OHA Transformation and Quality Strategy (TQS) **CCO:** PacificSource Community Solutions – Marion-Polk

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: Improving Access to Care and Monitoring

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

If continued, insert unique project ID from OHA: 187

B. **Components addressed**

i. Component 1: Access: Cultural considerations
ii. Component 2 (if applicable): Access: Timely
iii. Component 3 (if applicable): Access: Quality and adequacy of services
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 manage?
☐ 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:**

PacificSource Community Solutions – Marion-Polk (PCS-MP) supports the Access: Timely and Access: Quality and adequacy of services components by monitoring compliance with established standards through access surveys, site visit checklists, and member complaints. If three or more complaints concerning a particular provider or facility are received, the Provider Network Department conducts a site visit. Results from these visits help identify opportunities for improvement and corrective actions, if necessary. All data is analyzed and reviewed by the Quality Improvement Committee at least once per year. The Quality Improvement Committee consists of the Chief Medical Officer, Medical Directors, Director of Commercial Operations, Quality Improvement, Utilization Management, Health Management, Provider Network, Customer Service staff, and other staff members as needed.

In 2020, PCS-MP deployed the Contract Resource Management (CRM) tool. This tool enables our Provider Network Department to house, track, and evaluate site visit data from primary care, specialty, behavioral health, and oral health clinics in one location. The data helps us identify problems and trends relating to members' access to care, which we use to develop improvement strategies. To this end, PCS-MP also on-boarded a Provider Access Analyst to evaluate cross-functional information relating to access, identify gaps, and develop targeted interventions to improve members' access to care. Unfortunately, due to COVID-19, we were unable to collect sufficient access data via site visits and provider surveys. This directly impacted our ability to evaluate and implement our targeted provider education to better our members' access and meet these components' goals.

PCS-MP also sends quarterly Access Surveys to a sampling of its contracted providers and uses the responses to evaluate practitioners against access criteria, as outlined within the terms of their contract as well as the Provider Manual. PCS-MP's standard is that at least 90% of its providers meet access criteria. The Provider Network Service Team and the Provider Network Contracting Team identify deficiencies in the provider network, create corrective action plans, and coordinate outreach to providers.

As an example, the table below summarizes the analysis of PCP network accessibility for PCS-MP Health Plans in 2020:

Primary Care Responses:	2020 Percent of Providers Meeting Access	2020 Percent of Providers Not Meeting Access	2019 Percent of Providers Meeting Access	2019 Percent of Providers Not Meeting Access	2018 Percent of Providers Meeting Access	2018 Percent of Providers Not Meeting Access
Preventative Primary Care Appointments: Within 4 Weeks						
Total responses:	605	55	1,002	61	1036	78
Percent of total:	91.66%	8.34%	94.26%	5.74%	93.0%	7.00%
Routine Care: Within 5 Business Days						
Total responses:	619	41	1,020	45	1079	39
Percent of total:	93.78%	6.22%	95.77%	4.23%	96.51%	3.49%
Urgent Primary Care Appointments: Within 48 Hours						
Total response:	622	38	1,011	50	1087	49
Percent of total	94.24%	8.39%	95.28%	4.72%	95.69%	4.31%
Emergency Care Services: