30 days. The written notice shall specify why the additional time is necessary.

(3) PacificSource shall ensure that the individuals who make decisions on grievances follow all requirements in OAR 410-141-3875 MCE Grievance and Appeals System General Requirements.

(4) When informing members of PacificSource's decision, PacificSource:

(a) Shall provide its decision related to oral grievances orally but shall also, in all instances respond to oral grievances in writing. Both oral and written responses shall be made in the member's preferred language;
(b) Shall address each aspect of the grievance and explain the reason for the decision; and
(c) Shall respond in writing to written grievances in the member's preferred language. In addition to written responses, PacificSource may also respond orally in the member's preferred language.; and
(d) Shall notify members who are dissatisfied with the disposition of a grievance that they may present their grievance to the OHP Client Services Unit (CSU) toll free at 800-273-0557 or the Authority's Ombudsperson at 503-947-2346 or toll free at 877-642-0450.

(5) In compliance with Title VI of the Civil Rights Act and ORS Chapter 659A, PacificSource shall review and report to the Authority, as outlined in the CCO contract, member complaints related to their race and ethnicity, gender identity, sexual orientation, socioeconomic status, culturally or linguistically appropriate services requests, and disability status and other identity factors for consideration in improving services for health equity. Written notice shall be provided to members of the nondiscrimination policy and process to report a complaint of discrimination.

(6) If PacificSource receives a grievance related to a member's entitlement of continuing benefits in the same manner and same amount during the transition of transferring from one MCE to another MCE as defined in OAR 410-141-3850, PacificSource shall log the grievance and work with the receiving or sending MCE to ensure continuity of care during the transition.

(7) The MCE must allow Members to file a grievance (after receiving notice that an adverse benefit determination is upheld). The MCE must allow providers, or authorized representatives, acting on behalf of the Member and with the Member's written consent, to request an appeal, file a grievance, or request a state fair hearing request.

(8) The MCE shall give Members any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to providing Certified or Qualified Health Care Interpreter services and toll-free numbers that have adequate TTY/TTD and Certified or Qualified Health Care Interpreter capability.

1) Assistance from qualified community health workers, qualified peer wellness specialists, or personal health navigators to participate in processes affecting the member's care and services;
2) Free interpreter services or other services to meet language access requirements where required in 42CFR §438.10;
3) Providing auxiliary aids and services upon request including but not limited to toll-free phone numbers that have adequate TTY/TTD and interpreter capabilities; and

4) Reasonable accommodation or policy and procedure modifications as required by any disability of the member.

(9) PacificSource shall not discourage any Member from using any aspect of the Grievance and Appeal System. Nor shall PacificSource:

1) Encourage any Member to withdraw a Grievance, Appeal, or Contested Case Hearing request already filed;
2) Use the filing or resolution of a Grievance, Appeal, or Contested Case Hearing request as a reason to retaliate against a Member or as a basis for requesting Member Disenrollment, or
3) Take punitive action against a Provider who requests an expedited resolution or supports a Member's Grievance or Appeal.

CCO Appeal Requirements

(1) A member, provider, or authorized representatives, acting on behalf of the member with the member's written consent, may file an appeal with PacificSource to:

(a) Express disagreement with an adverse benefit determination; or
(b) Contest PacificSource's failure to act within the timeframes provided in 42 CFR § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

(2) Appeals may be initiated orally or in writing,

(3) Each MCE may have only one level of appeal for members, and members shall complete the appeals process with PacificSource prior to requesting a contested case hearing.

(4) For standard resolution of an appeal and notice to the affected parties, PacificSource shall establish a timeframe that is no longer than 16 days from the day PacificSource receives the appeal:

(a) If PacificSource fails to adhere to the notice and timing requirements in 42 CFR § 438.408, the member is considered to have exhausted PacificSource's appeals process. In this case, the member may initiate a contested case hearing;
(b) PacificSource may extend the timeframes from section (3) of this rule by up to 14 days if:

(A) The member requests the extension; or
(B) PacificSource shows to the satisfaction of the Authority upon its request that there is need for additional information and how the delay is in the member's interest.

(c) If PacificSource extends the timeframes but not at the request of the member, PacificSource shall:

(A) Make reasonable efforts to give the member prompt oral notice of the delay;
(B) Within two days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if the member disagrees with that decision.

(5) For purposes of this rule, an appeal includes a request from the Authority to PacificSource for review of a notice.

(6) A member, authorized representative, or the provider on the member's behalf may request an appeal either orally or in writing directly to PacificSource for any notice or failure to act within the timeframes provided in 42CFR §438.408(b)(1) and (2) regarding the standard resolution of appeals by PacificSource:

(a) PacificSource shall ensure oral requests for appeal of a notice are treated as appeals to establish the earliest possible filing date without the need for written follow-up;
(b) The member shall file the appeal with PacificSource no later than 60 days from the date on the notice.

(7) Parties to the appeal include, as applicable:

(a) The member; or
(b) Member's authorized representative; or
(c) Provider acting on behalf of a member, with written consent from the member; or
(d) Legal representative of a deceased member's estate; and
(e) PacificSource

(8) PacificSource shall resolve each standard appeal in time period defined above in section (4). PacificSource shall provide the member with a notice of appeal resolution as expeditiously as the member's health condition requires, or within 72 hours for matters that meet the requirements for expedited appeals in OAR 410-141-3895.

(9) If PacificSource or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, PacificSource shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination.

(10) If PacificSource or the Administrative Law Judge reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, PacificSource or the state shall pay for those services in accordance with the Authority policy and regulations.

(11) The written notice of appeal resolution shall be in a format approved by the Authority. The notice shall contain, as appropriate, the same elements as the adverse benefit determination, as specified in OAR 410-141-3885, in addition to:

(a) The results of the resolution process and the date PacificSource completed the resolution; and
(b) For appeals not resolved wholly in favor of the member:

(A) Reasons for the resolution and a reference to the particular sections of the statutes and rules involved for each reason identified in the Notice of Appeal Resolution relied upon to deny the appeal;
(B) The right to request a contested hearing or expedited hearing with the Authority and how to do so;

(C) The right to request to continue receiving benefits while the hearing is pending and how to do so; and
(D) An explanation that the member may be held liable for the cost of those benefits if the hearing decision upholds PacificSource's adverse benefit determination;
(E) Copies of the appropriate forms:

(i) Hearing request form (MSC 443) and Notice of Hearing Rights (OHP 3030); or
(ii) The Health Systems Division Service Denial Appeal and Hearing Request form (OHP 3302) or approved facsimile.

Expedited CCO Appeal Requirements

(1) PacificSource shall establish and maintain an expedited review process for appeals when the member or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function as set forth in 410-120-1860.

(2) PacificSource shall ensure that punitive action is not taken against a provider who requests an expedited resolution.

(3) For expedited resolution of an appeal and notice to affected parties, PacificSource shall complete the review of the expedited appeal in a timeframe that is no longer than 72 hours after PacificSource receives the appeal. PacificSource shall:

(a) Inform the member of the limited time available for receipt of materials or documentation for the review;
(b) Make reasonable efforts to call the member and the provider to tell them of the resolution within 72 hours after receiving the request; and
(c) Mail written confirmation of the resolution to the member within three days;
(d) Extend the timeframes by up to 14 days if:

(A) The member requests the extension; or
(B) PacificSource shows (to the satisfaction of the Authority upon its request) that there is need for additional information and how the delay is in the member's interest.

(e) If PacificSource extends the timeframes not at the request of the member, PacificSource shall:

(A) Make reasonable efforts to give the member prompt oral notice of the delay;
(B) Within two days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision.

(4) If PacificSource denies a request for expedited resolution of an appeal, it must transfer the appeal to the standard timeframe, PacificSource shall:

(a) Resolve the appeal no later than 16 days from the day the MCE receives the appeal with a possible 14-day extension;
(b) Make reasonable efforts to give the Member prompt oral notice of the denial, and follow-up within two days with a written notice; and
(c) The written notice must state the right of a Member to file a grievance with the MCE if he or she disagrees with that decision.

(5) If PacificSource provides an expedited appeal but denies the services or items requested in the expedited appeal, PacificSource shall inform the member of the right to request an expedited contested case hearing and shall send the member a Notice of Appeal Resolution, in addition to Hearing Request and Information forms as set forth in OAR 410-141-3890.

Contested Case Hearings Requirements

(1) PacificSource shall have a system in place to ensure its members, providers, or authorized representatives, acting on behalf of the member, have access to appeal for PacificSource's action by requesting a contested case hearing:

(a) Contested case hearings are conducted pursuant to ORS 183.411 to 183.497 and the Attorney General's Uniform and Model Rules of Procedure for the Office of Administrative Hearings, OAR 137-003-0501 to 137-003-0700. Processes for contested case hearings are provided in OAR 410-120-1860 Contested Case Hearing Procedures.;
(b) If a provider filed an appeal on behalf of a member, as permitted in OAR 410-141-3890, the provider may subsequently request a contested case hearing on behalf of the member in accordance with the procedures in this rule.;
(c) A provider that filed an appeal on the provider's own behalf for reasons set forth in OAR 410-120-1560 shall file a hearing request with the Authority no later than 30 days from the date of PacificSource's notice of appeal resolution. Appeals brought on the provider's own behalf are not subject to this rule, which governs appeals brought by member or by a provider on the member's behalf but are governed by OAR 410-120-1560.

(2) The member may not proceed to a hearing without first completing an appeal with their MCE and receiving written notice that PacificSource adverse benefit determination is upheld, subject to the exception under section (3), below:

(a) The member shall file a hearing request with the Authority using form MSC 0443 or any other Authority-approved appeal or hearing request form no later than 120 days from the date of PacificSource's notice of appeal resolution. The Authority shall consider the request timely with the exception as noted for expedited hearing requests in OAR 410-141-3905;
(b) If the member sends a contested case hearing request directly to the Authority and the Authority determines that the member qualifies for a contested case hearing, PacificSource shall immediately submit the required documentation to the Authority's Hearings Unit following their request;
(c) If the member files a request for an appeal or contested case hearing with the Authority prior to the member filing an appeal with PacificSource, and if the request does not satisfy section (3) below, the Authority shall transfer the request to PacificSource and provide notice of the transfer to the member. PacificSource shall:

(A) Review the request immediately as an appeal of PacificSource's notice of adverse benefit determination;
(B) Respond to the request for the appeal within 16 days and provide the member with a notice of appeal resolution.

(d) If a member sends the contested case hearing request to PacificSource after PacificSource has already completed the initial plan appeal, PacificSource shall:

(A) Date-stamp the hearing request with the date of receipt; and
(B) Immediately submit the following required documentation to the Authority:

(i) A copy of the hearing request adverse benefit determination, and notice of appeal resolution;
(ii) All documents and records PacificSource relied upon to take its action, including those used as the basis for the initial action or the notice of appeal resolution, if applicable, and all other relevant documents and records the Authority requests as outlined in detail in OAR 141-410-3890.

(3) If, after a member properly files an appeal, PacificSource fails to adhere to the notice and timing requirements in 42 CFR § 438.408, the Authority may consider the member to have exhausted PacificSource's appeals process for purposes of requesting a contested case hearing, as provided in OAR 410-141-3890(3). The Authority shall notify PacificSource of the Authority's decision to allow the member access to a contested case hearing.

(4) Effective February 1, 2012, the method described in OAR 137-003-0520(8)-(10) is used in computing any period of time prescribed in OAR chapter 410, divisions 120 and 141 applicable to timely filing of requests for hearing. However, due to operational conflicts, the procedures needing revision, and the expense of doing so, the provisions in OAR 137-003-0520(9) and 137-003-0528(2) that allow hearing requests to be treated as timely based on the date of postmark do not apply to MCE member contested case hearing requests.

(5) The parties to a contested case hearing include the following:

(a) The member;
(b) Member's authorized representative; or
(c) Legal representative of a deceased member's estate; and
(d) PacificSource

(6) The Authority shall refer the hearing request along with the adverse benefit determination or notice of appeal resolution to the Office of Administrative Hearings (OAH) for hearing. Contested case hearings are requested using Authority form MSC 443 or other Authority-approved appeal or hearing request forms.

(7) The Authority shall issue a final order, or the Authority shall resolve the case ordinarily within 90 days from the date PacificSource receives the member's request for appeal. The 90-day count does not include the days between the date PacificSource issued a notice of appeal resolution and the date the member filed a contested case hearing request.

(8) For reversed appeal and hearing resolution services:

(a) For services not furnished while the appeal or hearing is pending. If PacificSource or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, PacificSource shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination;
(b) For services furnished while the appeal or hearing is pending. If PacificSource or the Administrative Law Judge reverses a decision to deny authorization of services, and the

member received the disputed services while the appeal was pending, PacificSource or the state shall pay for those services in accordance with the Authority policy and regulations

Expedited Contested Case Hearings

(1) PacificSource shall have a system in place to ensure its members and providers have access to expedited review for PacificSource's action by requesting an expedited contested case hearing. Contested case hearings are conducted pursuant to ORS 183.411 to 183.497 and the Attorney General's Uniform and Model Rules of Procedure for the Office of Administrative Hearings, OAR 137-003-0501 to 137-003-0700. Processes for expedited contested case hearings are provided in OAR 410-120-1860 Contested Case Hearing Procedures.

(2) A member or provider who believes that taking the time for a standard resolution of a request for a contested case hearing could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function may request an expedited contested case hearing.

(3) The member may not request an expedited contested case hearing without first completing an appeal or expedited appeal with PacificSource, subject to the exception in OAR 410-141-3900(3). When a member files a hearing request prior to completion of a PacificSource appeal or expedited appeal, the Authority shall follow procedures set forth in OAR 410-141-3900.

(4) Expedited hearings are requested using Authority form MSC 443 or other Authority-approved appeal or hearing request forms.

(5) PacificSource shall submit relevant documentation to the Authority immediately following their request. The Authority shall decide from the date of receiving the relevant documentation whether the member is entitled to an expedited contested case hearing.

(6) If the Authority denies a request for an expedited contested case hearing, the Authority shall:
(a) Handle the request for a contested case hearing in accordance with OAR 410-120-1860; and
(b) Make reasonable efforts to give the member prompt oral notice of the denial and follow up within two days with a written notice.

(7) If a member requests an expedited hearing, the Authority shall request documentation from PacificSource, and PacificSource shall submit relevant documentation including clinical documentation to the Authority within two working days.

Continuation of Benefits

(1) A member who may be entitled to continuing benefits may request and receive continuing benefits in the same manner and same amount while an appeal or contested case hearing is pending:

(a) To be entitled to continuing benefits, the member or member's representative shall complete a PacificSource appeal request or an Authority contested case hearing request form and check the box requesting continuing benefits before the sooner of by:

(A) The tenth day following the date of the adverse benefit determination or the notice of appeal resolution; or
(B) The effective date of the action proposed in the notice, if applicable, whichever is later.

(b) PacificSource must continue the member's benefits if all of the following occur:

(A) The appeal involves the termination, suspension, or reduction of previously authorized services;
(B) The services were ordered by an authorized provider;
(C) The period covered by the original authorization has not expired; and
(D) Timely files for continuation of benefits. Timely files means filing on or before the later of the following:
(i) Within 10 days after the date of the NOABD; or
(ii) The intended effective date of the Action proposed in the NOABD.

(c) In determining timeliness, delay for good cause as defined in OAR 137-003-0528 is not counted;
(d) If at the member's request PacificSource continues or reinstates the member's benefits while the appeal or contested case hearing is pending, the benefits shall continue pending contested case hearing pursuant to OAR 410-141-3910. The benefits shall continue until:

(A) Unless the member or authorized representative requests a contested case hearing with continuing benefits, no later than 10 days following the date of PacificSource notice of appeal resolution, a final appeal resolution resolves PacificSource appeal;
(B) A final order resolves the contested case;
(C) The member withdraws the request for a hearing.

(2) For reversed appeal and hearing resolution services:

(a) Benefits not furnished while the appeal or hearing is pending. If PacificSource or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, PacificSource shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination;
(b) Benefits furnished while the appeal or hearing is pending. If PacificSource or the Administrative Law Judge reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, PacificSource or the Authority shall pay for those services in accordance with the Authority policy and regulations.

(3) PacificSource may, consistent with the state's usual policy on recoveries and as specified in the MCE contract, recover the cost of continued services furnished to the member while the appeal or state fair hearing was pending if the final resolution of the appeal or state fair hearing upholds the MCE's adverse benefit determination.

Grievance and Appeals System Recordkeeping

(1) PacificSource shall maintain records of grievances and appeals and shall review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the state quality strategy as stated in 42 CFR 438.416 and in alignment with contractual requirements.

(2) PacificSource shall document and maintain a record, in a central location for each grievance and appeal. The MCE's record of each grievance and appeal must be accurately maintained in a manner accessible to the state and available upon request to CMS. The record shall include, at a minimum: A general description of the reason for the grievance or appeal;

(a) The members name, ID;
(b) The date the member, or members representative, or provider filed the grievance;
(c) Notice of Adverse Benefit Determination;
(d) If filed in writing, the grievance;
(e) If an oral filing was received, documentation that the grievance was received orally;
(f) Records of the review or investigation at each level of the grievance;
(g) Notice of resolution of the grievance, including dates of each level;
(h) Copies of correspondence with the member and all documentation provided by the member, the member representative, or the member's provider; and
(i) All written decisions and copies of all correspondence with all parties to the grievance.

(3) PacificSource must maintain yearly logs of all appeals and grievances for ten (10) years, which must include information about the reasons for each grievance or appeal, as well as the resolution and supporting reasoning.

(4) PacificSource must review the log monthly for completeness, accuracy, and compliance with required procedures.

(5) PacificSource shall submit for the Authority's review the Grievance and Appeals Log, samples of Notices of Adverse Benefit Determination, and other reports as required under PacificSource contract.

(6) The PacificSource shall conduct analysis of its Grievances in the context of quality improvement activity and incorporate the analysis into the quarterly data provided to OHA. The Grievance System Report and Grievance and Appeals Log shall be forwarded to the PacificSource Quality Improvement committee to comply with the Quality Improvement standards as follows:

(a) Review of completeness, accuracy, and timeliness of documentation;
(b) Compliance with written procedures for receipt, disposition, and documentation; and
(c) Compliance with applicable OHP rules

Participating Providers and Subcontractors

PacificSource must cause its participating providers and subcontractors to comply with the Grievance and Appeal System requirements set forth.

PacificSource must provide to all participating providers and subcontractors, at the time they enter into a subcontract, written notification of procedures and timeframes for notices of adverse benefit determination, grievances, appeals, and contested case hearings as set forth in Exhibit I and must

provide all of its participating providers and other subcontractors written notification of updates to these procedures and timeframes within five (5) business days after approval of such updates by OHA.

Appointment of Representative

A member may appoint any individual to act as his or her representative during the grievance process. An Appointment of Representative form is available and provided to plan members upon notification to the plan that someone else is filing on their behalf. Both the member and the appointed representative must sign the form. Alternatively, if the member has appointed a Power of Attorney for Healthcare or a legal guardian, that individual may act as the authorized representative in the grievance process.

Supporting documentation to validate the basis in which an individual acts as a member representative in the grievance process will be maintained in the case record.

Parents/legal guardians may submit a grievance in the matter of a minor child without requiring an Appointment of Representative form.

Confidentiality

The plan maintains all grievance information confidential in accordance with HIPAA Privacy Rules. The plan and any provider whose authorizations, treatments, services, items, quality or care, or requests for payment are alleged to be involved in the grievance have a right to use this information without a signed release from the member for purposes of resolving the grievance, maintaining the grievance log, and for health oversight purposes by the Division.

If the member or any other individual requests that their information be released to others, the plan will ask the member to provide a signed release of information. Except as provided in OAR 410-141-3260, or as otherwise authorized by all other applicable confidentiality laws, the plan will request an authorization for release of information from the member if the plan needs to communicate with other individuals in the resolution of the grievance. In the case of a minor, the signature should be from someone authorized to act on their behalf, such as a parent or legal guardian. This documentation will be part of the case file and maintained in the member's electronic records.

Appendix

Policy Number: [Policy Number]

Effective: 1/1/2021 **Next review:** 7/1/2022

Policy type: Government

Author(s):

Depts: [Dept]

Applicable regulation(s): 410-141-3875 through 410-141-3915, 410-141-3525, 410-141-3751 through 410-141-3915, 410-120-1860, 137-003-0501 through 137-003-0700, 410-141-3915, 410-141-3500, 410-141-3885.

External entities affected: [External Entities Affected]

Approved by:

Modification History

Date	Modified By	Reviewed By	Modifications
2/1/2021	Jessica Waltman		Annual review, carved out from single systems policy
2/18/2021	JoEl Adams		Formatting correction
05/25/2021	JoEl Adams		Revisions following OHA PnP review
07/01/2021	JoEl Adams		Revised Continuation of Benefits verbiage to read more clearly and included member representative. Additionally, removed “with member’s consent” from contesting case hearing section per OHA feedback.
08/12/2021	JoEl Adams		Received OHA PnP approval dated 08/09/2021

Member Responsibility Policy

State(s):	LOB(s):
☐ Idaho ☐ Montana ☒ Oregon ☐ Washington ☐ Other:	☐ Commercial ☐ Medicare ☒ Medicaid ☐ PSA

Government Policy

Member Responsibilities

PacificSource Community Solutions (PSCS) ensure that CCO members are notified timely of member rights and responsibilities. Members have the following responsibilities pursuant to Exhibit B of the CCO contract, the PSCS member handbook, and OAR 410-141-3590:

• To choose, or help with assignment to, a managed care plan (such as PSCS).

• To choose a primary care provider (PCP).

• To choose or help us assign you to a behavioral health provider.

• To take your PSCS Identification (ID) card with you whenever you need care.

• To treat PSCS staff and health provider staff with respect.

• To be on time for appointments or call in advance to cancel if you are not able to make it or if you are running late.

• To tell your provider of your behavioral health problems.

• To decide about care before you receive it.

• To get behavioral health services from in-network providers. You may get services from an out-of-network provider only in an emergency.

• To call PSCS Customer Service to tell us if you had an emergency within three days.

• To use only your assigned behavioral health provider for your behavioral health needs.

• To get regular health exams and preventive services from your providers.

• To have yearly check-ups, wellness visits and other services to prevent illness and keep you healthy.

• To use your PCP or clinic for diagnostic and other care except in an emergency.

• To get a referral from your PCP before going to a specialist.

• To use urgent and emergency services appropriately.

• To give accurate information for your medical records.

• To help your providers obtain your medical records from other providers, which may include signing a release of information form.

• To ask questions about conditions, treatments, and other issues about your care that you don't understand.

• To use information to make informed decisions before receiving treatment.

• To be honest with your providers to get the best service possible.

• To help create treatment plans with your providers.

• To follow prescribed treatment plans to which you have agreed.

• To tell the provider that you have OHP coverage before receiving services and to show your plan ID card upon request.

• To tell your case worker if you change your address or phone number.

• To tell your case worker if you become pregnant, let him or her know when you are no longer pregnant or when your baby is born.

• To tell your case worker if any family members move in or out of your house.

• To tell your case worker and providers if you have any other insurance available.

• To pay for services that are not covered by your plan.

• To help the plan in pursuing any third party resources available (such as Workers Compensation or auto insurance).

• To pay the plan the amount of benefits it paid for an injury from any payment received for that injury.

• To tell the plan of any issues, complaints, or grievances about your care.

• To sign an authorization for release of healthcare information so that OHP and the plan can get information needed to respond to an Administrative Hearing request.

Procedure: Customer Service

PSCS conducts new member welcome calls to every new Medicaid member within 60 days of their enrollment. During this call, Customer Service informs the member of their responsibilities as a member of the PSCS plan.

Procedure: Marketing and Communications and Regulatory Communications

PSCS mails to every new Medicaid member a Member Handbook, which contains information regarding the member's benefits as well as their rights and responsibilities. The Member Handbook is also available to Members on the PSCS website. Not less than once a year, PSCS includes an article to remind members of their Responsibilities and where they can obtain a copy.

Appendix

Policy Number: [Policy Number]

Effective: 3/15/2019 **Next review:** 4/1/2022

Policy type: Government

Author(s): Jane Hannabach; Jake Vandemeer [Authors]

Depts:

Applicable regulation(s): CCO Contract Exhibit B, OAR 410-141-3590

External entities affected: N/A

Approved by:

Modification History

Date	Modified By	Reviewed By	Modifications
3/31/2021	Jake Vandermeer	Jane Hannabach	No Changes – annual review
6/19/20	Jane Hannabach		Accepted previous changes. No other changes.
3/24/20	Jane Hannabach		Updated OAR
3/15/19	Lindsey Hopper, Jane Hannabach, Tara Anderson	Lindsey Hopper, Jessica Sayers, Tara Anderson	Created for CCO 2.0

Quality Assessment and Performance Improvement Program

State(s):	LOB(s):
☐ Idaho ☐ Montana ☒ Oregon ☐ Washington ☐ Other:	☐ Commercial ☐ Medicare ☒ Medicaid ☐ PSA

Government Policy

PURPOSE: To describe the goals, strategies, structure, and evaluation process of PacificSource Community Solutions' quality assessment and performance improvement program. This provides a comprehensive overview of the quality program, including the processes used to determine impact and effectiveness of the program's interventions and strategies.

Procedure: Health Services- Quality- Government

PROCEDURE

I. Introduction

a. PacificSource Community Solution's Quality Program provides a comprehensive structure for organizing, monitoring, communicating and improving the health and care of PacificSource members by addressing the requirements and recommendations from the following references:
   i. Transformation Reporting, Performance Measures and External Quality Review outlined in the OHA OHP Health Plan Services Contract Exhibit B - Statement of Work – Part 10
   ii. 42 CFR 438.330 Quality Assessment and Performance Improvement Program
   iii. 42 CFR 438.340 Managed care State quality Strategy
   iv. OAR 410-141-3525 Outcome and Quality Measures
   v. CMS 1115 Medicaid Waiver

b. The program includes the following elements:
   i. Transformation and Quality Strategy
   ii. Performance improvement projects
   iii. Quality Incentive Metrics (QIM)- Collection and submission of performance measurement data
   iv. Mechanisms to detect both underutilization and overutilization of services
   v. Mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs, as defined by the State in the quality strategy under 42 CFR 438.340

c. The Quality Program of PacificSource Community Solutions (PCS) is designed to ensure that the members of our CCOs have access to high quality health care that is safe, effective, provides a positive experience, and results in positive outcomes. The quality program is driven by our mission, values, strategic goals, and objectives.

d. PacificSource's Clinical Quality and Utilization Management Committee (CQUM) is the advisory body for quality, utilization management, and performance improvement activities under the direct authority of the Chief Medical Officer (CMO) or a delegated Medical Director. The Chief Medical Officer collaborates with, and receives input and recommendations from the Committee regarding quality, utilization management,

appeals and grievances, and performance improvement activities. Regular reports of Committee's activities will be made to the internal Quality Improvement Committee.

e. PacificSource's Quality Improvement Committee (QIC) consists of PacificSource staff who work together to provide consistency in the oversight of clinical and service quality for the Medicaid, Medicare, Commercial, and Exchange lines of business. The QIC's areas of oversight include new and changing medical, dental, and behavioral technology, clinical policies and programs, member and provider satisfaction, and quality initiatives. The QIC reviews clinical care events and other identified quality concerns, recommending finalized QI program content to the Executive Management Group (EMG) for approval. The QIC provides oversight and accountability for the QI Program across all LOB. Strategic initiatives, as they pertain to QI programs are reviewed and approved by this Committee. As such, the QIC oversees the development of the Transformation and Quality Strategy and makes recommendations to EMG for review and approval.
f. Additional committees within PacificSource that support health transformation and quality improvement within our CCOs include the Medicaid Leadership Team, the Community Advisory Councils, the Provider Engagement Panels or Clinical Advisory Panels, the Quality Incentive Measures (QIM) Steering Committee, the Behavioral Health CQUM Committee, the Government Operations Committee, and the Cross Departmental Medicaid Committee.

II. Transformation and Quality Strategy

a. The Transformation and Quality Strategy (TQS) is a means by which PCS develops transformative, innovative, and member-driven strategies to improve member experience, increase efficiencies, address SDOH-E, and integrate care across the systems.
b. The TQS is a reporting requirement to the Oregon Health Authority (OHA) that aims to move health transformation forward, reduce duplication of efforts, align CCO priorities, and enhance innovation supported by targeted activities.
c. TQS Development Process:
    i. The development of the TQS is a collaborative effort involving multiple departments within PacificSource and input from many external partners including the CCO's health council governing boards and Community Advisory Councils (CACs). The PacificSource Executive Management Group (EMG), Medicaid Leadership Team (MLT), and TQS Advisory Committee have ultimate oversight of the TQS and provide adequate resourcing through an annual strategic planning and information technology support process. A charter, annual work plan, and multi-year work plan are developed and refined through multiple iterations of review and feedback by internal and external stakeholders.
    ii. The TQS is composed of projects that are representative of the CCO's activities related to health care transformation and quality. The TQS Quality Team and Project Leads utilize the following data sets to identify ongoing or new initiatives in the component areas specified by the Oregon Health Authority:
        1. Regional/Community Health Assessment
        2. Regional/Community Health Improvement Plan
        3. PacificSource Strategic Plan
        4. Delivery System Network (DSN) Evaluation
        5. External Quality Review
        6. Information Systems Capability Assessment
        7. Office of Inspector General Audit

    Utilizing these sources, the TQS Quality Team and Project Leads identify a short list of potential projects for inclusion in each year's TQS. This list, with project descriptions, is then proposed to internal stakeholders, including the MLT and QIC for input, feedback, and approval. The proposed list goes to the

health council boards and the CACs for input and guidance. Once drafted, the projects undergo a thorough review by the TQS Advisory Committee, which is comprised of department directors and subject matter experts (SMEs). The TQS Advisory Committee reviews each project to assess feasibility, transformational qualities, resource needs, and project scope. Once approved, the project descriptions are finalized for inclusion in the TQS. The final TQS is then reviewed in totality by the MLT, EMG, QIC, and local health council boards for final approval.

The TQS Quality Team meets throughout the year to manage projects, collect feedback, and address any concerns with the reporting requirements. The MLT and QIC continue to have oversight of the TQS, receiving regular status updates. Status updates are provided to the health council boards and CACs at regular intervals. The CACs are consulted on all aspects of member experience as it relates to projects within the TQS.

d. CCO Organizational Structure for Developing and Managing the TQS:

   i. PCS CCOs are operated by PacificSource and the health councils through formal Joint Management Agreements. PacificSource has responsibility for managing OHP benefits and quality improvement activities, including developing and implementing the TQS. While PacificSource staff take lead on the management of TQS projects, the design of the TQS and the project work is shared between PacificSource staff, health council staff and committees, and other community partners. These groups provide input on setting priorities, TQS program development, and evaluation.
   ii. The TQS is part of the PacificSource Strategic Plan, demonstrating the commitment of the company's EMG to its success. The TQS Advisory Committee provides subject matter expertise, oversight, and delivers regular updates to senior leadership. The health council boards and CACs also receive updates on the status of the TQS.

e. TQS Oversight Committees:

   PacificSource's Internal QIC consists of PacificSource staff who work together to provide consistent oversight of clinical and service quality and accountability for implementing the Quality Improvement Program for the Medicaid, Medicare, Commercial, and Exchange lines of business. As such, the QIC oversees the development of the TQS and makes recommendations to the PacificSource EMG for review and approval.

f. Evaluation of the impact and effectiveness of the TQS
   i. The TQS is an annual deliverable to the OHA due in March. . The TQS Quality Team meets with TQS Project Leads throughout the year to assess program effectiveness and identify areas for continued improvement. PacificSource evaluates the effectiveness in meeting project outcomes and deliverables and includes this information in the following years' TQS report.
   ii. The QIC and the CQUM Committee review and approve the TQS annually and offer guidance on improvement strategies and defining the following year's goals. The TQS Quality Team meets to review the progress of TQS projects to determine impact and course correct if there are deficiencies in meeting set targets and activities.

III. Performance Improvement Projects

a. As part of the CMS 1115 Medicaid Waiver and 42 CFR 438.330(d), all CCOs are expected to participate in a statewide Performance Improvement Project (PIP) and three additional PIPs on a topic of the CCO's choosing.
b. The intention of the PIPs is for CCOs to cover a wide array of clinical improvements that are important to meet identified community needs and CCO strategic direction in meeting the Triple Aim.
c. PIP topics are selected from eight Focus Areas:
    i. Reducing preventable re-hospitalizations
    ii. Addressing population health issues
    iii. Deploying care teams to improve care and reduce preventable or unnecessarily-costly utilization by super-utilizers
    iv. Integrating primary and behavioral health
    v. Ensuring appropriate care is delivered in appropriate settings
    vi. Improving perinatal and maternity care
    vii. Improving primary care for all population through increased adoption of the Patient-Centered Primary Care Home Model of care throughout the CCO network
    viii. Addressing Social Determinants of Health and Equity
d. Four of the above focus areas will be addressed for each CCO through one Statewide PIP, and three PIPs of the CCO's choosing. Topic selections among the Focus Areas is arrived at from the following criteria:
    i. Review of data and quality measures to identify areas of low performance against a benchmark.
        1. Including review of data by language, ethnicity, race, and gender
    ii. Alignment of projects with state and federal strategies and the health plan quality strategy.
    iii. Review of internal utilization data to identify areas of need for the population.
    iv. Input from panel providers and consideration of topics relevant to all lines of business.
e. Reports are submitted quarterly to OHA per contract deadlines.
f. The PIPs are reviewed and approved annually by PacificSource's QIC and by a panel of providers on the CQUM Committee.
g. The PIP reports include data on race, ethnicity, language, and gender when applicable to support project outcomes, determine health disparities, and in selection of a PIP's target population.
h. The PIPs undergo continuous quality improvement and evaluation to ensure the goals and interventions are effective and creating a positive impact for our CCO members.

IV. Quality Incentive Metrics (QIM)- Collection and submission of performance measurement data

a. Quality Incentive Metrics (QIMs) are tools to track the quality of health care services provided to our members. PacificSource works collaboratively with our provider partners to ensure our members receive quality care.
b. An integral component of the QIM Program is to ensure CCOs collect and report quality, cost, and utilization data in a consistent way so performance across state CCOs can be compared.
c. PCS collects and performs data analysis on the OHA QIM on a monthly basis. The QIMs are tracked and trended each month to ensure the success of the Program across the CCOs. The measurements cover various aspects of care and are measured using administrative and/or hybrid method, and aggregate electronic health record data. The organization follows specifications defined by NCQA and OHA and uses certified software.
    i. Measures fall into one or more categories:
        1. CCO Incentive measures, for which CCOs are eligible to receive payments based on their performance each year; and

2. State Quality measures, which OHA has agreed to report to the Centers for Medicare and Medicaid Services (CMS) as part of Oregon's 1115 Medicaid waiver.

d. PCS staff responsible for QIM meet monthly to review trends and areas of concern, sharing with Internal and External Stakeholders.
    i. The external Health Council Operations Committee, CCO Clinical Advisory Councils, CCO QIM Collaborations, QIM Regional Improvement Teams and QIM Regional Advisory Teams, and internal QIM Steering Committee review the QIM Program monthly to evaluate its effectiveness and implement strategies in areas of improvement.
    ii. The QIM Program Manager and regionally based QIM Practice Coaches meet with clinic staff to review clinic level performance, assist with mitigation planning, support providers to successfully submit qualified codes via claims submission, implement QI initiatives, and troubleshoot any issues that arise in complying with QIM reporting.
        1. Providers are responsible for pulling data from their EHRs according to Oregon Health Authority (OHA) technical specifications for each eCQM measure.
        2. Reports to identify gaps by providers and clinic are used to drive performance improvement and identify areas of underutilization.
    iii. Joint Steering Committees comprised of executive level PCS and clinic staff meet quarterly to monitor quality performance, oversee improvement strategies and endorse mitigation/escalation plans to improve quality performance.

e. Evaluation and Effectiveness of the QIM Improvement Work Plan and Initiatives
    i. Program evaluations are conducted annually and presented to the QIM Steering Committee and Quality Improvement Committee. This evaluation includes annual results, detailed trends, review of annual work plan progress and initiative effectiveness/outcomes. The annual review is used to inform program planning, identify focused efforts/initiative needs for the upcoming year's work plan.

V. Mechanisms to detect both underutilization and overutilization of services

a. PacificSource utilizes a variety of reports produced by the analytics and actuarial departments to detect over and underutilization. These reports include analysis and trending of all health services broken down by categories (such as inpatient, outpatient, physician, pharmacy, etc.), as well as more specific services, such as ED use rate and readmissions. Examples of recurring reports used to detect utilization trends include:
    i. Medicaid Utilization and Experience Reporting
    ii. CCO Dashboards
    iii. QIM Dashboards
    iv. DCO Dashboard (Dental Utilization Report)
    v. Behavioral Health Dashboards (SPMI Dashboard, SPMI ED_IP Dashboard)
    vi. CAP Steering Report (Hospital CAP Dashboard)
    vii. OHP Readmission report (FUHMI Readmit Dashboard)

    Examples of reports that have been generated ad hoc to investigate specific utilization trends include:

    i. Pre-post CAP Analysis
    ii. Out of area transfers (Air Ambulance Claims)

b. These reports are reviewed in a number of forums, including the internal Cost of Care Committee, which includes all company medical directors and line of business

vice presidents. In addition, specific dashboards are produced to monitor our capitated contracts and these are reviewed in meetings specific to those leadership individuals. Lastly, ad hoc reports are used to assess trends that may need to be addressed as a result of payment methodology or market conditions.

c. Specific trend reporting is achieved using the Medicaid Quarterly Experience and Utilization report, which provides data on utilization with comparison for same period in prior year, as well as pharmacy data that identifies medications with high cost and utilization. The Dental Quality Measure and Utilization report details utilization of dental services and the Behavioral Health dashboard monitors ED and IP stays for members with BH diagnoses.
d. In addition to the above, PSCS has a Quality Incentive Metric (QIM) Team that monitors for over- and underutilization of services. The QIM CCO Summary Report provides monthly utilization data and target graphs to determine where targeted outreach to providers is needed.
e. The Clinical Quality Team monthly reviews CCO, QIM, Behavioral Health, and Dental dashboards. As noted above, other reporting is reviewed in the Cost of Care meetings and in specific venues that address specific populations or contracts. Trends in underutilization are identified by analyzing our internal administrative data and comparing the monthly data points to our quarterly goals. Follow-up actions can include provider or member outreach/education, provider contracting changes, community partnerships and other strategic activities.

VI. Mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs

a. Members with "Special Health Care Needs" means individuals who have high health care needs, multiple chronic conditions, mental illness or Substance Use Disorders and either 1) have functional disabilities, 2) live with health or social conditions that place them at risk of developing functional disabilities, or 3) are a member of the Prioritized Populations listed in the OHA CCO contract.
b. Members with special health care needs are identified, are offered Case Management and screened for Intensive Care Coordination Services (ICCS).
    i. ICCS is a specialized care management service available to members who are aged, blind, or disabled, and/or who have complex medical needs, multiple chronic conditions, severe and persistent behavioral health issues and those receiving Medicaid-funded long-term care or long-term services and supports.
    ii. Early identification and intervention can positively impact the quality and cost associated with care, while also improving health care appropriateness and member satisfaction. PCS ICC Services is family and youth driven, strength based, culturally responsive and linguistically appropriate and is provided in a way that Members are served in the most natural and integrated environment possible and that minimizes the use of institutional care.
c. Individualized Care Planning
    i. Each care manager follows, coordinates, and maintains no more than 15 members in ICC care management services. In consultation with the member, the ICC Care Manager is responsible for compiling a list of Care Team members, including name, organization, contact information and role in addition to creating an individualized plan of care. PacificSource Care Managers create an individualized plan of care for members identified and prioritized with intensive care coordination or special health needs within 10 days of enrollment in ICC services. The plan of care is shared and coordinated with providers and specialists to ensure consideration is given to incorporate unique needs, including cultural and linguistic factors, as appropriate and in compliance with applicable privacy requirements. Member and member representatives participate in the development and implementation of the plan of care when possible.

ii. The plan of care for enrollees with special health care needs are reviewed and revised at least monthly or when the enrollee's circumstances change or the enrollee's needs change, or when the member requests it. In addition, members are reassessed at least annually to determine whether their care plans are effectively meeting their needs. Members receive an updated list of care team participants at least semi-annually, upon request, or when members of care team change. This list includes names, contact information, and roles of each team member and is documented in the member's health plan electronic medical record.
iii. Care management and coordination activities include:

1. Early identification of members eligible for ICCS and other care management services
2. Assistance to ensure timely access to providers and capitated services
3. Coordination with providers and community partners to ensure consideration is given to special health care needs in treatment planning
4. Assistance to providers in complex coordination of capitated services and transitions of care
5. Aid with coordinating necessary and appropriate linkage of community support and social service systems with medical care systems
6. Collaborative care planning with Medicaid Long Term Care or Long Term Care Support Specialists and referrals of mutual members prioritized for ICCS within 30 days
7. Contact with member's PCP within one month of ICC assignment, then additionally no less than once a month to ensure integrated care, or sooner if member's needs indicate.

d. The PacificSource Care Management team provides an integrated physical health/behavioral health approach to comprehensively address member care needs. The team collaborates internally, as appropriate, with the medical directors overseeing Physical and Behavioral Health, Pharmacy, Dental and Medicare/Commercial departments to create a comprehensive and individualized plan of care.
e. Additionally, the Care Management PacificSource staff collaborates and provides training externally with providers and community partners to best utilize and build member resources, promote awareness of care coordination services for the ICCS and special health care needs population, prevent duplication of services, and to involve these partners/providers in the members' individualized plans of care when appropriate.
f. To ensure direct access, members who are designated as eligible for Intensive Care Coordination Services are not required to have a PCP referral request for an initial specialist visit. More information about access is available in the Member Handbook and through the PacificSource Community Solutions website.
g. Care Managers and Care Coordination staff are trained and demonstrate skills in cultural awareness and communication with sensitivity to the unique barriers faced by ICCS and other special health care needs populations. Care Managers are encouraged to obtain their care management certification after two years of employment

Appendix

Policy Number: [Policy Number]

Effective: [Effective Date] **Next review:** 8/31/2022

Policy type: Government

Author(s): Stevi Bratschie

Depts: Clinical Quality

Applicable regulation(s): 42 CFR 438.330 (b); 42 CFR 438.340; 42 CFR 422.152; OHA CCO Contract Exhibit B - Part 10 – Transformation Reporting, Performance Measures and External Quality Review; OHA CCO Contract Exhibit G – Part 1 – Delivery System Network Provider Monitoring and Reporting Overview; OHA CCO Contract Exhibit M – Part 11 – Care Coordination/Intensive Care Coordination; OAR 410-141-3525; OAR 410-141-3500

External entities affected: [External Entities Affected]

Approved by:

Modification History

Date	Modified By	Reviewed By	Modifications
7/23/2019	Stevi Bratschie	Erin Fitzpatrick, Lizzy Randleman, Alison Little	New Policy
8/12/2020	Lindsay Atagi	Lizzy Randleman, Cody Phelps, Martin Stukel, Andrea Ketelhut	Updated regulatory citing and updated processes.
10/18/2021	Lindsay Atagi	Shonda Dahl, Andrea Ketelhut, Cody Phelps, Sarah Holloway	Updated regulatory citing and processes.

Reports to Quality and Utilization Committees

State(s):	LOB(s):
☒ Idaho ☒ Montana ☒ Oregon ☒ Washington ☐ Other:	☒ Commercial ☒ Medicare ☒ Medicaid

Enterprise Policy

Background

PacificSource collects, analyzes, and reports quality performance and utilization data to monitor and promote effectiveness and improvement of our programs. This information may be in the form of documented processes, materials, records or files, and/or reports, which are generically referred to as reports in this policy. The information is presented by a designated owner of the applicable report to quality and utilization committees for review, recommendations, and approval.

Procedure: Health Services and Quality

The following array of reports are presented to the list of committees for their review, recommendations, and approval, as applicable. The reports may be presented to additional committees for review and recommendations as warranted. Ad hoc reports may also be presented to comply with industry standards and regulations or to support operations further with responding to opportunities for improvement or identifying benchmarks and trends for evaluating effectiveness of an initiative.

Committee discussion and approval will be documented in the applicable meeting minutes.

REPORTS	LINE OF BUSINESS	FREQUENCY	APPROVING COMMITTEE(S)
Assessment of Delegate's Performance	Commercial	Annually	CQUM, QI
Clinical Criteria Policies and Protocols for medical and/or behavioral health services developed or customized for PacificSource use	All	When new or significant changes, annually	BHCQUM (for behavioral health policies and protocols), CQUM
Clinical Criteria Sources Used in UM Decisions	All	Annually	BHCQUM (for behavioral health sources), CQUM
Clinical Practice Guidelines	All	Annually	BHCQUM (for behavioral health

REPORTS	LINE OF BUSINESS	FREQUENCY	APPROVING COMMITTEE(S)
			guidelines), CQUM
Continuity and Coordination between Medical and Behavioral Health	Commercial	Annually	BHCQUM
Continuity and Coordination of Medical Care	Commercial	Annually	CQUM
Dental Program	Medicaid, Commercial	Annually	QI
Evaluation of Accuracy of Plan Benefit and Pharmacy Benefit Information	Commercial	Annually	QI
Evaluation of Members' Needs for Interpreter Services, Telephone Access Services, and Email Responses to Members	Commercial	Annually	QI
Grievances and Appeals	All	Quarterly	BHCQUM, CQUM, QI
Interrater Reliability (IRR) Monitoring	All	Annually	QI
Medication Criteria and Protocols for the clinical use of drugs administered under the pharmacy and medical benefits	All	When new or significant changes, annually	P&T
Member and Provider Experience, including CAHPS survey, satisfaction survey, complaints	All	Annually	CQUM, QI
New Member Understanding Survey	Commercial	Annually	QI
New Technology and Operational Committee Overview	Commercial	Annually	CQUM
Performance Improvement Projects (PIP), Quality Improvement Projects (QIP), Chronic Condition Improvement Projects (CCIP), Quality Improvement Strategies (QIS), Medical Assistant Workshops	Medicaid, Medicare	Annually	QI

REPORTS	LINE OF BUSINESS	FREQUENCY	APPROVING COMMITTEE(S)
Pharmacy & Therapeutics Overview	All	Annually	QI
Policies and Procedures related to implementation and management of the QI, UM, PHM, and pharmacy programs	All	Annually	BHCQUM, CQUM, P&T, QI (as applicable)
Population Health Management (PHM) Strategy Description and Annual Evaluation	All	Annually	CQUM, QI
Provider Access and Capacity, Language Availability, Network Adequacy, and Marketplace Network Transparency	All	Annually	QI
Provider/Delivery System Supports and Member Experience with Provider Network	All	Annually	QI
Provider Quality Events/Issues	All	Annually	CQUM, QI
Quality Improvement (QI) Program Description, Annual Work Plan, and Annual Evaluation	All	Annually	QI
Quality Measures Plan and Updates, including HEDIS, Quality Incentive Measures (QIM), and Stars	All	Annually	CQUM, QI
Risk Assessment Overview	All	Annually	QI
Transformation and Quality Strategy (TQS)	Medicaid	Annually	CQUM, QI
Utilization Management (UM) Program Description, Annual Evaluation, and Member Experience with UM Program	All	Annually	BHCQUM (for behavioral health components), CQUM, QI

Definitions

Annually: Is a frequency of presenting a report to a committee every 12 months, with a 2-month grace period.

Behavioral Health Clinical Quality and Utilization Management (BHCQUM) Committee: Is an advisory committee for the quality and utilization of services, practice guidelines, and policies related to behavioral health; collaborates with the Clinical Quality and Utilization Management (CQUM) committee to integrate and coordinate behavioral and medical health services. Chaired by the Behavioral Health Medical Director, the BHCQUM committee is comprised of external practicing practitioners representing psychiatry, primary care, clinical psychology, and clinical social work, and includes management and staff from internal teams.

Clinical Quality and Utilization Management (CQUM) Committee: Is an advisory committee for the quality, utilization management, and performance improvement activities of PacificSource. CQUM advises or comments on development, adoption, or application of practice guidelines and UM criteria and resources, and reviews and approves reports, as applicable. Chaired by a Medical Director, the CQUM committee is comprised of external practitioners representing primary and specialty care practitioners in our network, and includes management and staff from internal teams.

Documented Processes: Are policies and procedures, process flow charts, protocols, and other mechanisms that describe an actual process or methodology used to complete a task by PacificSource.

Materials: Are prepared information that PacificSource provides to our members, practitioners, and delegates, including contracts, agreements, written and electronic communication, websites, scripts, brochures, reviews, and clinical guidelines.

Pharmacy & Therapeutics (P&T) Committee: Evaluates the clinical use of drugs, including new drugs and new indications of existing pharmaceuticals, develops policies for managing pharmaceutical utilization, and is the advisory committee for formulary and clinical drug policies. Chaired by a Medical Director and managed by the Director of Pharmacy, the P&T committee is comprised of a majority of external practicing practitioners and pharmacists, and includes management and staff from internal teams.

Quality Improvement (QI) Committee: Provides leadership and stewardship of the quality of the clinical services provided by PacificSource and of the sub-committees (e.g., BHCQUM, CQUM, and P&T) that are associated with these services; oversees the analysis and evaluation of the Quality Improvement (QI) program and its activities, evaluates the effectiveness of the QI program, and recommends policies or revisions to policies to achieve the QI program objectives. Chaired by the Chief Medical Officer (CMO), or a designated Medical Director in the CMO's absence, the QI committee is comprised of executives, medical directors, directors, managers, and representatives from across the organization with knowledge and authority to support the committee's purpose.

Records or Files: Are a history of cases; proceedings; or verification of actions involving members or practitioners, such as documented completion of denial, appeal, or case management activities.

Reports: Are aggregated sources of evidence of action or performance on an NCQA element, regulatory requirement, or industry standard, including program management reports; key indicator reports; summary reports from member reviews; system output giving information such as number of member appeals; minutes; and other documentation of actions that PacificSource has taken.

Appendix

Policy Number:

Last review: 8/1/2020 **Next review:** 7/1/2022

Policy type: Enterprise

Author(s): Kevin McLean, Polly Watt-Geier

Depts: Health Services

Applicable regulation(s): 42 CFR 422.152; 42 CFR 423.120(b)(1); 42 CFR 438.236(b)(4); 42 CFR 438.330; NCQA Standards: Network Management (NET), Population Health Management (PHM), Quality Management and Improvement (QI), Utilization Management (UM), and Member Experience (ME); OAR 410-141-3525

Commercial Ops: 6/2021

Government Ops: 6/2021

Modification History

Date	Modified By	Reviewed By	Modifications
5/27/2021	K. McLean P, Watt-Geier	Justin Montoya, MD Alison Little, MD	Added Template Headings. In table, changed Provider Access and Capacity… report from CQUM and QI to QI and Provider/Delivery System Supports and Member Experience with Provider Network report from CQUM to QI; under applicable regulations, replaced OAR 410-141-3200 [repealed] with 410-141-3525.
8/3/2020	K. McLean L. LaFerriere	Justin Montoya, MD Alison Little, MD	Clarified role of CQUM committee from “recommends and approves” to “advises or comments on development, adoption, or application” of practice guidelines and UM criteria and resources, and added “as applicable” to reviewing and approving reports. Removed “including Complex Case Management (CCM) and Condition Support Programs and Experience with CCM” from report array since those are incorporated within the Population Health Management Strategy and Evaluation.
9/23/2019	Kathy Wiley Kevin McLean L. LaFerriere	Justin Montoya, MD Alison Little, MD Mike Franz, MD	Added the information “is presented by a designated owner of the applicable report” To the background section and “as warranted” to the procedure paragraph. Added “CQUM” to the assessment of delegate’s performance and “All” to the IRR monitoring**.**
9/26/2018		CQUM	Approved as written
8/13/2018	L. LaFerriere	Justin Montoya, MD Alison Little, MD Mike Franz, MD	Approved new enterprise policy
6/22/2018	A. Torrence E. Fitzpatrick K. McLean		Integrated the Medicaid and Medicare policy *Standard QAUM Reports* into the Commercial policy *UM Program Level of Approval*; renamed Commercial policy to *Reports to Quality and Utilization Committees* and published it as an Enterprise policy; added definitions and language to align with NCQA standards and Medicaid and Medicare regulations; updated applicable regulations
12/6/2017	K. McLean L. LaFerriere	CQUM	Added “Medical director for” to the behavioral Health title in both sections on pg.2
12/4/2017	K. McLean L. LaFerriere	Justin Montoya, MD	Updated QAUMPT committee to the pharmacy and therapeutics Committee (P&T). Updated Director of

			Medical Services title to the Director of Utilization Management title.
09/13/2016	M. Gabbard, L. Berthold, L. Mason, K. Fryburg, C. Gilmore, J. Viola, L. Stern E. Littlejohn and M. Dax	Mike Franz, MD and Justin Montoya, MD	Approved as written. Added Behavioral Health and BHCQUM. Updated format.
09/22/2015	M. Gabbard	Justin Montoya, MD	Approved as written.
08/21/2015	M. Gabbard	Clinton Smith, Director of Pharmacy	Page 1 and 2 changed CQUM to QAUMPT Committee for pharmacy criteria or protocols
06/18/2013	M. Gabbard	Josh Bishop, Director of Pharmacy Jim Riopelle, MD	Page 2 changed to reflect review and approval process, current committee oversight for the Commercial and PSA plans and added 2 additional columns reflecting the components for all lines of business current protocols, review and approval process and oversight.
10/30/2013	M. Gabbard	K. Blaine	Effective date and review date. CQUM approved document on 6/26/2013 Effective date should be 07/01/2013
07/29/2013	T. Barker		Migrated to new template. No changes.
05/28/2013	K. Blaine	J. Riopelle; CQUM Committee	Original

Background and Objectives

The purpose of the Patient-Centered Primary Care Home (PCPCH) value-based payment (VBP) programs is to provide financial and operational support for primary care clinics that provide advanced PCPCH services to PacificSource CCO members. These VBP programs are part of PacificSource's commitment toward paying for quality, value, and outcomes.
For 2022, three distinct VBP programs are offered:

1. PCPCH+
2. Behavioral Health Integration
3. Community Health Workers

Primary care clinics may apply to participate in one, two, or all three VBP programs depending on eligibility and interest. Participation in the VBP programs is voluntary, at the discretion of PacificSource, and is subject to periodic review and modification. Clinics should refer to their PacificSource contract terms and this program document when assessing eligibility.

VBP Programs Available for Primary Care Clinics

OHA PCPCH Tier Level	1) PCPCH+ VBP Program (See page 3)	2) Behavioral Health Integration VBP Program (See page 5)		3) Community Health Worker VBP Program (See page 12)	Total potential PMPM if PCPCH site is eligible for all 3 VBP programs	
PCPCH Tier 1 & 2	Base Rate PMPM	n/a		n/a	n/a	
		BHI Level 1	BHI Level 2		BHI Level 1	BHI Level 2
PCPCH Tier 3	$6.00 PMPM	$2.00 PMPM	$4.00 PMPM	$1.00 PMPM	$9 PMPM	$11 PMPM
PCPCH Tier 4	$9.00 PMPM	$2.00 PMPM	$4.00 PMPM	$1.00 PMPM	$12 PMPM	$14 PMPM
PCPCH Tier 5	$12.00 PMPM	$2.00 PMPM	$4.00 PMPM	$1.00 PMPM	$15 PMPM	$17 PMPM

VBP Program Application Process, Reporting Requirements, and Due Dates

All primary care clinics that wish to participate in one or more of the VBP programs must apply at the beginning of each year. Clinics will submit an electronic application via SurveyMonkey and will attest to meeting the program criteria. Clinics not already participating in a VBP program may apply to join mid-year in June for a July 1st payment start date. Clinics that join a VBP program at the beginning of the year do not need to reapply for that same program during the mid-year application process.

NOTE: A separate application must be submitted for each PCPCH site. The PacificSource VBP programs are aligned with Oregon Health Authority PCPCH recognition, therefore, a separate application is needed for each physical address/practice site.

To apply for one or more of the VBP programs and begin payment on January 1, 2022, clinics must submit an application between November 15 – December 15, 2021. Click here to access the electronic application starting on November 15, 2021.

Application Due Dates

VBP Programs Payment Start Date	Application Due Date
January 1, 2022	December 15, 2021
July 1, 2022	June 30, 2022

Clinics participating in one or more of the VBP programs must submit quarterly reports to PacificSource electronically via SurveyMonkey according to the following schedule. Failure to submit required reports may result in suspension of PMPM payments.

Reporting Due Dates

Report	Due Date
Q1 2022	4/30/2022
Q2 2022	7/31/2022
Q3 2022	10/31/2022
Q4 2022	1/31/2023

1) PCPCH VBP Program Participation

Primary care clinics recognized by the Oregon Health Authority (OHA) as a PCPCH are eligible to receive a per-member-per-month (PMPM) payment based on their tier of recognition. The "base rate" payment is applied according to a clinic's OHA PCPCH tier of recognition. Clinics that become recognized for the first time or have changed tier levels should send the letter from Oregon Health Authority to their PacificSource provider representative. Please note that payments are retroactive back to the date of recognition but may take 1-2 months for system changes.

Clinics that meet specified high-value PCPCH standards may opt to participate in the *PCPCH+ VBP program*. To receive the enhanced PCPCH+ rates, clinics must meet all the following parameters and reporting requirements:

- ✓ Be recognized by OHA as PCPCH tier 3, 4, or 5
- ✓ Maintain or improve their PCPCH tier of recognition
- ✓ Participate in any OHA PCPCH program site visits
- ✓ Submit quarterly reports to PacificSource, including a copy of the most recent OHA PCPCH application
- ✓ Acknowledge that expectations of clinics will continue to rise in subsequent years to ensure continuous quality improvement
- ✓ Meet all the PCPCH standards & measures outlined below:

To receive the PCPCH+ rate, clinics must meet all the following minimum requirements:

Note: Primary care clinics that participated in the 2021 PCPCH VBP program will have 6 months to meet the new 2022 requirements (3.C.1 and 5.C.2). Clinics are encouraged to participate in free technical assistance provided by PacificSource via Creach Consulting Group.

Please review the 2020 OHA PCPCH Technical Specifications & Reporting Guide for full measure descriptions.

Meets criteria?	PCPCH Standard	PCPCH Measure	Description & Reporting
☐	Quality Improvement	2.D.2 or 2.D.3	Quality improvement and population health activities should include a minimum of 4 hours/month of scheduled, paid team time for activities such as reviewing CCO performance metrics, conducting quality improvement projects, and proactive population health management activities.
☐	Behavioral Health Services	3.C.1	Collaborate, coordinate, and have a cooperative referral process with outside specialty mental health, substance use, and developmental providers including a mechanism for co-management (as needed). Submit to PacificSource de-identified examples of two-way communication and care coordination.
☐	Electronic Health Information Exchange	4.D.3	Participate in real-time electronic health information exchange and report on the clinic's HIE capabilities.
☐	Population Data Management	5.A.1 and 5.A.2	Demonstrate the ability to identify, aggregate, display and utilize up-to-date data regarding entire patient population, including the identification of subpopulations. Demonstrate the ability to stratify entire patient population according to health risk such as special health care needs or health behavior.
☐	Complex Care Management	5.C.2	Care management activities should include a minimum of 4 hours/month of scheduled, paid team time for activities such as registry review, conducting quality improvement projects, reviewing CCO performance metrics, and proactive population health management for patients with asthma, diabetes, hypertension, coronary artery disease or congestive heart failure, mental health, substance abuse, or other prevalent chronic conditions.
☐	CAHPS Patient Experience of Care Surveys	6.C.2 or 6.C.3	Assess patients' experience of care by administering and reporting on a CAHPS Clinician & Group survey (version 3.0 recommended). Submit top-box composite scores to PacificSource for the following two CAHPS domains: **Access to Care** (Getting timely appointments, care, and information) and **Care Coordination** (Provider's Use of Information to Coordinate Care). Clinics will report domain scores to PacificSource and, if not meeting the PCPCH benchmark for one or both domains, submit an improvement plan.

2) Integrated Behavioral Health VBP Program Participation

The purpose of this program is to provide financial and operational support for behavioral health integration at Patient-Centered Primary Care Homes (PCPCH). A minimum level of PCPCH functioning is necessary to effectively implement integrated behavioral health. Therefore, clinics must be PCPCH recognized as Tier 3, 4, or 5 to be eligible for the integrated behavioral health VBP program.

PacificSource supports the effective integration of behavioral health (BH) services into primary care as a key component of health system transformation. This program will specifically identify and provide additional support to those clinics that meet a fidelity level of integration based on Oregon's PCPCH program and the Integrated Behavioral Health Alliance (IBHA) minimum standards.
NOTE: For 2022, PacificSource is offering two levels of PMPM payments. Payments will be made retrospectively on a quarterly basis and will be based on meeting program metric benchmarks, along with successful participation in a site visit assessment.

For the purposes of this program, **integrated behavioral health** is defined as care provided to individuals and their families in a PCPCH by primary care providers (PCP), behavioral health clinicians (BHC), and other care team members working together to address the following: mental illness, substance use disorders, health behaviors that contribute to chronic illness, life stressors and crises, developmental risk/conditions, stress-related physical symptoms, preventative care, and ineffective patterns of health care utilization.

Behavioral health clinicians (BHC), adapted from ORS 414.025, include:
A licensed psychiatrist; A licensed psychologist; A certified nurse practitioner with a specialty in psychiatric mental health; A licensed clinical social worker; A licensed professional counselor or licensed marriage and family therapist; A board-registered associate or psychologist resident.

BHC same-day open access services include following activities as defined by the IBHA minimum standards for integration:

- ✓ Prevention and early intervention for common behavioral health issues
- ✓ Same-day brief patient consultations, assessments & interventions
- ✓ Warm hand-offs between the primary care team and BHC(s)
- ✓ Consultations between the primary care team and BHC(s)
- ✓ BHC(s) participation in pre-visit planning, team meetings, and huddles
- ✓ Care management and care coordination with entities outside the PCPCH including specialty behavioral health clinicians, psychiatrists, other specialist providers, hospitals, schools and teachers, etc.

Co-located specialty behavioral health services delivered at primary care clinics are not eligible for the integrated behavioral health payment program but may establish a separate contract with PacificSource as a panel behavioral health provider. Specialty behavioral health services are provided by mental health professionals on an episodic, repetitive basis for mental health and substance use disorder conditions that often are more severe or complex than can be handled by a primary care team. Clinics providing specialty services will score lower than 5 on the IBHA standards found in the *Assessment Tool for Integrated Behavioral Health Services* (See Appendix A). However, it is possible for clinics to provide both integrated and specialty behavioral health services.

Integrated Behavioral Health VBP Program Requirements

An integrated PCPCH may qualify for a BHI PMPM payment (in addition to fee-for-service payments) based on meeting all the criterion below.

Meets criteria?	Requirements	BHI Level 1 $2 PMPM	BHI Level 2 $4 PMPM
☐	Be recognized by OHA as PCPCH Tier 3, 4 or 5 including meeting standards 3.C.1 (2020 standards) and 3.C.3	X	X
☐	Meet a minimum staffing ratio • Must have least .5 FTE on-site Behavioral Health Clinician(s) (BHC) as defined above • After .5 FTE, clinics must meet a staffing ratio of 1.0 FTE BHC per 6.0 FTE PCPs per clinic site	X	X
☐	Each BHC included in the staffing ratio above must have at least half of their hours at the practice each week available for **same-day open access services**, as defined above (e.g., a 1.0 FTE BHC must have 20 hours/week available for same-day open access services)	X	X
☐	Score 5 or higher on all IBHA standards as defined in the *Assessment Tool for Integrated Behavioral Health Services* (See Appendix A)	X	X
☐	Track and report 3 metrics to PacificSource on quarterly basis by the designated due dates	X	X
☐	Achieve a minimum population reach benchmark with of 8%, calculated according to specifications below	X	
☐	Achieve a minimum subpopulation reach benchmark of 10% with one identified priority subpopulation, calculated according to specifications below	X	
☐	Achieve a minimum population reach benchmark of 12%, calculated according to specifications below		X
☐	Achieve a minimum subpopulation reach benchmark of 25% with one identified priority subpopulation, calculated according to specifications below		X
☐	Participate in annual verification site visits and/or documentation review conducted by PacificSource or its designated representative	X	X

☐	Participate in technical assistance activities offered by PacificSource such as community of practice meetings, group learning opportunities, onsite or virtual technical assistance, and other collaborative events	X	X
☐	Bill for BHC services consistent with PacificSource policies, including using the "–AG modifier" to submit BHC claims to PacificSource.	X	X

BHI site visits and/or documentation review will be conducted by a subject matter expert consultant to verify each practice site's eligibility utilizing the *Assessment Tool for Integrated Behavioral Health Services* (See Appendix A). BHC scheduling templates must clearly designate same-day open access hours each week and should accurately reflect services that count as "same-day open access behavioral health services," as defined above. Scheduling templates and other documentation are subject to review by PacificSource and its representatives to demonstrate that a participating practice is meeting the same-day availability hours each week in addition to other program requirements.

BHI Reporting Requirements & Data Specifications

PCPCHs participating in the integrated behavioral health payment program will submit the following 3 metrics to PacificSource on a quarterly basis (see reporting schedule on page 2). Data must be calculated and reported according to the specifications below and must be submitted electronically in SurveyMonkey via a link provided by PacificSource. Payments will be made retrospectively on a quarterly basis and will be based on meeting program metric benchmarks, along with successful participation in a site visit assessment.

Metric #1: Population Reach of Integrated Behavioral Health Care

Percentage of unique PacificSource CCO patients seen by a BHC during the reporting period. Note: Each patient will only count once even if they are seen multiple times in the clinic during the reporting period.
To qualify for Level 1 BHI payment, clinics must achieve at least 8% population reach.
To qualify for Level 2 BHI payment, clinics must achieve at least 12% population reach.

Denominator

Required data elements for the denominator: Number of unique PacificSource CCO patients seen in the primary care clinic.

Include in denominator:

- Patients seen for all PCP office visits except exclusions (below)
- Patients seen at the primary care clinic for BHC-only office visits

- (If applicable) Patients with a behavioral health condition who are managed via a registry as part of a fidelity Psychiatric Collaborative Care model

Required exclusions for denominator:

- Patients who were seen for nurse-only visits and/or shot/vaccine-only appointments outside of a standard office visit
- *Optional exclusion*: Patients who were seen for PCP office visit outside of regular business hours (M-F 8am – 5pm) when a BHC is not at the clinic, e.g., the clinic is open during evenings and weekends for urgent care but the BHC is not working during those times.

Numerator

Data elements required for numerator: Of those in the denominator, number of patients seen by a BHC.

Include in numerator:

- All unique PacificSource CCO patients who had a direct patient/family encounter by the BHC that resulted in a warm hand-off, assessment, triage, or intervention (in-person or over phone)
- BHC telehealth/telemedicine encounters that meet the requirements of a billable encounter
- (If applicable) Patients with a behavioral health condition who are managed via a registry as part of a fidelity Psychiatric Collaborative Care model

Required exclusions for numerator: Care coordination contacts via phone

Metric #2: Population Reach with a Priority Subpopulation

Percentage of a priority subpopulation of PacificSource CCO patients who could benefit from BHC involvement and had a BHC encounter during the reporting period. This metric also provides an important opportunity to identify possible disparities by preferred language or race/ethnicity to ensure equitable access to integrated care.

Participating clinics choose one of the priority subpopulations listed in the table below to prioritize for BHC involvement.

To qualify for Level 1 BHI payment, clinics must achieve at least 10% priority subpopulation reach.
To qualify for Level 2 BHI payment, clinics must achieve at least 25% priority subpopulation reach.

Priority Subpopulation	Denominator	Numerator
1) Patients who identify as a person of color or whose preferred language is not English	# of unique PacificSource CCO patients seen at the primary care clinic during the reporting period who identify as a person of color (non-white) or whose preferred language is not English **Include:** • Patients seen for all PCP office visits except exclusions (below) • Patients seen at the primary care clinic for BHC-only office visits • (If applicable) Patients with a behavioral health condition who are managed via a registry as part of a fidelity Psychiatric Collaborative Care Management model **Required exclusions:** • Patients who were seen for nurse-only visits and/or shot/vaccine-only appointments outside of a standard office visit **Optional exclusions:** • Patients who were seen for PCP office visit outside of regular business hours (M-F 8am – 5pm) when a BHC is not at the clinic; e.g., the clinic is open during evenings and weekends for urgent care but the BHC is not working during those times.	Of those in the denominator, # of unique patients seen by a BHC **Include:** ● All direct patient/family encounters by a BHC that resulted in a warm hand-off, assessment, triage, or intervention ● BHC telehealth/telemedicine encounters that meet the requirements of a billable encounter ● (If applicable) Patients with a behavioral health condition who are managed via a registry as part of a fidelity Psychiatric Collaborative Care Management model **Required exclusions:** Care coordination contacts via phone
2) Patients with diabetes and positive depression screening	# of unique PacificSource CCO patients age 12 years or older who scored positive on the PHQ-9 (≥10) and had a diagnosis of Diabetes Mellitus who had at least one HbA1c ≥9 during the reporting period **Include:** ● Unique PacificSource CCO patients age 12 years or older ● Completed a PHQ-9 or PHQ-9A screening tool and scored a 10 (moderate) or higher ● Had a diagnosis of Diabetes Mellitus with at least one HbA1c ≥9 **Required exclusions:** None	Of those in the denominator, # of unique patients seen by a BHC **Include:** ● All direct patient/family encounters by a BHC that resulted in a warm hand-off, assessment, triage, or intervention ● BHC telehealth/telemedicine encounters that meet the requirements of a billable encounter **Required exclusions:** Care coordination contacts via phone

3) Early childhood developmental and social-emotional health	# of unique PacificSource CCO patients who received the ASQ-3 or ASQ:SE-2 screening tool and scored either in the monitoring zone or below the cutoff during the reporting period **Include:** ● A score falling into the grey or black shaded areas in any of the domains; Includes children scoring in the "monitoring zone" and those scoring below the cutoff **Required exclusions:** None	Of those in the denominator, # of unique patients seen by a BHC **Include:** ● All direct patient/family encounters by a BHC that resulted in a warm hand-off, screening, assessment, triage, or intervention ● BHC telehealth/telemedicine encounters that meet the requirements of a billable encounter **Required exclusions:** Care coordination contacts via phone

Metric #3: Access to Same-Day Behavioral Health Care

Percentage of same-day BHC encounters during the reporting period.
This is a report-only measure with no required benchmark, however, PCPCHs with robust integrated care services should strive for 50% of BHC encounters to be same-day.

Denominator

Data elements required for denominator: Total number of BHC encounters

Include in denominator:

- All direct patient/family encounters by the BHC at the practice site that resulted in a warm hand-off, assessment, triage, or intervention (in-person or over phone)
- All BHC patient encounters at the practice site (all patients, not only PacificSource)
- BHC telehealth/telemedicine encounters that meet the requirements of a billable encounter may be included

Required exclusions for denominator: Care coordination contacts via phone

Numerator

Data elements required for numerator: Of those in the denominator, number of BHC encounters that are same-day.

Include in numerator:

- BHC same-day patient encounters for all patients at the practice site (not only PacificSource patients)
- BHC encounters that meet the definition of "same-day" include:

- A behavioral health appointment is both requested (scheduled) and attended on the same day; or
- The patient was seeing the PCP and had a brief warm hand-off, assessment, or intervention completed on the same day by the BHC

Required exclusions for numerator: BHC encounters not defined as same-day and care coordination contacts via phone

3) Community Health Worker VBP Program Participation

The purpose of this program is to provide financial and operational support for Community Health Workers (CHW) at Patient-Centered Primary Care Homes (PCPCH). A minimum level of PCPCH functioning is necessary to effectively integrate CHWs, therefore, clinics must be PCPCH recognized as Tier 3, 4, or 5 to be eligible for the CHW VBP program. A Community Health Worker (CHW) is a frontline public health worker who works in a PCPCH under the direction of a licensed health provider. CHWs assist individuals and their community to achieve positive health outcomes. Clinics should utilize CHW supervision and integration best practices outlined in the Traditional Health Worker Toolkit. **To be eligible for the CHW VBP program, PCPCHs must meet all the following criteria:**

Meets criteria?	Criteria	Description & Reporting
☐	Have a certified CHW on-site at the PCPCH	Certified CHW must be at least .5 FTE on-site at the PCPCH regularly to collaborate with care team members and routinely working in the community with patients and community partners.
☐	Meet PCPCH standard 3.D.2 or 3.D.3 or 5.E.3	3.D.2 - PCPCH tracks referrals to community-based agencies for patients with health-related social needs. Connect Oregon/Unite Us is the referral tracking platform supported across PacificSource CCO regions. 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. Connect Oregon/Unite Us is the referral tracking & care coordination platform supported across PacificSource CCO regions. 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 services, foster care (either adult or child), public health, traditional health workers, school-based health centers, behavioral health providers and organizations, and pharmacy services. Connect Oregon/Unite Us is the referral tracking & care coordination platform supported across PacificSource CCO regions.
☐	CHW serves a minimum of 10-20 unique PacificSource CCO patients per month	Clinics can count the same patient over consecutive months; includes group and 1:1 services.
☐	PCPCH reports the # of PacificSource CCO patients served by the CHW	PCPCH will report quarterly on the number of unique PacificSource CCO patients served by the CHW and must also submit the "Traditional Health Worker Data Report" quarterly via secure email to: THWreports@pacificsource.com

Appendix A: Assessment Tool for Integrated Behavioral Health Services*

IBHA/PCPCH Integrated Care Standard*	Level of Integration **NOTE: Primary care clinics must score a 5 or higher on each IBHA/PCPCH standard and must meet PCPCH 3.C.1 and 3.C.3 to meet the minimum requirements to be considered integrated.**			
1. Integrated BH services are provided as part of routine care at the PCPCH including licensed Behavioral Health Clinician(s) (BHC)[1] delivering an array of services onsite. BHC(s) provides care at the PCPCH with a ratio of 1 FTE BHC for every 6 FTE of Primary Care Clinicians (PCC).	No BHC practices on-site in the PCPCH, or practices in same building but not co-located inside the primary care clinic 0 1	A BHC is co-located inside the PCPCH but clinic does not meet staffing ratio of 1 FTE BHC for every 6 FTE PCCs 2 3 4	One or more BHCs provide integrated behavioral health services on-site in the PCPCH at a ratio of at least 1 FTE BHC for every 6 FTE PCCs 5 6 7	One or more BHCs provide integrated behavioral health services on-site in the PCPCH at a ratio that exceeds 1 FTE BHC for every 6 FTE PCCs 8 9 10
2. Integrated BHC provides a broad array of comprehensive evidence-based behavioral health services.	No BHC practices on-site in the PCPCH, or practices in same building but not co-located inside the primary care clinic 0 1	The BHC provides longer-term therapy services, primarily via referral from PCCs, to few patients with higher acuity mental health and/or substance use issues; Unknown if BHC is using evidence-based treatments 2 3 4	BHC provides short-term, evidenced-based care for all of the following: mental illness, substance use disorders, health behaviors that contribute to chronic illness, life stressors and crises, developmental risks and conditions, stress-related physical symptoms, preventive care, and ineffective patterns of health care utilization; Most patients see the BHC for 4 or fewer sessions during an episode of care; Evidence-based interventions include those listed in the SAMHSA Evidence-Based Practices Resource Center 5 6 7	8 9 10

[1] Behavioral health clinicians (BHC), as defined by ORS 414.025, include: A licensed psychiatrist; A licensed psychologist; A certified nurse practitioner with a specialty in psychiatric mental health; A licensed clinical social worker; A licensed professional counselor or licensed marriage and family therapist; A board-registered associate or psychologist resident.

*Developed by Creach Consulting Group, based on the Integrated Behavioral Health Alliance (IBHA) recommended minimum standards for PCPCHs providing integrated care (2015).

IBHA/PCPCH Integrated Care Standard*	Level of Integration **NOTE: Primary care clinics must score a 5 or higher on each IBHA/PCPCH standard and must meet PCPCH 3.C.1 and 3.C.3 to meet the minimum requirements to be considered integrated.**			
3. Integrated BHC provides same-day open access behavioral health services. (Same-day services are provided in real-time at the point of care when behavioral health issues are identified, including the following BHC activities: warm hand-offs, brief assessments and interventions, consultations to PCCs and other care team members)	No BHC in the PCPCH or BHC is not readily available for same-day services; BHC appointments are typically scheduled as traditional 50-minute therapy sessions; BHC is not interruptible when with a patient 0 1	BHC same-day availability is minimal; may occur at times but not defined; Majority of appointments are scheduled therapy for traditional mental health issues; Ability to interrupt BHC is limited; Unknown or low population reach (less than 5%) 2 3 4	BHC is available for same-day services at least half of their hours at the clinic each week; same-day warm-hand offs occur regularly; BHC may average about 6 BHC encounters per day; BHC is interruptible most of the time; Evidence of moderate population reach (5-10%) 5 6 7	BHC is available for same-day access during all times the clinic is open and is interruptible at any time when patient needs arise; BHC averages 8 or more BHC encounters per day; Evidence of high population reach (15% or more) 8 9 10
4. Primary care clinicians, staff, and BHC utilize shared medical records and have a mechanism in place for collaborative care planning and co-management of patients.	No BHC in the PCPCH or no use of shared EHR; All medical and behavioral health information is separate; Little to no evidence of care coordination or collaborative treatment planning 0 1	BHC & PCC share EHR but BH notes & treatment plans are separate from PCC documentation; BHC & PCC may occasionally communicate, but have different treatment goals; Little to no evidence of care coordination or collaborative treatment planning 2 3 4	PCCs and BHC utilize a fully shared EHR for all documentation; PCC and BHC documentation is integrated and treatment plans are coordinated; BHCs and PCCs participate in collaborative treatment planning and co-management via case conferences, consults, pre-visit planning and/or daily huddles 5 6 7	Utilizing shared EHR, BHC and PCCs jointly develop and coordinate one shared treatment plan and involve patient in setting health goals; BHCs and PCCs regularly participate in collaborative treatment planning and co-management via case conferences, consults, pre-visit planning and/or daily huddles 8 9 10

IBHA/PCPCH Integrated Care Standard*	Level of Integration **NOTE: Primary care clinics must score a 5 or higher on each IBHA/PCPCH standard and must meet PCPCH 3.C.1 and 3.C.3 to meet the minimum requirements to be considered integrated.**			
5. BHC is an integrated part of the primary care team.	No BHC at the PCPCH or the BHC is co-located in the clinic, but does not participate in regular clinic activities 0 1	BHC primarily utilized as a referral resource, but otherwise does not participate in regular clinic activities along with other staff & providers; BHC may have an office on-site in the PCPCH where appointments are conducted 2 3 4	PCCs, BHCs, and other care team members utilize shared physical space; BHC conducts many same-day services in clinic exam rooms when possible; BHC participates in practice activities such as team meetings, daily huddles, pre-visit planning, and quality improvement (QI) projects 5 6 7	Services and physical space completely integrated and seamless; BHC maintains consistent visible presence; BHC practices side-by-side with PCCs and is represented in leadership roles; Patient appointments regularly scheduled jointly with PCC and BHC; BHC routinely participates in daily huddles, pre-visit planning, and QI projects 8 9 10
6. PCPCH utilizes a population-based approach to delivering and coordinating integrated behavioral health services.	No systematic process in place to conduct universal screening for BH needs and connect patients to treatment and resources 0 1	May track individual patients based on circumstances or provider judgement, but no standardized pathways exist for screening, referral to services, coordinating care, and maintaining continuity 2 3 4	PCPCH utilizes universal BH screening, care coordination, and panel management to monitor the BH needs and outcomes of the patient population. PCPCH utilizes written protocols for referrals to appropriate BH specialist(s) and hospitalization if clinically indicated 5 6 7	Systems in place to ensure all patients are screened, assessed, treatment is scheduled & follow-up coordination is maintained; Outcome measures are tracked and used for QI purposes; Patient registry is actively utilized with criteria and outreach protocols to monitor patients & make care plan adjustments; Outreach performed consistently with information flowing back to care team 8 9 10

IBHA/PCPCH Integrated Care Standard	Level of Integration **NOTE: Primary care clinics must score a 5 or higher on each IBHA/PCPCH standard and must meet PCPCH 3.C.1 and 3.C.3 to meet the minimum requirements to be considered integrated.**			
7. The integrated team includes psychiatry consultative resources.	No coordination with external or internal psychiatric resources (i.e., psychiatrist or psychiatric mental health nurse practitioner) 0 1	Minimal coordination and consultation may occur with psychiatric resources in specialty mental health settings 2 3 4	PCPCH identifies the psychiatric care needs of their population, determines viable psychiatric consultation strategies and provider options, and develops a care model that includes these services; Routinely uses Oregon Psychiatric Access Line (OPAL-K/A) and/or has systematic consultation with psychiatrist or psychiatric mental health nurse practitioner 5 6 7	PCPCH has implemented a fidelity Collaborative Care model with fully functional registry to track patient populations and outcomes, including weekly reviews with a psychiatrist to identify patients who are not improving and adjust treatment accordingly 8 9 10
PCPCH 3.C.1 (2020 Standards)	PCPCH has a cooperative referral process with specialty mental health, substance abuse, and developmental providers including a mechanism for co-management as needed (see full specifications in the PCPCH TA Guidelines) _____ Meets 3.C.1 under 2020 Standards _____Does not meet 3.C.1			
PCPCH 3.C.3	PCPCH provides integrated behavioral health services, including population-based, same-day consultations by behavioral health providers (see full specifications in the PCPCH TA Guidelines) _____ Meets 3.C.3 _____Does not meet 3.C.3			

OHA Medicaid Efficiency and Performance Program **CCO:** PacificSource
Community Solutions – Columbia Gorge

2020/2021 MEPP: Asthma Episode Closeout Report

Brief Description

The Oregon Health Authority's (OHA) Medicaid Efficiency and Performance Program (MEPP) challenges CCOs to leverage the MEPP tool to identify actionable opportunities where they can implement meaningful interventions to lower Adverse Actionable Events (AAE) and episode costs. PacificSource Community Solutions (PCS) submitted the first round of action plans in 2020 for episode interventions taking place between 2020 and 2021. PCS selected three episodes of focus for these action plans: asthma, diabetes, and substance use disorder (SUD). We chose these episodes for their significant contributions to state-wide costs, broad impacts on Oregon's population, and alignment with the OHA, organizational, and community-based goals.

PCS elected to send patients an action plan to optimize their asthma management, in conjunction with a conversation with their primary care physician, for the asthma project. Asthma action plans help patients understand which medications to use based on a measurement of their peak flow. This tool may initiate a new prescription of preventative asthma inhalers and a peak flow meter if the patient does not have these already. PCS set a target of mailing the asthma action plan to at least 70% of PCS members with an asthma diagnosis, along with a letter explaining its purpose. In addition, the PCS Population Health Team conducted provider education on the asthma action plan and sent letters to providers to make them aware of the project and prepare them for conversations with their patients.

Intersections with Health Equity

The PCS MEPP: Asthma Workgroup confirmed the prevalent languages within each PCS region (as defined as meeting a prevalence of 5% of the membership or 1,000 members). In each PCS region, the prevalent languages are English and Spanish. We translated all member materials into Spanish, and internal teams and the OHA reviewed them to ensure that they met plain language and reading level standards. Members who indicated Spanish as their preferred language received the materials in Spanish. Additionally, the MEPP: Asthma Workgroup worked to make sure we offered culturally and linguistically appropriate materials. These efforts included positive steps to advance health equity. Due to the relatively small volumes of inpatient admits and population sizes, we are not splitting out the asthma-related Inpatient Admissions Per Thousand Members Per Year (PTMPY) by Race, Ethnicity, Language, and Disability (REALD) segment at this time as variation in outcomes will likely not have the sample sizes required for statistically meaningful differences.

Changes to the Opportunity

Given the severe impact of COVID-19 on the medical community, there was a decline in bandwidth for our provider partners to focus on projects that are not directly COVID-19-related. Due to this, the MEPP: Asthma Workgroup had less engagement than anticipated from provider partners.

Updated Estimate of Potential Costs and/or Savings

The final cost associated with the project was close to the estimates in the initial action plan. PCS spent $3,209.11 on the member educational mailings. Since the initial submission, the updated CY18-20 MEPP Dashboard shows even higher AAE costs for asthma episodes, signaling that this area of opportunity remains high. PCS believes the outcome of this intervention to have a positive return on investment, considering the relatively low project costs and large AAE opportunity identified in the MEPP tool.

Attestation on Project Completion

Milestone 1: *Analysis and outreach strategy development. PCS identifies the Impact of AAE from asthma episodes, including top diagnostic and procedure codes associated with AAE. Develop a method for identifying the target population for asthma patients and their contact information.*

Status: Completed in CY2021.

Milestone 2: *Member Education Materials & Staff Training. PCS develops member education materials on asthma management. Member Support Specialist staff receive information on asthma education mailer in order to respond to member questions or inquiries. Targeted employees receive the information contained in member education materials on asthma management.*

Status: Completed in CY2021. The OHA approved the developed asthma education materials. PCS provided training to the Member Support Specialist team on how to respond to member questions regarding the asthma-related material.

Milestone 3: *Member Contact. At least 70% of target asthma members and their providers are sent educational materials via appropriate channels (mailing, email, discussion with CM, etc.)*

Status: Completed in CY2021. PCS mailed members with an asthma diagnosis the asthma-related educational materials in April 2021. PCS Provider Service staff shared the asthma materials with all providers in PCS CCO regions.

Milestone 4: *Follow-up and progress assessment.*

Status: Completed in CY2021. PCS Population Health and Quality Improvement staff track dissemination of asthma education materials and continue to assess its impact.

Milestone 5: *Report submitted to OHA.*

Status: Completed 3/15/2021.

Performance Measure Descriptions: Percent of Members with Asthma Provided Educational Materials

Measure Description	Percent of members with asthma provided with educational materials on asthma management
Numerator	Number of members with asthma provided with educational materials on asthma management
Denominator	Number of members with asthma identified in the target group for outreach
Measurement Period	PCS sent member educational materials in the spring of 2021, the measurement period for this MEPP action plan metric.
Baseline Period	N/A
Data Source	The Quality team tracked the number of members provided with educational mailings during the member mailing process. We generated the

	member with asthma mailing list using our internal Member Insight Data Access Layer using an algorithm for asthma condition.
Definition of success	The original action plans identified a target of outreaching at least 70% of the members in the targeted population.

Performance Measure Outcome

In PCS – CG, there were 143 members on the list identified to receive the asthma educational materials. Of those members, 16 had a REALD reading language of Spanish, and we sent member materials to members in their preferred language. We did not send the member mailing to one member on the do not contact list. Therefore, this outcome measure was 142/143 or 99.3%, which exceeds our initial target of 70% of members provided with a mailing.

Measurement Challenges and Strategies

There were no measurement challenges to report on this metric.

Interpretation of Outcomes

At the onset of this project, the MEPP: Asthma Workgroup aimed to send asthma educational materials to at least 70% of members with asthma identified for outreach. Ultimately, the team was able to send the mailings more widely. Except for a few members on the do-not-contact list, everyone in the target group was on the final mailing list to send the member materials. Therefore, the outcome of this project exceeded our target for success.

Performance Measure Descriptions: Inpatient Admissions for Asthma-Related Diagnoses per Thousand Members per Year (PTMPY)

Measure Description	Inpatient Admissions for Asthma-Related Diagnoses per Thousand Members per Year (PTMPY)
Numerator	The number of inpatient admissions for members with asthma where the admission has an urgent or emergent admit type with admission or primary diagnosis beginning with J4.
Denominator	PCS used medical member month exposure for members with a diagnosis of asthma to calculate admissions PTMPY.
Measurement Period	Calendar year 2021.
Baseline Period	Calendar year 2020.
Data Source	Internal enrollment data and claims information (including inpatient admissions and an asthma condition algorithm that incorporates medical, pharmacy, and risk score data).
Definition of success	This metric was used as a reporting measure only to monitor potential impacts since, at the onset of the efforts, we defined success via the process measure of the number of members provided asthma materials.

Measurement Challenges and Strategies

The COVID-19 pandemic affected the baseline for this metric, which created downward pressure on healthcare utilization and access. We used a comparison population to compare baseline to

measurement period trends, which means we need to adjust for population risk scores to account for potential differences in age or morbidity. Finally, due to the timing of the final MEPP reporting, the claims data for the measurement period of 2021 will not be fully complete. Therefore, we will apply an inpatient admit completion factor calculated by our PCS Actuarial team.

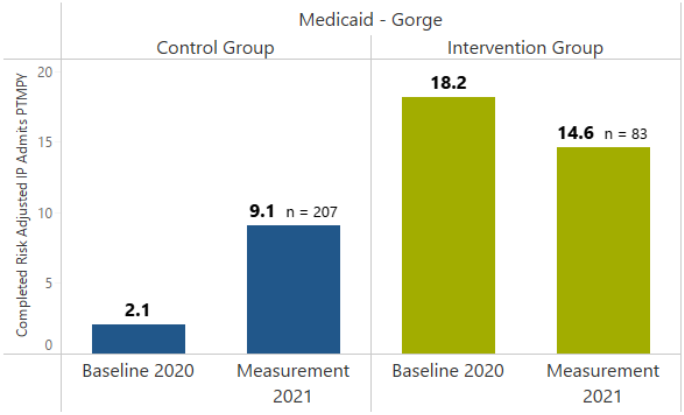
As part of the measurement, we pulled member month exposure for the baseline of 2020 and the measurement period of 2021 for members with an internal conditional asthma flag indicator. The members were categorized as part of the intervention group if they appeared on the point-in-time mailing list used to send the member educational materials. If the members did not appear on the mailing list, we considered them part of the comparison group. We computed the average risk score for the intervention and control groups for the baseline and measurement period. We then pulled data for inpatient admits of admit type "emergency" or "urgent" with an admitting or primary diagnosis indicating asthma (J4*) for both the baseline and measurement periods. We matched these inpatient admit counts to the control and intervention groups based on whether or not the member appeared on the mailing list to receive the educational materials.

For the final measurement, we applied a completion factor to the 2021 measurement period since the available data included claims paid through December 2021. Since we used claims paid through December 2021, we assumed the 2020 baseline period is complete.

Then we calculated the number of completed inpatient admissions PTMPY by dividing the completed inpatient admit counts by the appropriate member month exposure for the control and measurement groups to calculate the PTMPY rate. Finally, we divided the rates by the average risk score to account for differences in age and risk between the two populations.

Performance Measure Outcomes

Risk-Adjusted Asthma Related Inpatient Admissions PTMPY Among Members with Diagnosis of Asthma
Primary or Admitting Inpatient Diagnosis includes J4*, Admit Type of Emergency or Urgent
n = average membership
Claims incurred between 1/2020 and 12/2021, paid through 12/2021 with completion factor applied



Measurement for PCS – CG shows an increase in the risk-adjusted inpatient admissions for asthma-related reasons among members diagnosed with asthma in the control group between the baseline and

the measurement period. Conversely, the members with asthma in the measurement group who received educational materials had declining inpatient utilization for asthma-related reasons. This means that the provision of the member educational materials correlated with a decrease in inpatient utilization for reasons regarding asthma.

Interpretation of Outcomes

The MEPP: Asthma Workgroup defined success for this process measure by tracking the number of members who received asthma-related educational materials mailing. We achieved the definition of success for this project by meeting the target we identified in the MEPP: Asthma Action Plan. The overall goal of selecting an outcome measure on inpatient utilization for asthma-related reasons was to reduce costly inpatient admissions through member education. Although many confounding factors among our Medicaid population make causality difficult to prove, we saw a reduction in the number of inpatient admissions correlated with the educational materials provided between the baseline and measurement periods.

OHA Medicaid Efficiency and Performance Program **CCO:** PacificSource
Community Solutions – Columbia Gorge

2020/2021 MEPP: Diabetes Episode Closeout Report

Brief Description

The Oregon Health Authority's (OHA) Medicaid Efficiency and Performance Program (MEPP) challenges CCOs to leverage the MEPP tool to identify actionable opportunities where they can implement meaningful interventions to lower Adverse Actionable Events (AAE) and episode costs. PacificSource Community Solutions (PCS) submitted the first round of action plans in 2020 for episode interventions taking place between 2020 and 2021. PCS selected three episodes of focus for these action plans: asthma, diabetes, and substance use disorder (SUD). We chose these episodes for their significant contributions to state-wide costs, broad impacts on Oregon's population, and alignment with the OHA, organizational, and community-based goals.

For the diabetes episode intervention, PCS developed a strategy to create educational materials on the importance of dental care for members with diabetes. PCS offered these resources to providers with the highest AAE dollars associated with diabetes. In addition, there will be member newsletters that focus on oral health and dental screenings.

Intersections with Health Equity

For the MEPP diabetes intervention, PCS aimed to increase dental care utilization for members with diabetes regardless of race, language, heritage, gender identity, or sexual orientation. We expected the project to have a neutral impact on health equity. One way we can monitor the health equity outcomes for dental care among members with diabetes is to stratify the oral evaluation for members with diabetes quality metric. We report this metric by the primary race integrated into our Member Insight Data Access Layer.

Columbia Gorge CCO	**2020**				**2021**			
Primary Race	NUM	DEN	RATE	% DIFF FROM TOTAL	NUM	DEN	RATE	% DIFF FROM TOTAL
Asian or Pacific Islander	4	14	28.6	20%	4	16	25.0	-24%
Black or African American	0	1	0.0	-100%	2	2	100.0	206%
White	**83**	**368**	**22.6**	**-5%**	**103**	**358**	**28.8**	**-12%**
Hispanic or Latinx	**27**	**96**	**28.1**	**18%**	**54**	**134**	**40.3**	**23%**
American Indian or Alaska Native	1	7	14.3	-40%	4	10	40.0	22%
Not Provided	16	62	25.8	8%	29	79	36.7	12%
Total	131	548	23.9	0%	196	599	32.7	0%

Among member populations with at least 30 members in the denominator (bolded in the table above), we see that Hispanic/Latinx members had favorable outcomes relative to White members. In general, metric outcomes for small populations were volatile over time, but outcome patterns by race were mostly unchanged between CY2020 and CY2021 during the timeframe of this intervention. The project

likely had minimal impacts on health equity. However, health equity is an increasing area of focus for PCS and will continue to be a core consideration in our future efforts.

Changes to the Opportunity

In the first quarter of CY2020, the COVID-19 pandemic led to access restrictions for most dental care offices, which significantly affected the ability to access dental care. In addition, many members, especially those with underlying health conditions such as diabetes, may have been hesitant to access dental care services for fear that it may put them at risk of contracting COVID-19. The decline in members with diabetes receiving periodontal care between CY2019 and CY2020 elevated the need for this project.

Given the severe impact of COVID-19 on the medical community, we anticipated a decline in bandwidth for our physician partners to focus on projects that are not directly COVID-19-related. In addition, many of our dental provider partners faced staffing shortages. Due to this, we were unsure how many physicians would utilize the educational materials.

Updated Estimate of Potential Costs and/or Savings

The final cost associated with the project was close to the estimates in the initial action plan. PCS spent $418.13 on printing and postage for educational materials. Since the initial submission, the updated CY2018-2020 MEPP Dashboard shows even higher AAE costs for the diabetes episode, signaling that this area of opportunity remains high. PCS believes the outcome of this intervention to have a positive return on investment, considering the low project costs and large AAE opportunity identified in the MEPP tool.

Attestation on Project Completion

Milestone 1: Analysis and outreach strategy development. Patients with diabetes who complete periodontal treatments have reduced AAE dollars associated with overall medical costs, as well as hospital admissions. We will identify providers with the highest AAE associated with diabetes for outreach.

Status: Completed 7/14/2020. PCS developed lists of provider groups comprising the top 50% of AAE dollars to outreach as part of this project.

Milestone 2: Content Creation. PCS will create educational materials on the importance of dental care with diabetes. We will offer this content to providers to disseminate to their patients. Additionally, we will develop an educational article on dental screenings to include in a member newsletter.

Status: Completed in CY2021. PCS created a Dental Care “Rx Pad” for primary care providers to give to their patients. The “Rx Pads” provide recommendations for people with diabetes to access oral health care, and we provide clinics the material with their branded information. To date, we have provided dental “Rx Pads” to 29 clinics representing 12 provider partners across PCS CCO regions. Additionally, provider partners in the PCS – LN and PCS – CO region have requested the informational brochure on Oral Health and Diabetes for physicians to give to their patients. PCS also developed a template letter for physicians to send their patients on diabetes and oral health. Provider partners in the PCS – CO, PCS – LN, and PCS – CG region took advantage of these letters. PCS supported providers by mailing letters on behalf of providers to 500 patients who had an annual oral health evaluation for patients with diabetes

gap in care in June 2021 and 418 patients with a gap in November of 2021 throughout our CCO regions. Finally, PCS developed educational material on dental screening, which we included in the winter 2021 member newsletter.

Milestone 3: Provider Contact. PCS will provide outreach to at least 50% of the identified providers to acquaint them with the materials and disseminate them.

Status: Completed in CY2021. PCS Provider Network and Population Health staff provided outreach to all contracted Primary Care Provider (PCP) clinics in each PacificSource CCO region.

Milestone 4: Follow up. Follow-up and progress assessment for each provider completed and documented.

Status: Completed in CY2021. All of the key provider partners identified at the onset of the project engaged in the project and requested educational materials to send to their patients.

Milestone 5: Report submitted to OHA.

Status: Completed 3/15/2021.

Performance Measure Descriptions: Percent of Provider Groups Supported by Oral Health & Diabetes MEPP Efforts

Measure Description	Number of Provider Groups Supported by Oral Health & Diabetes Efforts
Numerator	Number of participating provider groups supported through efforts
Denominator	Number of provider groups defined at the onset of the program based on highest AAE costs
Measurement Period	Training and materials offered during the first half of CY2021 and the measurement period is 1/1/2021 to 7/1/2021
Baseline Period	Not applicable
Data Source	Population Health Staff have been manually tracking provider engagement in these efforts and have provided counts of participating clinics for the first half of 2021
Definition of success	At the onset of this project, the commitment was to offer educational support to providers with the highest associated AAE costs. Success would be offering educational materials and support to all of the identified provider groups in the early phases of the project.

Performance Measure Outcome: Percent of Provider Groups Supported by Oral Health & Diabetes MEPP Efforts

PCS offered educational materials widely to provider groups. At the onset of the project, PCS identified three key partners to contact based on member assignment and tools from the MEPP Dashboard. These provider groups were contacted, making this outcome measure (3/3) or 100%.

Gorge CCO Partner	Outreach Confirmed
One Community Health	Y

Waters Edge Medical Clinic	Y
MCMC Family Medicine	Y

Measurement Challenges and Strategies

This process measure was easy to track, and there were no significant measurement challenges.

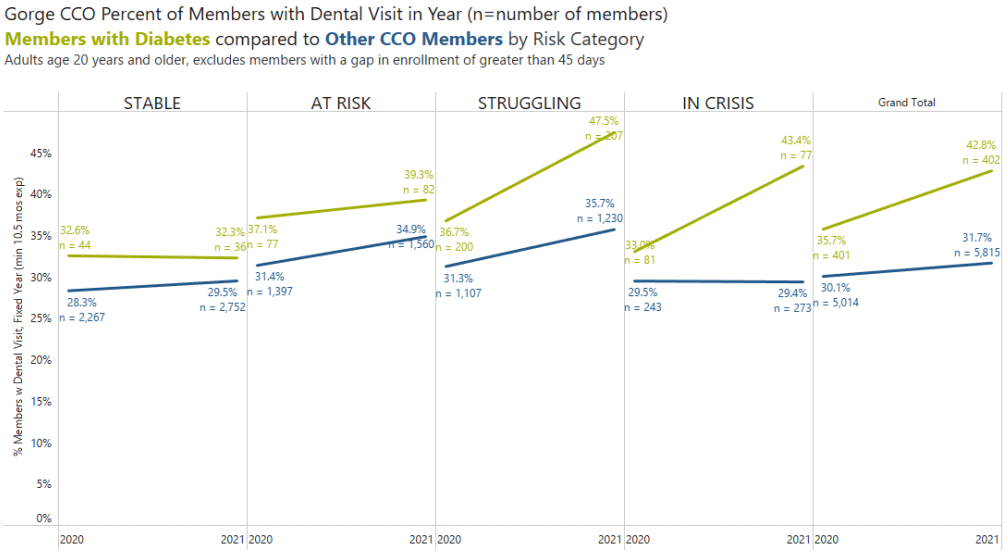
Interpretation of Outcomes

PCS planned this MEPP project before the COVID-19 pandemic. We met the definition of success for this intervention by contacting each of the identified provider groups to offer them free materials designed to boost dental care for members with diabetes. Due to the significant unforeseen challenges faced by our provider partners, the provider partners might not have used the materials as much as they might have in a typical year.

Performance Measure Descriptions: Percent of Adult Members with Diabetes with a Dental Visit in the last 12 Months

Measure Description	Percent of Adult Members with Diabetes with a Dental Visit in the last 12 Months.
Numerator	Adult CCO members (age 20 and older as of December 31, 2021) with a diagnosis of diabetes with a dental visit in the last 12 months. Member may not have an enrollment gap of greater than 45 days in the year.
Denominator	Adult CCO members (age 20 and older as of December 31, 2021) with a diagnosis of diabetes. Member may not have an enrollment gap of greater than 45 days in the year.
Measurement Period	Implementation began in the first half of 2021, and the measurement period will be the 12-month rolling rate calculated for December 2021.
Baseline Period	PCS calculated the baseline with data as of December 2020, reflecting a 12-month lookback period to the beginning of 2020.
Data Source	PCS calculated the measure using the internal Member Insight Data Access Layer, which leverages claims and enrollment data. The measurement is calculated using December 2021 data, reflecting a 12-month lookback period to the beginning of 2021.
Definition of success	This metric is a reporting measure to monitor potential impacts. At the onset of the efforts, PCS defined success via the process measure “Number of Provider Groups Supported by Oral Health & Diabetes MEPP Efforts.”

Performance Measure Outcomes



The percent of members with diabetes who had a dental visit in the calendar year increased between CY2020 and CY2021 from 35.7% to 42.8%, outpacing the trend of other PCS members who did not have a diabetes diagnosis. The trend between the CY2020 baseline and CY2021 measurement period shows a slightly more pronounced increase in the percent of members with diabetes with a dental visit compared to the control group within the same risk category in the "struggling" and "in-crisis" categories.

Measurement Challenges and Strategies

Lowered dental utilization during the COVID-19 pandemic affected the CY2020 baseline and CY2021 measurement periods. Fear of exposure to the COVID-19 virus, office closures, stay-at-home orders, and staffing shortages means that dental access and utilization have not been consistent over time. Thus, to monitor for changes in utilization, we wanted to include a comparison group including PCS members without diabetes.

To look at dental utilization trends between members with diabetes and a comparison group, we opted to show the trends by our internal risk score segments. This helps to control the differences in age and chronic condition prevalence between the two groups.

Interpretation of Outcomes

The 2020 MEPP Action Plan for the diabetes episode was to increase dental utilization among PCS members with diabetes. According to this reporting, the program correlated with increasing dental utilization among members with diabetes. However, we cannot attribute the increase in dental utilization among members with diabetes to this project directly.

OHA Medicaid Efficiency and Performance Program **CCO:** PacificSource
Community Solutions – Columbia Gorge

2020/2021 MEPP: SUD Episode Closeout Report

Brief Description

The Oregon Health Authority's Medicaid Efficiency and Performance Program (MEPP) challenges CCOs to leverage the MEPP tool to identify actionable opportunities where they can implement meaningful interventions to lower Adverse Actionable Events (AAE) and episode costs. PacificSource Community Solutions (PCS) submitted the first round of action plans in 2020 for episode interventions between 2020 and 2021. PacificSource Community Solutions selected three episodes of focus for these action plans: asthma, diabetes, and substance use disorder (SUD). We chose these episodes for their significant contributions to state-wide costs, broad impacts on Oregon's population, and alignment with OHA, organizational, and community-based goals.

For the SUD episode intervention, PCS developed, marketed, and implemented educational webinars for the use of Medication-Assisted Treatment (MAT) for patients with alcohol use disorders (AUD). Alcohol use disorder was a focus of the webinar because they are the most common substance use disorder subtype with the highest AAE cost in the MEPP tool. PCS invited all primary care provider groups with assigned CCO membership to the webinar offerings. Through these efforts, the group promoted MAT's effective use to lower the overall medical costs and AAE costs of one of the most costly episode subtypes of SUD.

Intersections with Health Equity

The provider training focused on educating attendees on the use of MAT for patients with AUDs with the overall goal of improving the treatment of AUD regardless of a member's race, language, heritage, gender identity, or sexual orientation. When we consider health equity through the lens of our members struggling with substance use disorder, who often experience unfair treatment due to the stigmatization of SUD conditions, this intervention advances health equity.

When we view health equity through the lens of race, the impact of the intervention is unclear. Reviewing the performance on the initiation and engagement of alcohol and other drug (AOD) treatment by member race in 2020 (close to when the intervention took place), we see some variation of rates in performance outcomes.

For example, when considering races with at least 30 members in the denominator, rates of initiation of AOD treatment in PCS – Columbia Gorge (CG) as of December 2020 were higher for Hispanic/Latinx members (51.5%) than Caucasian members (at 41.7%). As of December 2021, the rate of initiation of AOD treatment for Hispanic/Latinx members (at 30.3%) was lower than the rate for White/Caucasian members (at 38.7%). Importantly, the denominator for the Hispanic/Latinx population was 33 members in these periods, and we may expect to see volatility in performance over time. Therefore, the impact of this intervention on health equity is unclear. The difference in quality measure outcomes necessitates further monitoring. It emphasizes the importance of our ongoing efforts to advance culturally and linguistically appropriate care and reduce barriers for BIPOC and other member populations. (Note that Asian/Native Hawaiian Pacific Islander, Black or African American, and American Indian/Alaska Native member populations included less than 30 members in 2020 and 2021).

However, there are many layers to health equity. The outcome variation by race in the initiation of AOD treatment would not reflect, for example, that some member populations may be less likely to seek care due to various barriers such as the availability of culturally and linguistically appropriate services. Therefore, quality measures may not capture some member populations. It remains critical to continue our work to advance Culturally and Linguistically Appropriate Services (CLAS) and health equity for our CCO members.

Changes to the Opportunity

Due to the complexities of a global pandemic, an increasing number of our CCO members are likely experiencing heightened stress, which may increase the use of substances as a coping mechanism, including alcohol. A study published in The Journal of the American Medical Association on alcohol use during the pandemic shows increased alcohol consumption frequency and heavy drinking and alcohol-related problems.[1] Likewise, The Lund Report released an article in February 2021 stating that hospital admission rates for alcohol-related liver disease have increased by 30%-50% since the pandemic began.[2] We feel this lends to the importance of the project more than ever.

PCS' data does not reflect an increase in diagnosed SUD prevalence, likely due to the competing trends of the suspension of redetermination and a reduced likeliness to seek care during the pandemic, which could be a barrier to SUD diagnoses that are the foundation of our prevalence reporting. However, SUD remains one of the most prevalent conditions in our member population. Anecdotally, we can expect our members with SUD are facing more challenges than before, as the pandemic increases stress, isolation, and economic challenges for our members. Again, increasing the access and quality of SUD treatment remains a critical project for the CCO to improve member well-being.

Updated Estimate of Potential Costs and Savings

The cost for the educational webinar for MAT use for members with AUD was greater than the initial estimates at $6,600 due to the higher than anticipated hourly rate of partnering provider presenters. Since the initial submission, the updated CY18-20 MEPP Tool shows an even higher AAE cost for AUD episodes, signaling that the area of opportunity is still significant.

Educational webinar participants received training via discussion, presentation, and educational materials to increase MAT awareness for AUD. Medication-Assisted Treatment effectively lowers medical costs yet remains underutilized as a treatment method. The educational program helped expand awareness of MAT's effectiveness for AUD within the provider groups serving PCS members. The outcomes of these efforts are consistent with the original estimates provided in the action plan submission.

Attestation on Project Completion

Milestone 1: Analysis and outreach strategy development. *Medication-Assisted Treatment (MAT) has been shown to reduce medical costs for those with Alcohol Use Disorders (AUD). Current evidence shows*

[1] Pollard, M. (2020). Changes in Adult Alcohol Use and Consequences During the Covid-19 Pandemic in the US. Journal of the American Medical Association. September 29, 2020. doi:10.1001/jamanetworkopen.2020.22942

[2] Cahan, E. (2021, February 10). Pandemic-Fueled Alcohol Abuse Creates Wave of Hospitalizations for Liver Disease. The Lund Report. https://www.thelundreport.org/content/pandemic-fueled-alcohol-abuse-creates-wave-hospitalizations-liver-disease?mc_cid=1fc2b8c594&mc_eid=f37db63868

that MAT is underutilized in the treatment of AUD. Identify providers that are good candidates based on the volume of member assignment for education on offering MAT as part of a comprehensive treatment approach.

Status: Completed 7/20/2020. The MEPP: SUD team opened up the educational program to all providers and did not restrict outreach based on member assignment volume. However, the MEPP: SUD team ensured that primary care providers were all invited to the webinar, including the provider partners identified as key partners during the beginning phases of the project planning.

Milestone 2: Provider *Education Materials & Staff Training. Provider education and strategies developed internally for identified providers who will be targeted for outreach via informative material provided by the Population Health Team.*

Status: Completed 9/10/2020

Milestone 3: Provider Contact. *The identified providers will be offered education via discussion, training either in person or by webinar, or written materials to increase awareness and knowledge of MAT best practice standards for AUD. Training by region will be scheduled for those identified providers. Training will be tracked for provider participation.*

Status: Completed 10/7/2020. PacificSource Community Solutions hosted three webinars entitled "Medication-Assisted Treatment for Alcohol Use Disorder in the Primary Care Setting." We provided this webinar for free and gained approval to offer participants Continuing Medical Education (CME) credit. The webinar topics included:

- The extent of the AUD problem in Oregon
- A brief overview of the epidemiology of AUD
- Treatment options for AUD
- Primary education on when to provide medications for AUD and patient characteristics to keep in mind when choosing from the FDA-approved medications
- The new 2020 Medicaid Quality Incentive Metric for SUD

Milestone 4: *Follow up and progress assessment. Completed and documented.*

Status: Completed 2/1/2021. We reviewed and aggregated all webinar evaluations for improvement opportunities.

Webinar hosted 11/2/2020:

- Attendance-24
- 2 evaluations submitted
- Return rate- 8.3%

Webinar hosted 11/3/2020

- Attendance-27
- 3 evaluations
- Return rate- 11%

Webinar hosted 11/9/2020

- Attendance-17
- 7 evaluations submitted

- Return rate- 41%

Milestone 5: *Report submitted to OHA.*

Status: Completed 3/15/2021

Performance Measure Descriptions: Webinar Reach among Key Provider Partners

Measure Description	Number of Participants in Webinar on MAT for AUD
Numerator	The number of participants in the MAT for AUD webinar offered in each CCO region (not including internal PacificSource staff)
Denominator	Number of provider groups identified as key partners during project planning based on member assignment volumes
Measurement Period	Webinars were offered to participating provider groups in November of 2020
Data Source	Population Health staff manually tracked attending participants in the webinars and the methods for outreach to providers regarding this educational opportunity.
Definition of success	All provider groups with assigned CCO membership were invited to participate in the educational webinar.

Performance Measure Outcome: Webinar Reach among Key Provider Partners

Invitations to the provider training were distributed widely through existing channels including, provider newsletters and email distribution lists. All primary care provider partners received communications inviting them to the educational opportunity, *meeting our definition of project success*. In total, there were 68 attendees of "Medication-Assisted Treatment for AUD in the Primary Care Setting," representing a diverse set of organizations.

In the PCS-CG region, three out of the nineteen primary care provider groups selected as key partners at the beginning of the project attended for an outcome measure of 15.7% of provider partners represented.

Measurement Challenges and Strategies

The most significant measurement challenge was capturing all the provider groups represented at the training. However, the Population Health Team successfully captured attendee lists to facilitate this measurement.

Interpretation of Outcomes

We developed this project before the onset of the COVID-19 pandemic, and we had initially envisioned the provider training to have slightly higher attendance. However, at the time, it was not a requirement of the MEPP project to define a specific target. Due to the unprecedented challenges our provider partners faced during the COVID-19 pandemic, we consider the overall attendance rate—and the richness of the conversations it stimulated—a success.

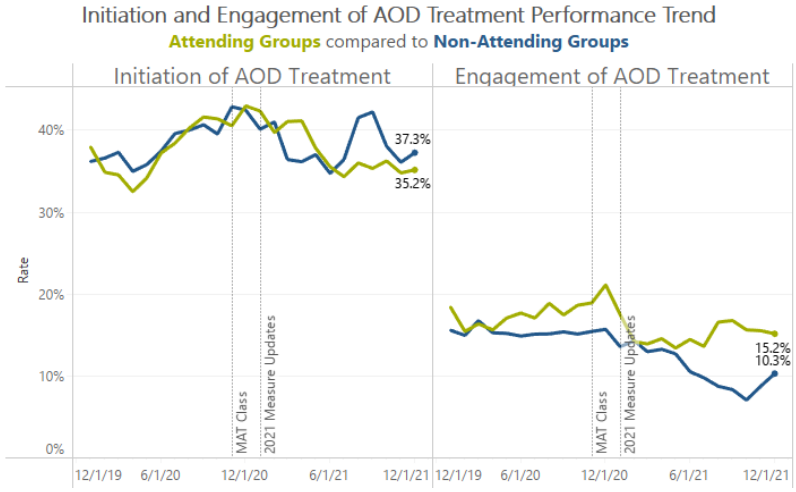
OHA Medicaid Efficiency and Performance Program **CCO:** PacificSource
Community Solutions – Columbia Gorge

Performance Measure Descriptions: Initiation & Engagement of AOD Treatment

Measure Description	Initiation & Engagement of AOD Treatment
Numerator	Numerator for initiation & engagement of AUD treatment is consistent with defined CCO incentive measure specifications for 2020/2021 measurement. The measure will be split out for participating provider groups and non-participating provider groups to evaluate potential impacts of the education.
Denominator	Denominator is consistent with defined CCO incentive measure specifications for 2020/2021 measurement. The measure will be split out for participating provider groups and non-participating provider groups to evaluate potential impacts of the education.
Measurement Period	Webinars were offered to participating provider groups in November of 2020. The measurement period will be December 2020 to December 2021.
Baseline Period	The baseline is defined as January – November 2020.
Data Source	Internal quality incentive metric measures and training attendance rosters.
Definition of success	This metric is intended as a reporting-only metric to monitor for the impacts of the intervention. During the creation of action plans there was no concrete target identified. However, a successful outcome would be if provider groups attending the training improved in Initiation and Engagement of AOD rates and/or had a favorable trend in outcomes compared to provider groups who did not attend.

Performance Measure Outcomes

In PCS – CG, we compared the Initiation and Engagement of AOD Treatment metric performance between provider organizations represented at the training to the provider groups who were not present:



Measurement Challenges and Strategies

An update to the measurement algorithms for the measurement year in 2021 made pre and post-metric performance difficult to assess. However, we applied these differences to both the attending provider

groups and the provider groups who were not present. This means that the metric specification changes had a similar impact on both groups.

Interpretation of Outcomes

There is a more pronounced decline in performance in 2021 in the Initiation of AOD Treatment for participating provider groups and a less favorable performance in this metric compared to provider groups who did not participate in the training. However, participating provider groups did outperform non-participating groups in the engagement metric. Due to confounding factors, we cannot attribute the difference in performance among these two groups to participation in the class alone.

DEPT	ANNUAL QI WORK PLAN ACTIVITIES & OBJECTIVES	BUSINESS OWNERS
QI	**QI INFRASTRUCTURE**	***Carmel A.*** ***Angela T.***
QI	**QI INFRASTRUCTURE**	***Carmel A.*** ***Angela T.***
QI	**QI INFRASTRUCTURE**	***Carmel A.*** ***Angela T.***
QI	**QUALITY OF SERVICE**	***Avery S.***

QI	**QUALITY OF CLINICAL CARE**	***Carmel A.*** ***Gretchen H.*** ***Chelsea H.*** ***Jeanette S.***
CS	**QUALITY OF SERVICE**	***TBD*** *(MarrComm)*
QI	**SAFETY OF CLINICAL CARE**	***Shonda D.***
HS	**QUALITY OF CLINICAL CARE**	***Paul R.***
HS	**QUALITY OF CLINICAL CARE**	***Paul R.***
HS	**QUALITY OF CLINICAL CARE**	***Paul R.***
HS	**QUALITY OF CLINICAL CARE**	**Diane Y.**

HS	**QUALITY OF CLINICAL CARE**	***Diane Y.***
HS	**QUALITY OF CLINICAL CARE**	***Kevin M.*** ***Diiane Y.*** ***Paul R.*** ***Charis A.***
HS	**QUALITY OF CLINICAL CARE**	***Kevin M.***
HS	**QUALITY OF CLINICAL CARE**	***Kevin M.***
HS	**QUALITY OF CLINICAL CARE**	***Paul R.*** ***Charis A.***
HS	**QUALITY OF CLINICAL CARE**	***Kevin M.***

HS	**QUALITY OF CLINICAL CARE**	***Kevin M.***
HS	**QUALITY OF CLINICAL CARE**	***Kevin M.*** ***Connie R.***
HS	**SAFETY OF CLINICAL CARE**	***Kevin M.***
HS	**SAFETY OF CLINICAL CARE**	***Kevin M.***
PN	**SAFETY OF CLINICAL CARE**	***Julie M.*** ***Corey C.***
PN	**SAFETY OF CLINICAL CARE**	***Julie M.*** ***Corey C.***
PN	**SAFETY OF CLINICAL CARE**	***Julie M.*** ***Corey C.***

HS	**SAFETY OF CLINICAL CARE**	***Lucia L.*** ***Kevin M.*** ***Connie R.***
HS	**SAFETY OF CLINICAL CARE**	***Kevin M.*** ***Connie R.***
HS	**SAFETY OF CLINICAL CARE**	***Kevin M.***
HS	**SAFETY OF CLINICAL CARE**	***Kevin M.***
HS	**SAFETY OF CLINICAL CARE**	***Connie R.***
HS	**SAFETY OF CLINICAL CARE**	***Jessica W.***
HS	**SAFETY OF CLINICAL CARE**	***Kevin M.***
PN	**QUALITY OF SERVICE**	***TBD***

CS	**MEMBERS' EXPERIENCE**	***Lindzee P.***
CS	**MEMBERS' EXPERIENCE**	***Katie Jaye S.*** ***Jessica W.***
HS	**QUALITY OF SERVICE**	***Connie R.***
CS	**QUALITY OF SERVICE**	***Lindzee P.***
PN	**QUALITY OF SERVICE**	***Amanda W.***
PN	**QUALITY OF SERVICE**	***Rebecca H.***
CS	**MEMBERS' EXPERIENCE**	***Lindzee P.***

DEPT	ANNUAL QI WORK PLAN ACTIVITIES	BUSINESS OWNERS
QI	**PERFORMANCE IMPROVEMENT PROJECT: STATEWIDE OPIOD REDUCTION**	
QI	**PERFORMANCE IMPROVEMENT PROJECT: HPV VACCINCATION COMPLETION**	
QI	**PERFORMANCE IMPROVEMENT PROJECT: ORAL HEALTH DURING PREGNANCY**	
QI	**PERFORMANCE IMPROVEMENT PROJECT: SDoH**	

QI	**TRANSFORMATION & QUALITY STRATEGY**	
QI	**MA CHRONIC CARE IMPROVEMENT PROJECT**	
QI	**MA QUALITY IMPROVEMENT PROGRAM PLAN**	

QI	**MA QUALITY IMPROVEMENT PROGRAM REVIEW**	
QI	**MA QUALITY IMPROVEMENT WORK PLAN**	

Project Legend

Black: 0	
Green: 3	
Yellow: 2	
Red: 1	

PLANNED ACTIVITY	RELATED STANDARDS OR REGULATIONS
MAINTAIN QI PROGRAM STRUCTURE	QI 1A
DEVELOP & MAINTAIN QI ANNUAL WORK PLAN	QI 1B
MAINTAIN QI PROGRAM EVALUATION	QI 1C
CAHPS/ SURVEY ADMINISTRATION	ME 7D

IDENTIFY AND IMPLEMENT ACTIVITIES THAT SUPPORT PRACTITIONERS AND PROVIDERS IN MEETING POPULATION HEALTH GOALS	**PHM 3A-B**
ENSURE NEW MEMBER UNDERSTANDING OF PLAN & BENEFITS	**ME 3C**
REPORT HEDIS RESULTS AND COMPARE AGAINST QUALITY COMPASS BENCHMARKS	**HEDIS**
MAINTAIN THE CS PROGRAM DESCRIPTION	**CONDITION SUPPORT**
EVALUATE THE EFFECTIVENESS OF THE CS PROGRAM	**CONDITION SUPPORT**
EVALUATE THE EFFECTIVENESS OF THE CS PROGRAM	**CONDITION SUPPORT**
ASSESS MEMBER SATISFACTION WITH THE CCM PROGRAM	**COMPLEX CASE MANAGEMENT**

MEASURE THE IMPACT OF INTERVENTIONS ON MEMBERS IN THE CCM PROGRAM	**COMPLEX CASE MANAGEMENT**
OUTLINE THE POPULATION HEALTH MANAGEMENT STRATEGY FOR MEETING THE CARE NEEDS OF THE ENTIRE MEMBER POPULATION	**PHM 1A-B**
ASSESS THE CHARACTERISTICS AND NEEDS, OF THE MEMBER POPULATION, INCLUDING SDOH, & IDENTIFY AND ASSESS THE NEEDS OF RELEVANT SUBPOPULATIONS; INCLUDING CHILDREN & ADOLESCENTS, MEMBERS WITH DISABILITIES, & MEMBERS WITH SPMI	**PHM 2B-D**
CONDUCT A COMPREHENSIVE ANALYSIS OF THE IMPACT OF THE PHM STRATEGY FOR RELVANT CLINICAL, COST/UTILIZATION& EXPERIENCE MEASURES & USE THE RESULTS TO IDENTIFY AND ACT ON OPPORTUNITIES FOR IMPROVEMENT	**PHM 6A-B**
MONITOR THE PERFORMANCE OF PHM DELEGATES	**PHM 7C-D**
MONITOR & TAKE ACTION AS NECESSARY TO IMPROVE CONTINUITY & COORDINATION OF CARE ACROSS THE HEALTH CARE NETWORK	**QI 3A-C**

ANNUALLY COLLECT DATA ABOUT OPPORTUNITIES FOR COLLABORATION BETWEEN MEDICAL CARE & BEHAVIORAL HEALTH	**QI 4A-C**
MONITOR THE PERFORMANCE OF DELEGATES	**UM 13C-D** **ME8C-D**
MAINTAIN THE UM PROGRAM DESCIPTION	**UM 1A**
EVALUATE THE UM PROGRAM, AND MAKE UPDATES AS NECESSARY	**UM 1B**
MONITOR SANCTIONS, COMPLAINTS AND ADVERSE EVENTS AT THE PROVIDER LEVEL TO IDENTIFY QUALITY OF CARE IMPACT	**CR 5A**
MONITOR CONTRACTED HOSPITALS, HOME HEALTH AGENCIES, SNFS, NURSING HOMES, & FREE STANDING SURGICAL CENTERSCONTRACTED FACILTIES PROVIDING MENTAL HEALTH & SUBSTANCE ABUSE SERVICES, INCLUDING INPATIENT, RESIDENTIAL, & AMBULATORY SERVICES	**CR 7A-D**
MONITOR PERFORMANCE & CONDUCT OVERSIGHT AUDITS OF DELEGATED ENTITIES FOR CREDENTIALING	**CR 8C**

ENSURE CONSISTENCY OF UM CRITERIA USED IN DECISION MAKING & ACT ON OPPORTUNITIES TO IMPROVE CONSISTENCY	**UM 2A-B**
EVALUATE THE CONSISTENCY WITH WHICH HEALTHCARE PROFESSIONALS INVOLVED IN UM APPLY CRITERIA THROUGH THE MEDICAL, BEHAVIORAL HEALTH , AND PHARMACY IRR REPORTS	**UM 2C**
REVIEW OF NON-BH DENIAL FILES TO ENSURE THAT ALL REQUIREMENTS ARE MET	**UM 4C**
REVIEW OF BH DENIAL FILES TO ENSURE THAT ALL REQUIREMENTS ARE MET	**UM 4D**
REVIEW OF PHARMACY DENIAL FILES TO ENSURE THAT ALL REQUIREMENTS ARE MET	**UM 4E**
REVIEW OF APPEALS FILES TO ENSURE THAT ALL REQUIREMENTS ARE MET	**UM 7A-B**
ASSESS MEMBER & PROVIDER EXPERIENCE WITH UM PROGRAM	**UTILIZATION MANAGEMENT**
ASSESS THE CULTURAL, ETHNIC, RACIAL & LINGUISTIC NEEDS OF MEMBERS	**NET 1A** **ME 2B**

ASSESS THE QUALITY & ACCURACY OF INFORMATION PROVIDED TO MEMBERS VIA THE WEBSITE & TELEPHONE	**ME 6C-D**
MONITOR COMPLAINT & APPEALS RATES AND IDENTIFY OPPORTUNITIES TO IMPROVE CUSTOMER SATISFACTION	**ME 7C, E-F**
EVALUATE THE QUALITY IIMPROVEMENT PROCESSES FOR THE QUALITY & ACCURACY OF PHARMACY BENEFIT INFORMATION	**ME 5C**
EVALUATE ACCURACY OF INFORMATION COMMUNICATED TO MEMBERS THROUGH WEBSITE AND TELEPHONE FUNCTIONALITY	**ME 4A-B**
EVALUATE THE AVAILABILITY OF PRACTITIONERS WHO PROVIDE PRIMARY CARE, BEHAVIORAL HEALTHCARE, & SPECIALTY CARE TO ENSURE GEOGRAPHICAL AVAILABILITY	**NET 1B-D**
EVALUATE & MEASURE PERFORMANCE AGAINST STANDARDS FOR ACCESS TO PPRIMARY CARE, BEHAVIORAL HEALTHCARE, & SPECIALITY CARE SERVICES	**NET 2A-C**
ANNUALLY COLLECT DATA AND PERFORM AN ANALYSIS FOR TIMELY PERFORMANCE OF CALL CENTERS ACCESSED BY CUSTOMERS FOR HEDIS MEAUSRES	

PLANNED ACTIVITY	RELATED STANDARDS
REDUCE THE OVER-PRESCRIBING OF HIGH DOSE OPIOIDS AMONG OUR CCO POPULATION.	42 CFR 438.240 OAR 410-140-0200
INCREASE THE PERCENTAGE OF ADOLESCENTS AGES 9 TO 14 WHO COMPLETE THE HPV VACCINATION SERIES.	42 CFR 438.240 OAR 410-140-0200
TO INCREASE THE PERCENTAGE OF PREGNANT WOMEN WHO ARE ENROLLED IN THE CCO THAT RECEIVE ORAL HEALTH SERVICES DURING THEIR PREGNANCY, FROM THEIR PRIMARY CARE DOCTOR AND/OR DENTAL PROVIDER	42 CFR 438.240 OAR 410-140-0200
SYSTEMATICALLY IDENTIFY THROUGH SCREENING, COLLECTION, AND ANALYSIS OF SOCIAL DETERMINANT DATA, MEDICIAD MEMBERS WHO HAVE SOCIAL NEEDS AND DEVELOP STRATEGIES TO PROVIDE WRAPAROUND CARE	42 CFR 438.240 OAR 410-140-0200

ANNUAL DELIVERABLE TO OHA ON TRANSFORMATION AND QUALITY STRATEGY FOR THE MEDICAID LOB. WORK WITH PROJECT LEADS TO DEVELOP, MONITOR, AND REPORT ON 14 CORE ELEMENTS REQUIRED OF THE TQS	**42 CFR 438.240** **OAR 410-140-0200**
PROMOTE EFFECTIVE MANAGEMENT OF CHRONIC DISEASE, IMPROVE CARE, AND HEALTH OUTCOMES FOR ENROLLEES WITH CHRONIC CONDITIONS	**42 CFR 422.152**
ANNUAL PROGRAM REVIEW PROCESS FOR FORMAL EVALUATION OF THE QI PROGRAM THAT, AT A MINIMUM, ADDRESSES THE QI PROGRAM'S IMPACT AND EFFECTIVENESS	**42 CFR 422.152**

ANNUAL PROGRAM REVIEW PROCESS FOR FORMAL EVALUATION OF THE QI PROGRAM THAT, AT A MINIMUM, ADDRESSES THE QI PROGRAM'S IMPACT AND EFFECTIVENESS	**42 CFR 422.152**
ANNUAL PROGRAM REVIEW PROCESS FOR FORMAL EVALUATION OF THE QI PROGRAM THAT, AT A MINIMUM, ADDRESSES THE QI PROGRAM'S IMPACT AND EFFECTIVENESS	**42 CFR 422.152**

Project/Reporting Complete and Finalized
Project is on schedule, milestones are being achieved, and business outc
Warning. Project is behind, and one or more milestones have been miss
Project is in serious trouble, little or no progress is being made toward tl the business outcome cannot be achieved by original planned end date.

2021 Annual QI Work Plan and Yearly Planned QI Activities - Co

REPORT NAME	COMMITTEE	REPORT APPROVAL DATE	NEW (N*) OR PREVIOUSLY IDENTIFIED (PI)
QI PROGRAM STRUCTURE/PROGRAM DESCRIPTION	QIC	Q3 2021	PI
QI WORK PLAN	QIC	Q3 2021	PI
QI PROGRAM EVALUATION	QIC	Q3 2021	PI
COMPLAINT & APPEALS ANALYSIS	QIC	Q3 2021	PI

PHM STRATEGY	QIC/CQUM	Q4 2021	PI
NEW MEMBER UNDERSTANDING SURVEY REPORT	QIC	Q4 2021	PI
HEDIS MEASURES & TARGET DEVELOPMENT	QIC	Q4 2021	PI
CS PROGRAM DESRIPTION	CQUM	Q4 2021	PI
CS PROGRAM EVALUATION	CQUM	Q4 2021	PI
CS SATISFACTION REPORT	CQUM	Q4 2021	PI
CCM EXPERIENCE REPORT	CQUM	Q4 2021	PI

ASSESSMENT OF THE CCM PROGRAM	CQUM	Q4 2021	PI
PHM STRATEGY	QIC/CQUM	Q4 2021	PI
PHM ASSESSMENT	QIC/CQUM	Q4 2021	PI
PHM IMPACT REPORT	QIC/CQUM	Q4 2021	PI
DELEGATE PERFORMANCE REPORT	CQUM	Q4 2021	PI
CONTINUITY & COORDINATION OF MEDICAL CARE REPORT	CQUM	Q4 2021	PI

CONTINUITY & COORDINATION OF BEHAVIROAL HEALTHCARE REPORT	**BHCQUM**	**Q4 2021**	**PI**
DELEGATE/VENDOR PERFORMANCE REPORT	**CQUM**	**Q4 2021**	**PI**
UM PROGRAM DESCRIPTION	**CQUM**	**Q1 2021**	**PI**
UM PROGRAM EVALUATION	**CQUM**	**Q1 2021**	**PI**
PROVIDER QUALITY EVENTS & DELEGATION REPORT	**CREDENTIALING QIC CQUM**	**Q4 2021**	**PI**
PROVIDER QUALITY EVENTS & DELEGATION REPORT	**CREDENTIALING QIC CQUM**	**Q4 2021**	**PI**
PROVIDER QUALITY EVENTS & DELEGATION REPORT	**CREDENTIALING QIC CQUM**	**Q4 2021**	**PI**

CLINICAL CRITERIA USED IN UM DECISIONS UPDATES/CHANGES	**QIC/CQUM**	**ANNUALLY**	**PI**
ASSESSMENT OF INTER-RATER RELIABILITY REPORT	**QIC/CQUM**	**ANNUALLY**	**PI**
DENIAL FILE AUDITS	**QIC**	**ANNUALLY**	**PI**
DENIAL FILE AUDITS	**BHCQUM**	**ANNUALLY**	**PI**
DENIAL FILE AUDITS	**P&T**	**ANNUALLY**	**PI**
DENIAL & APPEAL FILE AUDITS	**CQUM**	**ANNUALLY**	**PI**
PROVIDER & MEMBER EXPERIENCE WITH THE UM PROCESSES	**CQUM**	**Q1 2021**	**PI**
EVALUATION BASED ON LINGUISTIC NEED OF MEMBERS' FOR INTERPRETER SERVICES	**QIC**	**Q4 2021**	**PI**

QUALITY & ACCURACY OF INFORMATION	QIC	Q3 2021	PI
COMPLAINT & APPEALS ANALYSIS REPORT	QIC	Q3 2021	PI
QUALITY & ACCURACY OF PHARMACY BENEFIT INFORMATION	QIC	Q4 2021	PI
QUALITY & ACCURACY OF COMMUNICATED BENEFIT INFORMATION TO MEMBERS	QIC	Q3 2021	PI
PROVIDER AVAILABILITY REPORT	QIC	Q4 2020	PI
PROVIDER ACCESS REPORT	QIC	Q3 2021	PI
QUALITY & ACCURACY OF CALL CENTER PERFORMANCE	QIC	Q3 2021	PI

REPORT NAME	COMMITTEE	REPORT APPROVAL DATE	NEW (N*) OR PREVIOUSLY IDENTIFIED
PERFORMANCE IMPROVEMENT PROJECT (PIP)	QIC	Q2 2021	PI
PERFORMANCE IMPROVEMENT PROJECT (PIP)	QIC	Q2 2021	PI
PERFORMANCE IMPROVEMENT PROJECT (PIP)	QIC	Q2 2021	PI
PERFORMANCE IMPROVEMENT PROJECT (PIP)	QIC	Q2 2021	PI

TRANSFORMATION AND QUALITY STRATEGY	**QIC/CQUM**	**Q1 2021**	**PI**
MA QUALITY IMPROVEMENT PLAN	**QIC**	**Q3 2021**	**PI**
MA QUALITY IMPROVEMENT PLAN	**QIC**	**Q3 2021**	**PI**

MA QUALITY IMPROVEMENT REVIEW	**QIC**	**Q3 2021**	**PI**
MA QUALITY IMPROVEMENT WORK PLAN	**QIC**	**Q3 2021**	**PI**

come will be realized on time.
ed, or project is incomplete.
he stated objective. One or more milestones have been missed and

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YEARLY OBJECTIVE
Annually update the QI Program Structure and processes necessary to improve the quality and safety of clinical care and services to members. Oversee the QI program, and make recommendations for improvement activities to EMG for approval
Maintain, document, and execute the annual QI work plan to reflect ongoing activities throughout the year
Annually conduct a written evaluation of the QI program that includes a description of completed and ongoing QI activities that address quality, and safety of clinical care, and quality of service
Oversee CAHPS survey administration and work with subject matter experts to identify improvement opportunities, reduce abrasion and execute interventions across the continuum of care.

Annual description of how the organization supports the delivery system, patient-centered medical homes, and the use of value-based payment arrangements through working with practitioners and providers to achieve population health management goals through the sharing of data, offering certified decision-making aids, providing practice transformation support to PCPs, providing comparative quality information, and pricing on selected specialties, and one additional activity to support practitioners or providers in achieving PHM goals.
Monitor trends in new member understanding surveys and implement an action plan for improvement in key areas.
Exceed a 4-Star Benchmark for each HEDIS measure targeted for improvement
Annually update the CS program description as necessary. The CS program actively works to improve, and intervenes to help members and practitioners manage chronic conditions.
Annually evaluate the CS program outcome measures and assess the effectiveness of the cs program. Monitor the program for identifcation and intervention based on the assemsnet and participation rates.
Annually member satisfaction with services through member feedback, and analysis of member complaints and inquiries.
Annually member satisfaction with services through member feedback, and analysis of member complaints and inquiries.

Annually collect and analyze data using established methodology and reporting parameters for measurement of satisfaction and improvement of health status.

Annually outline the population health management strategy plan of action and populations targeted for the 4 targeted focus areas (keeping members healthy, managing members with emerging risk, patient safety or outcomes across settings, managing multiple chronic illnesses) include goals, programs offered to members, activities that are not direct member interventions, program coordination, and how members are informed about the available PHM programs.

Annually assess the needs of the population and determine actionable categories for appropriate intervention by integrating the data for medical and behavioral health claims or encounters, pharmacy claims, laboratory results, health appraisals, electronic health records, health services programs, and advanced data sources.
At least annually, conduct a comprehensive analysis of the impact of the PHM Strategy using a comparison of results that include a benchmark or goal for relevant clinical, cost/utilization, and experience measures, using the results to identify and act on opportunities for improvement.
Annually conduct a review of all delegated entities/vendor performance for all PHM delegated functions.
Annually identify opportunities to improve the coordination of medical care by collecting data on member movement between practitioners, and across settings. Conduct a quantitative & qualitative analysis of data to identify & select four opportunities for improvement, taking actions for improvement on three of the four opportunities, and re-measurement of the three chosen opportunities.

Annually collect data about opportunities for collaboration between medical care & behavioral health care for the exchange of information, appropriate diagnosis, treatment, and referral of behavioral disorders commonly seen in primary care, appropriate use of psychotropic medications, management of treatment access and follow-up for members with coexisting medical and behavioral disorders, primary or secondary preventative behavioral healthcare program implementation, and special needs of members with SPMI.
Annually conduct a review of all delegated entities/vendor performance for all UM delegated functions.
Annually update and approve the UM Program Description. The UM program is a well structured program and makes utilization decisions affecting the health care of members in a fair, impartial, and consistent manner.
Annually evaluate the UM Program, to ensure the program remains current, and appropriate. Update the program as needed, including recommendations for improvement
On a monthly basis, collect and review Medicare and Medicaid sanctions, or limitations on practitioners' licensure, complaints, and serious adverse events. Implement appropriate interventions when poor quality of care is identified.
On a monthly basis, report issues with contracted facilities to the Credentialing Committee as appropriate.
Annually monitor & conduct oversight audits of all delegated credentialing entities

Review and revise medical policies and develop new medical policies as needed. Evaluate new technology related to medical procedures, behavioral health procedures, pharmaceuticals and devices, and develop or revise any medical policies as appropriate.
Evaluate the consistency with which health care professionals invovled in UM apply criteria in decision making, and act on opportunities to improve consistency, if applicable
Annually complete an audit of non-BH denial files.
Annually complete an audit of BH denial files.
Annually complete an audit of pharmacy denial files.
Annually complete an audit of appeal files.
Annually assess member and provider satisfaction with the UM processes and implement actions to improve the member and provider satisfaction.
Annually assess the cultural , ethnic, racial, and linguistic needs of members and the effectiveness of interpreter services in meeting the needs of members'.

Annually assess the quality and accuracy of benefit information communicated to members through the website and telephone functionality.
On a quarterly basis, report complaints and appeals by month related to quality of care, attitude and service, billing and financial issues, and quality of practitioner office site. Identify opportunities to improve the data for analysis. Applies to Commerical & Marketplace for behavioral & non-behavioral complaints & appeals.
Annually evaluate the quality and accuracy of pharmacy benefit information. Analyze results, and act to improve on any identified deficiencies.
Annually assess the quality and accuracy of benefit information communicated to members through the website and telephone functionality.
Annual and continuous monitoring of practitioner availability and pursue contracting relationships with licensed practitioners to fill gaps in availability. Re-assess geographic and ratio improvements annually.
Annually collect data regarding timely access as outlined in the policies and analyze so interventions are imposed as necessary.
Answer 80% of calls in 30 seconds or less in Customer Service.

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YEARLY OBJECTIVE
Decrease the number of members with at least one opioid prescription in one year, who have no opioids prescribed in the prior 6 months, among members in the population by days' supply (i.e., ≤ 3, 4-7, 8-13, and ≥ 14).
Improve adolescent HPV immunization rates in youth ages nine to fourteen through targeted interventions focused on increasing compliance between doses.
Pregnant women who are assigned to the CCO who delivered a baby and were assigned to a DCO, who had a dental visit (based on global claims data).
Increase the number of CCO members who are screened for SDoH either through the AHC grant or internally by PacificSource Case Management Support Specialists and develop a closed loop referral system to track member's screened and provided navigation services.

PS will continue to move health transformation forward to meet the triple aim of better health, better outcomes, and lower costs. The TQS will support the sharing of CCO's best practices, health transformation through innovation and quality methods, and state monitoring of CCO's progress.
Chronic Care Improvement Project topic: Type 2 Diabetes: Develop a Diabetes Care Management Program to provide members with accurate information and the support needed to make positive lifestyle changes to achieve full body health.
Medicare Advantage Quality Improvement Plan created and maintained yearly to explain the goals, strategies, structure, and evaluation processes identified to promote quality heatlh care. The document outlines how compliance elements related to quality care met with relation to the seven required components of a quality program.

The Medicare Advantage Quality Review is in conjunction with the Program Plan, and is used to evaluate work that occurred in the year prior for all departments within the health plan that directly impact the Medicare Advantage members and provders. This tool is utilized to address current functionality and any current or future needs for the program that may need to be adjusted throughout the next plan year for quality improvement and the improvement of CAHPS/HOS/STARs ratings. Reveiw of document once per yer by the QI committee.
Alongside the Medicare Quality Improvement Review is the Work Plan that addresses all departments and functionalities that directly impact the MA review within a high level/quick glance document.

UPDATES/TIMEFRAME FOR COMPLETION	WORK PLAN COMMITTEE REVIEW/APPROVAL & PROGRESS COMPLETION (MM/DD/YYYY)	STATUS
Q3 2021 in progress for review & approval by Committee	**Reviewed & Approved 7/27/2021 QI Committee**	●
Q3 2021 ongoing review & approval by Committee	**Reviewed & Approved 7/27/2021 QI Committee**	●
Q3 2021 in progress for review & approval by Committee	**Reviewed & Approved 7/27/2021 QI Committee**	●
Q3 2021 ongoing review & approval by Committee	**Reviewed & Approved at 9/24/201 CQUM Committee**	●

Q4 2021 in progress for review & approval by Committee	**Reviewed & Approved at 12/1/2021 CQUM Committee**	
Q4 2021 in progress for review & approval by Committee	**Approved at 11/23/21 QI Committtee**	
Q4 2021 in progress for review & approval by Committee	**Project is on schedule**	
Q4 2021 in progress for review & approval by Committee	**Reviewed & Approved at 12/1/2021 CQUM Committee**	
Q4 2021 in progress for review & approval by Committee	**Reviewed & Approved at 12/1/2021 CQUM Committee**	
Q4 2021 in progress for review & approval by Committee	**Reviewed & Approved at 12/1/2021 CQUM Committee**	
Q4 2021 in progress for review & approval by Committee	**Reviewed & Approved at 12/1/2021 CQUM Committee**	

Q4 2021 in progress for review & approval by Committee	**Reviewed & Approved at 12/1/2021 CQUM Committee**	●
Q4 2021 in progress for review & approval by Committee	**Reviewed & Approved at 12/1/2021 CQUM Committee**	●
Q4 2021 in progress for review & approval by Committee	**Reviewed & Approved at 12/1/2021 CQUM Committee**	●
Q4 2021 in progress for review & approval by Committee	**Reviewed & Approved at 12/1/2021 CQUM Committee**	●
Q4 2021 in progress for review & approval by Committee	**Reviewed & Approved at 12/1/2021 CQUM Committee**	●
Q4 2021 in progress for review & approval by Committee	**Reviewed & Approved at 12/1/2021 CQUM Committee**	●

Q4 2021 in progress for review & approval by Committee	**Reviewed & Approved at 12/21/2021 BHCQUM Committee**	
Q4 2021 in progress for review & approval by Committee	**Reviewed & Approved at 12/1/2021 CQUM Committee**	
Q3 2021 in progress for review & approval by Committee	**Reviewed & Approved at 3/2021 CQUM Committee.**	
Q3 2021 in progress for review & approval by Committee	**Reviewed & Approved at 3/2021 CQUM Committee.**	
Q4 2021 in progress for review & approval by Committee	**Reviewed & Approved at 11/23/2021 QI Committee**	
Q4 2021 in progress for review & approval by Committee	**Reviewed & Approved at 11/23/2021 QI Committee**	
Q4 2021 in progress for review & approval by Committee	**Reviewed & Approved at 11/23/2021 QI Committee**	

Q1 2021 in progress for review & approval by Committee. Reviewed & Approved at 3/2021 CQUM. Reviewed & Approved 7/2021 CQUM Committee.	**Reviewed & Approved at 3/2021 and 7/2021 CQUM Committee.**	
Q4 2021 in progress for review & approval by Committee	**Reviewed & Approved at 12/1/2021 CQUM Committee**	
Q4 2021 in progress for review & approval by Committee	**Reviewed & Approved at 12/1/2021 CQUM Committee**	
Q4 2021 in progress for review & approval by Committee	**Reviewed & Approved at 12/21/2021 CQUM Committee**	
Q1 2021 in progress for review & approval by Committee	**Reviewed & Approved at 11/23/2021 QI Committee**	
Q4 2021 in progress for review & approval by Committee	**Reviewed & Approved at 12/1/2021 CQUM Committee**	
Q1 2021 in progress for review & approval by Committee	**Reviewed & Approved at 3/2021 CQUM Committee.**	
Q4 2021 in progress for review & approval by Committee	**Reviewed & Approved at 12/1/2021 QI Committee**	

Q3 2021 in progress for review & approval by Committee	**Reviewed & Approved at the 7/2021 QI Committee**	
Q3 2021 in progress for review & approval by Committee	**Reviewed & Approved at the 12/1/2021 CQUM Committee**	
Q4 2021 in progress for review & approval by Committee	**Reviewed & Approved at the 11/23/2021 QI Committee**	
Q3 2021 in progress for review & approval by Committee	**Reviewed & Approved at the 7/2021 QI Committee**	
Q4 2021 in progress for review & approval by Committee	**Reviewed & Approved at 9/24/201 QIC Committee**	
Q3 2021 in progress for review & approval by Committee	**Reviewed & Approved at 9/24/201 QIC Committee**	
Q3 2021 in progress for review & approval by QI Committee	**Reviewed & Approved at the 7/2021 QI Committee**	

UPDATES/TIMEFRAME FOR COMPLETION	WORK PLAN COMMITTEE REVIEW/APPROVAL & COMPLETION (MM/DD/YYYY)	STATUS
Reviwed & Approved at the 3/2021 QI Committee	**Complete**	
Reviwed & Approved at the 3/2021 QI Committee	**Complete**	
Reviwed & Approved at the 3/2021 QI Committee	**Complete**	
Reviwed & Approved at the 3/2021 QI Committee	**Complete**	

Reviewed & Approved at the 3/2021 CQUM Committee	**Complete**	
Reviewed & Approved at the 7/2021 QI Committee	**Complete**	
Reviewed & Approved at the 7/2021 QI Committee	**Complete**	

Reviewed & Approved at the 7/2021 QI Committee	**Complete**	
Reviewed & Approved at the 7/2021 QI Committee	**Complete**	

DEPT	ANNUAL QI WORK PLAN ACTIVITIES & OBJECTIVES	BUSINESS OWNERS
BH-HEALTH SERVICES	**TARGET I: OVERSIGHT AND QUALITY ASSURANCE**	***CMHPs*** ***Panel Providers*** ***PacificSource***

BH-HEALTH SERVICES	**TARGET II: PERFORMANCE MEASURES**	***CMHPs*** ***Panel Providers*** ***PacificSource***
BH-HEALTH SERVICES	**TARGET III: INTEGRATION/BI-DIRECTIONAL CARE**	***PacificSource***

Project Legend

Black: 0
Green: 3
Yellow: 2
Red: 1

2020 Medicaid B
PLANNED ACTIVITY/GOAL
TARGET I: ***I.*** *Measure, analyze, and report performance of the CMHP's and panel providers. Reporting is based on the required and contractual standardized measures.* ***CMHP REPORTING:*** • *Critical incidents* • *Crisis Report* • *Financial Performance Report* • *Exclusion Database* •*New Hire and Provider Roster Credentialing Report* ***PANEL PROVIDER REPORTING:*** • *Critical Incidents* ***WRAPAROUND PROGRAM REPORTING:*** *Wraparound* *Utilization - *CMHP's include:* • *DESCHUTES COUNTY HEALTH SERVICES* • *LUTHERAN COMMUNITY SERVICES NORTHWEST* *MID-COLUMBIA CENTER FOR LIVING* *LANE COUNTY BEHAVIORAL HEALTH* *MARION COUNTY HEALTH AND HUMAN SERVICES* • *POLK COUNTY BEHAVIORAL HEALTH*

TARGET II:

II. *Meet OHA Performance Measure: Access to emergent/urgent, routine, and specialty behavioral health care.*

III. Meet or exceed the OHA targets for behavioral health Quality Incentive Measures (QIM's).

These include:

- *Assessments for children in DHS custody*
- *Disparity measure: emergency department utilization among members with mental illness.*
- *Screening, brief intervention and referral to treatment (SBIRT) for drugs and alcohol use (no target; reporting only for 2020).*
- *Initiation and engagement of alcohol and other drug abuse or dependence treatment.*

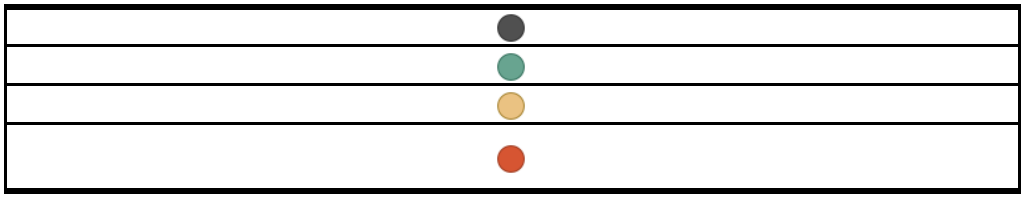
IV. *Follow-up after hospitalization for mental illness: Improve transition planning and access to care for members who have experienced an acute psychiatric hospitalization.* ***V.*** *Decrease psychiatric hospital readmissions for members who have had a recent psychiatric hospitalization.*

VI. *Reduce ED utilization by focusing on specific visit types.*

TARGET III:

VII. *Measure/improve bi-directional integrated health care by increasing the availability of behavioral health services offered in primary care homes.*

- *Additionally, measure the availability of integrated medical primary care services provided on behavioral health homes.*



ehavioral Health Annual QI Work Plan		
YEARLY OBJECTIVE	**ACTION**	**COMMITTEE**
TARGET I: ***I.*** *100% of reports received on or before the deliverable date.* • *Improve system of care to members based on data.*	***TARGET I:*** ***I.*** *Track compliance with deliverable submissions per organization/per report.* *.* • *Perform analysis on deliverables; report back to BH-CQUM .* • *Provide technical assistance and follow-up with CMHPs and panel providers based on data. .*	**BH-CQUM**

TARGET II: ***II.*** *100% of Oregon Health Plan (OHP) members will be seen within:* *• Immediate for emergent/urgent care.* *• One week from date of request for routine care.* • *Immediate access for defined specialty populations.* ***III.*** *Meet or exceed the improvement target for each measure as determined by the OHA.* ***IV.*** *Increase percentage of members who have a follow-up appointment within 7 days of discharge from acute psychiatric hospitalization.* ***V.*** *Reduce readmission rates, focusing on readmissions that occur within 30 and 50 days of discharge.* ***VI.*** *Decrease ED utilization for BH reasons.*	***TARGET II:*** ***II.*** *Compile/review data.* *• Provide technical assistance and follow-up with CMHP's and panel providers based on data.* ***III.*** *Compile/review data.* *• Provide technical assistance and follow-up with CMHP's and panel providers based on data.* ***IV.*** *Compile/review data.* *• Develop performance targets for CMHP's that include this as a performance measure in contract.* ***V.*** *Develop data collection methodology.* *• Develop strategies to reduce readmissions.* ***VI.*** *Develop data collection methodology.* *• Develop performance targets for CMHP's that include this as a performance measure in contract.*	**BH-CQUM**
TARGET III: ***VII.*** *Identify the percentage of CCO members that are assigned to a primary care home that meet's PacificSource's BHI Fidelity Requirements.* *• Additionally, identify the percentage of CCO members with behavioral health diagnoses that have a behavioral health home with integrated physical health services.*	***TARGET III:*** ***VII.*** *Develop data collection methodology, specifically for identifying primary care services provided at behavioral health homes.* *•Interpret/report results; implement system changes based on data.*	**BH-CQUM**

Project/Reporting Complete and Finalized
Project is on schedule, milestones are being achieved, and business outcome will be realized on time.
Warning. Project is behind, and one or more milestones have been missed, or project is incomplete.
Project is in serious trouble, little or no progress is being made toward the stated objective. One or more milestones outcome cannot be achieved by original planned end date.

UPDATES/TIMEFRAME FOR COMPLETION	STATUS	UPDATES
QUARTERLY AND MONTHLY DEPENDING ON REPORT		

QUARTERLY		
QUARTERLY		

have been missed and the business

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Committee Members/Internal Staff

Edward McEachern MD, Executive VP and CMO-Senior Medical Director; **Justin Montoya MD,** Medical Director-Commercial**; Mike Franz MD**, Medical Director-Behavioral Health**; Alison Little MD,** Medical Director-Medicaid; **David Stenstrom MD** Medical Director-Medicare MD; **Liz Bainter**, VP, Quality & Population Health-EMG; **Lizzy Randleman,** Director of Clinical Quality Improvement; **Mihir Patel,** VP of Pharmacy Services-EMG; **Susan Alger,** Director of Care Management; **Jeanette Simms,** IT, Director of Analytics Manager; **Sheila Albeke,** Director of Pharmacy Services-Commercial; **Tim Hughes,** Director of Risk Assessment; **Lisa Kaiser,** Director, Utilization Management-Medicare; **Carmel Miller,** NCQA Program Manager**; Jessica Waltman,** Manager of Grievance and Appeals; **Charis Allenbaugh,** Health Promotion and Wellness Manager; **Aimee Wise**, Customer Service and PSA Operations Manager; **Connie Riffle**, Manager of Pharmacy Administration-Medicare;**, Chelsea Hammers,** Population Health Manager; **Jana Halligan**, Manager, Case Management-Medicaid; **Lara Kuny,** Manager of Pharmacy Administration-Commercial; **Andrea Ketelhut,** QIM Program Manager; **Shonda Dahl,** Quality Performance Manager; **Heather Simmons,** Dental Services Program Manager; **Shana Hodgson,** Manager of Case Management-Medicaid; **Martin Stukel,** Manager-Case Management; **Corey Coffin,** Credentialing Team Lead; **Jeremy Fleming**, Behavioral Health Clinical Quality Improvement-Team Lead; **Stevi Bratschie,** Clinical Quality Improvement Team Lead-Medicaid; **Angela Torrence,** Quality Program Coordinator; **Lauren Orwick**, Delegation Oversight Coordinator; **Avery Stewart,** Quality Performance Strategist; **Katie Jaye Shelby,** Customer Experience Strategist, Community Strategy; **Lindzee Prasch**, Customer Service Business Analyst; **Charity Kennedy,** Clinical Quality Improvement Strategist; **Lucia LaFerriere,** Nurse Case Manager-Commercial Grievance & Appeals; **Kevin McLean,** Senior Nurse Case Manager-Commercial; **Kayla Kauffman**, Pharmacy Compliance Specialist-Medicare; **Sheri Sturko**, Quality Improvement Coordinator-Govt.; **Lindsay Atagi**, Senior Quality Improvement Coordinator-Medicaid; **Cynthia Seger,** Nurse Case Manager- Medicaid; **Shannon McCormick,** Associate Population Health Strategist; **Kelsey Bandelow**, Provider Network Audit & Reporting Analyst; **Amanda Williams,** Provider Network Access to Care Analyst; **Iris Bicksler**, Traditional Health Worker Liaison; **Tanya Nason,** Traditional Health Worker Liaison; **Kate Karlson,** Traditional Health Worker Liaison; **Savannah Davis,** Behavioral Health Clinical Quality Improvement Coordinator; **Hannah Tacke,** Behavioral Health Quality Improvement Specialist; **Sara Dooley,** Behavioral Health Quality Improvement Specialist**; Fawn Sybrant,** Behavioral Health Clinical Quality Improvement Coordinator; **Cassandra Vigil,** Quality Improvement Coordinator; **Michelle Zuiderweg**, Quality Improvement Coordinator; **Alma McAlpine,** Executive Assistant to EVP & CMO- Commercial; **Melissa Eld,** STARs Program Manager

Committee Members not in Attendance

Jeanette Simms, Sheila Albeke, Connie Riffle, Chelsea Hammers, Lara Kuny, Andrea Ketelhut, Shana Hodgson, Martin Stukel, Lauren Orwick, Charity Kennedy, Lucia LaFerriere, Kayla Kauffman, Cynthia Seger, Shannon McCormick, Savannah Davis, Hannah Tacke, Sara Dooley, Fawn Sybrant, Alma McAlpine, Melissa Eld

Agenda Item	Discussion Leader	Discussion	Follow-Up Action Items	Person/Dept. Responsible
Call to Order:	Dr. Montoya	• Dr. Montoya called the meeting to order at 10:00 am. • Next QIC Meeting 10/1/2021	None	
Review of Previous Meeting Minutes	Dr. Montoya	Upon review of the minutes from 5/25/2021 QI Committee, a motion was made, seconded, and passed to approve the minutes as transcribed.	Approved	Dr. Montoya
CQUM last met July 28, 2021	Dr. Montoya	**The next CQUM meeting is scheduled for Wednesday September 29, 2021** Topics reviewed and approved at the last committee: • 2 Enterprise Policies • 1 Medicaid Policy • TQS Update	None	Dr. Montoya
BH-CQUM last met June 15, 2021	Dr. Franz	**The next BH-CQUM meeting is scheduled for Tuesday October 19, 2021** Topics reviewed and approved at the last committee: • Q4 2020 BH-Work Plan • Q4 2020, and Q1 2021 A&G Update • Recruiting for a new practitioner for BH-CQUM	None	Dr. Franz

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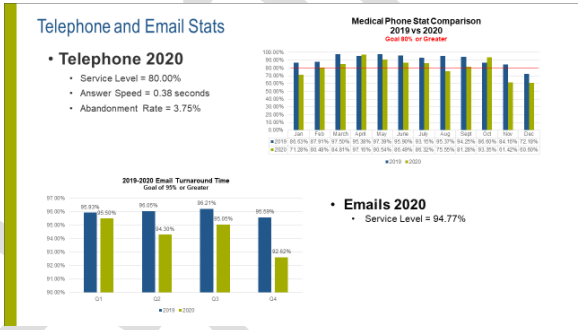
Agenda Item	Discussion Leader	Commercial Reports	Follow-Up Action Items	Person/Dept. Responsible
2021 Annual Telephone & Email Functionality Report	Lindzee Prasch	***Lindzee Prasch*** presented the 2021 Telephone Access for Member Services and Email Turn Around Time Report to the committee stating that this 2021 report reflects our 2020 data. The Customer Service call center serves all Commercial and Exchange plans in in Oregon, Idaho and Montana. The department maintains high standards for accessing services by telephone and email. SSRS and Outlook reports are run daily, weekly, and monthly to gather statistical information. Results are analyzed and reported to the Customer Service Leadership Team, on a weekly and monthly basis. The leadership team reviews the data to ensure goals are being met, and to address any deficiencies, if applicable. The analyzed results and any identified actions are then shared with our Executive Leadership Team on a monthly basis and reviewed annually as a whole. The overall goals are as follows: **Telephone Service:** ➢ 80% or more of calls answered within 30 seconds or less ➢ 5% or less abandonment rate **Email Turnaround Time:** ➢ 95% or more of emails answered within 1 business day **Telephone and Email Stats:** The stats below reflect our 2019 and 2020 service levels for telephone and emails. The average number of calls per month for 2020 was 30,840. This resulted in a slight decrease from 2019 which averaged 32,770 per month. January and December have had the highest call volume per month for the last several years. There was an 18% increase in call volume from December 2019 to January 2020, which is the highest increase in call volume when comparing month to month. In 2020, our annual average service level was 80.00%, answer speed was 0.38 seconds, and our abandonment rate was 3.75%. Overall average stats decreased in 2020 from the previous year in 2019.  We fell short of meeting our service level for several months, both at the beginning of the year and at the end of the year, call volume and increased talk time directly affected our stats. January and December typically always prove to be challenging months or us, however, we are now also starting	Approved	Lindzee Prasch

		to see an increase in call volume early in the month of November, as we head into our open enrollment season. The call volume tends to increase due to a large number of groups that renew during that time frame. Providers call to get updated benefits and members call to inquire about their new plans. In addition, due to COVID mandates, and our work ultimately being completely virtual work from home, our overall average stats decreased, due to technical and connectivity issues. We also replaced our phone system during the month of October, which contributed to some lower stats for both November and December. Due to the challenges this transfer brought, we developed more specific stat tracking, and individual production tracking for each of our representatives. This has helped us zone in on any and all technical issues, productivity, connectivity, etc., as well as using this reporting to help us make changes around staffing, hiring, and training. ***Dr. Montoya*** asked what percentage of the overall volume is telephone, versus emails. ***Lindzee Prasch*** stated that the majority falls under telephone. While we had an increase of approximately 3% in membership from January 2019 to January of 2020, our call level in January increased by about 7.5%. This increase could be attributed to expanding our business into Washington, with a new population of members. While there was an increase in call volume in 2020, it was not as much as we have seen in previous years. This may be due to a process improvement that was put into place in t 2019 that increased the number of auto renewals. We continued to utilize this process in 2020 for both our small groups, and a handful of larger groups. This process allowed the team to focus more on new groups and groups with benefit changes which in turn enabled benefits to appear in the system sooner, new members were enrolled quicker, and ID cards were sent out faster, therefore reducing the number of calls, and return calls for members trying to obtain information. **Opportunities and Action Plans:** • Continue to implement more specific tracking/reporting • Continue to evaluate staffing needs • Continue to help identify cross departmental process improvements to assist with improving our ***service levels*** ***Dr. Montoya*** asked if we had any updates regarding the ability to offer "live chat" to our members. ***Lindzee Prasch*** stated that this is still on the horizon, and being looked into further for when this may be able to be deployed. There were no additional questions raised by the committee. A motion was made, seconded, and passed to approve the 2021 Annual Telephone & Email Functionality Report.		
2021 Annual Evaluation of Accuracy of Benefit Information Report	Lindzee Prasch	***Lindzee Prasch*** presented the **2021 Annual Customer Service Quality and Assurance Report** to the committee stating that the purpose of this report is to maintain standards for accuracy and timeliness for all of the service routes (telephone, email, and our self-service website) and take action to monitor the quality and accuracy of information provided to our members via all of the above mentioned service methods. **The following audits are performed to ensure accuracy and quality:** • Telephone and Emails: 2 random calls and/or emails audited per week • Self-service website (InTouch): 5 random audits per month • Audits are performed by specially trained mentor/auditors using standardized audit tools focusing on accuracy, quality of service, and functionality • Calls/emails consist of specific questions within specific categories that are either scored, or provides written feedback	Approved	Lindzee Prasch

- Greeting
- Quoted Information
- Closing
- Subjective Overview
- Additional Opportunities

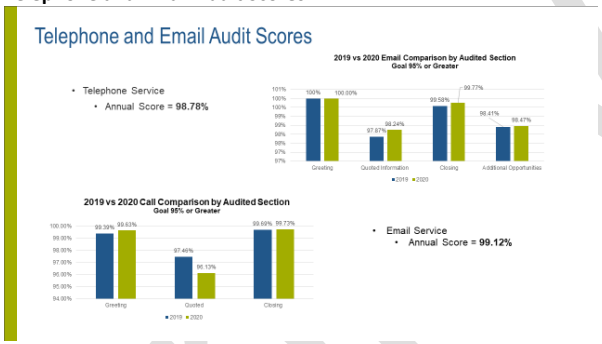
Website is audited against 5 standards:

- Ability to order ID cards
- Update or select a primary care provider
- Referral requirements are shown; ***and,***
- Authorization requirements are shown
- Accurate member financial responsibility for specific services with a specific provider

Goals:

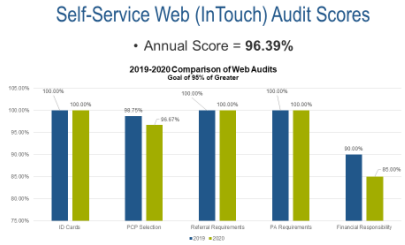
- 95% or greater in all areas, for the department as a whole and on an individual basis
- Continuously seek out and identify opportunities to maintain or improve our service to our clients

Telephone and Email Audit Scores:



Overall we had strong scores in both the Greeting and Closing sections. These scores continue to support that our representatives are providing a high quality level of service by listening and answering all the member questions and maintaining a friendly tone throughout the call. We also exceeded our goal of 95% or more in the quoted section. We held strong scores regarding quoting benefits accurately, network status, and provider status, which is very important, as it is directly related to member financial responsibility. Our lower scores again were related to the exclusion section when quoting benefits. During the second and third quarter of the year is where we saw lower scores in this area. We have continued our specific tracking in this area, which is discussed with the Leadership and Training team to discuss methods for improvement. Based on these findings we continue to include this information in weekly huddle topics, mentor lessons, and monthly department meetings. We implemented more specific tracking to help determine what is lacking, this data showed us that overall in regards to exclusions, we have a few very specific areas that we need to focus on. We also implemented additional resources for our department to assist with quoting this particular exclusions. This is the third year that we have continued to work and improve this area, and all though we fell short of this goals around exclusions, we have continued to

gain more clarity and what exactly needs to improve, and how we can really work towards meeting this goal in the future.



We held strong scores of 100% in all elements, but two, ending the year with a 96.39% annual average score. Treatment Cost Navigator (TCN) which shows member patient financial responsibility fell below goal during the third quarter, this was due to a system update that was made during September, that was not allowing our members to compare providers vs service cost. However once this was corrected, our scores continued to hold strong throughout the rest of the year. During the third quarter it was also reported that that PCP function was not working properly, however this was an incorrect markdown, and gave us some opportunities for more training, and updated resources. All other search options functioned as expected.

Barriers:

- Telephone and Email Service
  - Exclusions
  - Virtual Environment
  - Large amount of staffing hired at once
- Self-Service Web (InTouch)
  - Audits not being performed appropriately

Opportunities for Improvement:

- **Telephone and Email Service**
  - Continue to discuss audit scores in team meetings
  - Continue to expand and streamline our Audit/Mentor Program
  - Create better and more specific tracking for areas that need improvement
  - Continue to track common trends and meet regularity with Training and Leadership Teams.
  - Continue to evaluate staffing needs vs volume of emails being received
- **Self- Service Web (InTouch)**
  - Work to provide both additional training, and resources to help streamline the process in regards to a system limitation vs true errors or set up barriers
  - Work to have the same person perform these monthly, to create better consistency

Dr. Montoya inquired about the types of exclusions we are referring to in these stats. Lindzee Prasch stated that these are typically related to a handful of benefits that while there is coverage for specific services, there are certain services that fall under these benefits that are not covered (i.e., physical therapy – take home supplies or educational benefits). ***Dr. Montoya*** asked where the CS rep's go to find this information to see what is covered or excluded. ***Lindzee Prasch*** said, they use

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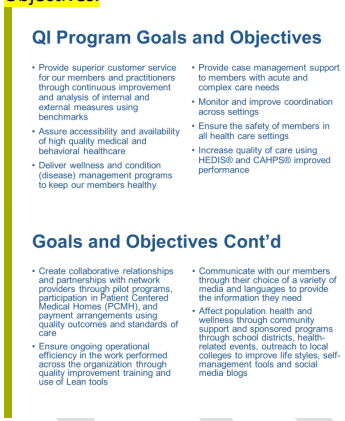
		our online authorization grid. There were no additional questions raised by the committee. A motion was made, seconded, and passed to approve the 2021 Annual Evaluation of Accuracy of Benefit Information Report.		
2021 Annual QI Program Presentation: • **2021 QI Program Description** • **2021 Annual QI Work Plan** • **2021 Annual QI Evaluation**	Carmel Miller	***Carmel Miller*** presented the 2021 QI Program Presentation to the committee stating that this presentation will highlight the QI Program highlights, and provide an overview of the QI Program to include review of : • 2021 QI Program Description • 2021 QI Work Plan • 2021 QI Program Evaluation PacificSource is operationally guided by the principle of continuous improvement, and in that spirit engages in an annual evaluation of the effectiveness of the QI program to ensure our members have access to high-quality health care that is effective, safe, and results in positive outcomes. The QI Program Description and Annual Work Plan are used together as the basis for the 2020 QI Program Evaluation. All quality improvement activities found in the QI Program Description and QI Work Plan are addressed within the QI Evaluation, however, the sequence and organization of the activities is not the same among the three documents. The slide below reflects the QI Program Goals and Objectives.  QI Program Goals and Objectives • Provide superior customer service for our members and practitioners through continuous improvement and analysis of internal and external measures using benchmarks • Assure accessibility and availability of high quality medical and behavioral healthcare • Deliver wellness and condition (disease) management programs to keep our members healthy • Provide case management support to members with acute and complex care needs • Monitor and improve coordination across settings • Ensure the safety of members in all health care settings • Increase quality of care using HEDIS® and CAHPS® improved performance Goals and Objectives Cont'd • Create collaborative relationships and partnerships with network providers through pilot programs, participation in Patient Centered Medical Homes (PCMH), and payment arrangements using quality outcomes and standards of care • Ensure ongoing operational efficiency in the work performed across the organization through quality improvement training and use of Lean tools • Communicate with our members through their choice of a variety of media and languages to provide the information they need • Affect population health and wellness through community support and sponsored programs through school districts, health-related events, outreach to local colleges to improve life styles, self-management tools and social media blogs **2021 Quality Improvement Program Description** The PacificSource QI Program extends to all departments within the organization, and all levels in the recognition that teamwork and collaboration are essential for quality improvement. Department directors, and managers are responsible to develop and oversee quality improvement activities aimed at optimal clinical care, service, and organizational efficiency within their own departments as well as coordinate interdepartmental quality improvement activities as applicable. The organization clearly defines its quality improvement (QI) program structure and processes, assigns responsibility to appropriate individuals and operationalizes its QI program. The organization has the infrastructure necessary to improve the quality and safety of clinical care and services it provides to its members and to oversee the QI program. The QI Program Description specifies:	Approved	Carmel Miller

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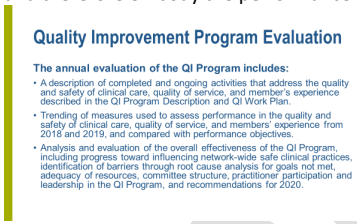
- The QI program structure
- The behavioral healthcare aspects of the program
- Involvement of a designated physician in the QI program
- Involvement of a behavioral healthcare practitioner in the behavioral aspects of the QI program
- Oversight of QI functions of the organization by the QI Committee
- Objectives for serving a culturally and linguistically diverse membership

2021 Quality Improvement Evaluation

To assess the effectiveness of the QI program PacificSource produces and Annual QI Program Evaluation which depicts the plan's measurable performance achievements over the course of the year, with trended data when available, and includes:

- Identification of the barriers which make quality improvement difficult to achieve
- The interventions recommended to overcome these barriers
- A summary of the overall effectiveness of the program with consideration given to the adequacy of resources
- Committee structure and leadership involvement

The organization uses its QI Program Description and Annual QI Work Plan as the basis for the evaluation. These documents provide the program's framework and guides its quality initiatives, and therefore embody the performance expectations used in the evaluation.



Quality Improvement Program Evaluation

The annual evaluation of the QI Program includes:

- A description of completed and ongoing activities that address the quality and safety of clinical care, quality of service, and member's experience described in the QI Program Description and QI Work Plan.
- Trending of measures used to assess performance in the quality and safety of clinical care, quality of service, and members' experience from 2018 and 2019, and compared with performance objectives.
- Analysis and evaluation of the overall effectiveness of the QI Program, including progress toward influencing network-wide safe clinical practices, identification of barriers through root cause analysis for goals not met, adequacy of resources, committee structure, practitioner participation and leadership in the QI Program, and recommendations for 2020.

2021 Quality Improvement Program Work Plan

The organization documents and executes an Annual QI Work Plan that reflects the ongoing activities throughout the year. The work plan is a dynamic document that encompasses all planned activities and objectives each year. The QI work plan lists each planned initiative or ongoing activities that are addressed and includes a brief description of the:

- Program scope
- Yearly objectives
- Planned activities, and timeframes within which each activity is to be achieved
- Staff members responsible for each activity
- Monitoring of previously identified issues and new activities
- Evaluation of the QI program

PacificSource updated the QI work plan frequently during 2019 and 2020 to reflect progress on QI activities and maintained the QI work plan as a clear and useful guide to the organization's QI activities. The full Program Description, Work Plan, and Evaluation of the QI Program were provided to the committee. Additionally, these documents are available at all times and are stored in the internal SharePoint site for our NCQA Accreditation. There were no other questions raised by the committee. A motion was made, seconded, and passed to approve the 2021 Annual QI Program Description, 2021 Annual QI Work Plan, and 2021 Annual QI Evaluation.

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Agenda Item	Discussion Leader	Government Reports	Follow-Up Action Items	Person/Dept. Responsible
2021 Medicare QI Evaluation	Cassandra Vigil	***Cassandra Vigil*** presented the Medicare Quality Improvement Program presentation to the committee stating that the Quality Improvement Program Plan is required by contract and federal regulation, however, it does not need to be submitted to CMS but we need it on file in case of audit. At a minimum the plan will: • Identify program goals, objectives, and outcomes. • Identify the quality committee that monitors the strategy and work plan. • Describe mechanisms for detecting and monitoring under and over utilization. • Identify how the plan will assess the quality and appropriateness of care to members. • Describe how the plan will assess disparities in care based on race, language, and cultural considerations. • Be reviewed by the Quality Improvement Committee annually. • This document does not need to be submitted to CMS but is required to have on file in case of audit. Aligned with Chapter 5 of Medicare Managed Care Manual and CFR we are required to: • Maintain a Chronic Care Improvement Program (CCIP), Stars Program, and Health Information (HIE) system. • Encourage provider participation in QI initiatives. • Contracting with an approved vendor for CAHPS. • Correct all problems via surveillance, complaints, or other mechanisms. • Implement an annual QI Program review (evaluation) process. • Supports requirements for CFR 44. 422.152- we must have an annual QIPP evaluation for Medicare LOB. **2021 Medicare QIPP Overview** • High level program descriptions for the various quality programs involved in the Medicare LOB. QIPP Outline / Lead/ SME CCIP / Sherri Sturko Stars Program / Melissa Evans Clinical Pharmacy Programs / Hope Tolman, Sheila Albeke CAHPS and Health Outcome Surveys / Avery Stuart Provider Quality Events / Sherri Sturko Grievance and Appeals / Jessica Waltman Member and Provider engagement in Programs / Ami Poppleton, Provider Network, Population Health Organizational Structure and Operation / Varies PacificSource Health Plans (Medicare) Quality Improvement Program (QIP) is a document which is updated annually, and outlines its Quality Improvement (QI) strategy to ensure members have access to high-quality health care that is safe, effective, delivers a positive experience and results in improved outcomes. Each year, the Clinical Quality Improvement team reviews the previous years' Medicare QI Program plan to measure the impact and effectiveness of its quality improvement program. Each year, the Clinical Quality Improvement team reviews the previous years' Medicare QI Program plan to measure the impact and effectiveness of its quality improvement program. Quality Improvement Program Review is updated annually. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityInitiativesGenInfo/Downloads/CMS-Quality-Strategy-Overview.pdf	Approved	Cassandra Vigil

Despite COVID-19 there was still an increase in the number of members screened in 2020 compared to 2019.

CCIP Program Evaluation Highlights

QI Program Component	Performance Indicator/Process Measure
CCIP Program: • Diabetes Comprehensive Care Program (DCCP)	• Members enrolled in the DCCP Program • Total diabetic members screened for depression • Medicare members screened for Social Determinants of Health (SDOH)

Despite COVID-19 there was still an increase in the number of members screened in 2020 compared to 2019.

- DCCP Enrollment began 5/2020 – 12/31/2020
  - 22 members enrolled
- Diabetic members screened:
  - 121 members screened in 2020
  - 54 members screened in 2019
- Members screened for SDOH:
  - 68 members screened in 2020

29 members in 2019 (baseline year)

Provider and Member Satisfaction and Safety

QI Program Components	Performance Indicator/Process Measure
Making Care Safer: Correcting all problems - Provider Quality Events - Grievance and Appeals - Fraud, Waste, and Abuse	• PQEs and provider to provider event trends that resulted in corrective action plans • Trends in G&A data • Medicare FWA trends

Provider Quality Events:

- Review of all Provider Quality Events, cases with potential harm, and corrective action plans for the prior year.
- Brief Analysis to reflect on any trends that occurred. (**Due to COVID- there was low volume of recorded events.)**
  - 39 Quality of Care Grievances in 2020
  - 93 reported in 2019.

Grievance and Appeals:

- Analysis of G&A trends reported for the Medicare LOB.
- Includes graph of total complaints from prior year.
- Note: Complaints were monitored related to the COVID-19 pandemic.

FWA:

- Table of all FWA cases reported in the prior year and cases that were closed.
- In 2020, the compliance department investigated 56 Medicare cases, and 18 were referred to an external agency.
- Along with a high-level overview of the program itself.

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CAHPs and Health Outcome Surveys (HOS)

QI Program Component	Performance Indicator/Process Measure
• Consumer Assessment of Healthcare Providers and Systems (CAHPS) performance • Health Outcomes Survey (HOS) performance	• CAHPS rating trends (compared to prior years) • HOS rating trends (compared to prior years)

Health Outcome Survey :

Due to COVID-19 the HOS was not deployed until August 2020, and performance data will not be available until the fall 2021.

- This section highlights year-to-year comparisons for the HMO & PPO plans HOS measures and ratings. (Showing overall consistent performance from year to year.)

CAHPS Program:

Due to COVID-19, CMS eliminated 2020 survey data submissions, so we did not have ratings to show in the evaluation.

- Normally for this section, we highlight CAHPS rating trends from prior years and provide an opportunity to discuss trends and barriers.

Stars Program Evaluation

QI Program Component	Performance Indicator/Process Measure

Stars Program performance - Clinical Pharmacy and Part D measures	• Individual Stars measure scores and weight (trended against prior years)
	  • Home Access Kits deployed to members
	  • Completed visits for the Matrix Home visit program
	• Medication Adherence Star ratings
	  • Comprehensive Medication Adherence Star ratings
	  • Medication Reconciliations completed

Due to the COVID-19 pandemic, all scores for HEDIS and CAHPS were rolled over from the 2020 Star rating.

- Tables show HEDIS Measure performance for each Stars Measure and scores compared to the prior years.
- Matrix in-home assessments and Access kits data is included to show additional work that is being done to improve Star Measures.
- **Clinical Pharmacy measures and pharmacy programs** aimed to help improve health outcome and Part D Stars performance.
  - This includes performance related to the Medication Reconciliation program such as CMR's completed documented Med Recs post discharge.
  - Additional data is also included for Eliza late to fill calls.
  - Med Adherence Stars Ratings provided in tables.

Other Performance Indicators in the Evaluation

QI Program Component	Performance Indicator/Process Measure
• Member outreach, education, and other supplemental performance indicators	• Case Management calls and member outreach • Updates to member benefits

Informal adoption of this plan is needed by the committee. There were no additional questions raised by the committee. The committee agreed to an informal adoption of the program for 2021.

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Chronic Care Improvement Program (CCIP)	Sherri Sturko	***Sherri Sturko*** presented the Chronic Care Improvement Program (CCIP) update to the committee, stating that the CCIP is a CMS Regulation- that requires each Medicare Advantage Organization to develop and implement a CCIP as part of their QI Program. The program is a three year long program, based on the "Plan-Do-Study-Cat" model that requires the health plan to promote effective management of chronic diseases, and improve care and health outcomes for our members with chronic conditions, and to improve and/or carry out change within the program. The program population and goals are outlined below:
		Date range: 1/1/2019 - 12/31/21
		Type 2 Diabetes: Managing the Whole Person to Improve Outcomes
		• Target group (MiPi Report 5/2021)
		  • Approximate Medicare enrollment: 35,950
		  • Number of members with diabetes: 5,050 (14%)
		  • Number of member with diabetes and depression: 1,645 (33%)
		• Demographics:
		  • 50% male, 50% female, with an average age of 72
		  • Ethnicity, language, location- not available; 2 members w/ primary language other than English; 42% live in Idaho, 53% live in Oregon, 1.6% in Montana, 3.6% in Washington
		• Average risk score: 6 ~ At Risk: 9.8%, Struggling: 58.6%, In Crisis: 31.5%
		
		Program Goals:
		1. Develop a Comprehensive Diabetes Care Program (CDCP) for Medicare Members with Diabetes
		2. Screen Medicare Members with Diabetes for Depression
		3. Meet the needs of Medicare Diabetic Members with Social Determinants of Health (SDOH) concerns
		
		Goal # 1:
		Develop a Comprehensive Diabetes Care Program (CDCP) for Medicare Members with Diabetes
		2019/2020- planning & design
		• Operated through the Condition Support team
		• Phone support, motivational interviewing, goal setting, newsletter, PAM survey, PHQ-2, connection to other program benefits
		  • Length: 90 days w/ option for add'l 90 days
		• 5/2020(start date)/2021- enrollment and sustainability
		  • Three phase roll out
		  • March 2021, 300-400 invite letters/month until all 5,000 identified members are reached
		
		The program mirrors our Condition Support Diabetes Program for our Commercial population.
		Program eligibility is as follows:
		• Members with a diagnosis of Diabetes, who have PS Medicare as their primary coverage, and are able to actively participate in health coaching.
		• Members who have depression, and/or anxiety, or gaps in care related to diabetes are prioritized
		Note: *Excludes pre-diabetes, members that are currently in our TOC program, members that have ESRD, or who are on dialysis, and members who are active organ or bone marrow transplant recipients, or receiving active cancer treatment*
		Other program offerings include:
		• RN Line
		• Silver & Fit Program
			Reviewed	Sherri Sturko

		• Think Nourish Move
		• RD consultations
		• Addressing gaps in care
		• Dental screenings
		Phase 1 ~ 5/1/20:
		• Referrals from MCR CM/MSS team through Dynamo. Referrals can come from: UM, IP, A&G, Rx, Matrix Medical, Home Access kit alerts, provider referrals and self-referrals. Also excluded Dual members
		Phase 2 ~ 7/1/20:
		• Included dual members
		Phase 3 ~ 9/1/20:
		• Mail introductory letter and begin outbound calls to all identified members, (identify through internal CPIA, claims based data, HRA, IP admit and PA, RN CM referrals, concurrent review, member and practitioner referrals, e-health record review) and examine ways to notify providers of this program.
		Goal # 2:
		Screen Medicare Members with Diabetes for Depression
		• 1/2019- CM added PHQ-2 screens to member calls
		  • Results are reviewed w/ members. Positive screens (≥3) are encouraged to follow up with their PCP for further screening
		  • CM notifies PCP via letter to encourage provider outreach on all positive screens.
		• Offer PHQ-2 screens to 80% of calls
		  • Hospitals and health clinics conduct depression screenings.
		  • To avoid screening fatigue, members can opt out
		According to the National Institute of Mental Health, approximately 66% of all cases of depression go undiagnosed and thus untreated. People who have depression and another medical illness tend to have more severe symptoms of both illnesses. They may have more difficulty adapting to their co-occurring illness and more medical costs than those who do not also have depression.
		Goal # 3:
		Meet the needs of Medicare Diabetic Members with Social Determinants of Health (SDOH) concerns
		• Identify members with SDOH concerns through internal CM screens and Matrix Diabetic Program assessment results. Link members with Member Support Specialists to assist with navigation
		• Increase the success rate for concerns met by 3% each year
		
		Similar to depression, limitations in any one of the SDOH areas directly affects an individual's ability to care for oneself or obtain access to care when needed. We want to help resolve SDOH barriers so the member can focus on controlling their diabetes. Matrix- is a vendor we use who deploys nurse practitioners to the member's home. The nurse practitioner is able to gain insight into the members health, and environment, and is able to share this assessment with the member's PCP and PS. The goal is to ensure that the provider has the most complete picture of the member's health and healthcare needs including SDoH so that optimal care can be provided to achieve better outcomes.
		
		***Note**: Matrix has a separate diabetes program for Medicare members. PacificSource identifies members for this program by the frequency of primary care or preventive care visits, diabetes management and testing, and with the assistance of Matrix.*
		Program Results		

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CDCP

Count (May-Dec 2020)	
CM referred to CS team	42
Members enrolled	16
Results	
Coverage termed	5
Member opt out	3
Ineligible/Other	4
Completed	4
Snapshot of 2021	
Members enrolled	35
NCM referral	25
Invitation letter	4
Self referral	4

PHQ-2

Screens	165
Score 0-2	158
Score of 3+	7
Results	
Spoke w/ mbr about results	110
Spoke w/ caregiver about results	7
Letter sent to PCP & spoke w/ mbr	7
Blank	41

SDOH

Year	Concerns	Goal Met	Rate
2019	46	25	54%
2020	101	66	65%

SDOH

Case Management	
Screens	351
SDOH Concerns	(+) screen
Safety	8
Transportation	12
Isolation	1
Housing	9
Physical barriers	9
Medication assistance	15
Food insecurity	16
Economic Stability	7
Cultural Variance/Language	5
Other	5

Outcomes	
CLARA completed	17
Connected w/ services	10
Benefit info provided	2
Coordination of care	13
Other	9

Matrix Diabetes Program 2020	
Mbrs identified and called	1,032
Spoke with	526
Home Visit	93
Referral to PS CM	0

Barriers

1. Care Coordination: No tracking on whether PCP followed up w/ mbr based on our PHQ-2 letter.
2. Technology: Not having all desired data or all in one place.

Mitigation

1. Work w/ internal teams who are provider facing and gather feedback on the provider process when a letter is received.
2. Project has many components, including vendor data. Adjust measures based on info that is available.

When CM started the depression screening program on the commercial side, a postcard went out to all par providers to inform them and a section of the PS provider webpage was developed to educate on the depression screening. Now we are screening across all LOB. Circling back with providers to learn how they respond, what's working and what isn't.

The team worked with Patty and Sarah in analytics to develop a robust report for program tracking and outcomes for the DCCP.

2021 Plan ahead

- Continue to share project and provide updates internally and w/ providers; obtain feedback, make needed adjustments.
- Finalize systematized processes to ensure program achieves long term success.
- Provide support to the CS/CM team where needed.

Lessons learned

- Solving 100% of SDOH concerns is admirable, but not attainable.
- Understand the data- where it comes from and if there is enough to draw conclusions.

SDOH- Programs/resources come and go as funding is available, offerings vary by location, and can have a variety of requirements to be eligible. While we would love to resolve 100% of the identified needs, we are limited to the assistance available at the time. We are using the Minnesota Method with a goal of increasing the goal met

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		category by 3% of benchmark each year, which we accomplished with an 11% increase over baseline year data- We are learning to examine existing reports thoroughly, the best questions to ask when working with analytics, making requests clear and concise, and that some requests aren't warranted. There were no additional questions or concerns raised by the committee regarding the 2021 CCIP program.		
Parking Lot Agenda Items:	None	None		
Meeting Adjourned		**The meeting was adjourned at 10:50am PST**		

_____

Justin Montoya MD, Commercial Medical Director
Date: October 1, 2021

Actions Report for 2021					
Opportunity	**Priority**	**Chosen Action**	**Targeted Goals**	**Outcome Date**	**Completed**
7/27/21 **None**					

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5/25/2021 **None**					
3/23/2021 **None**					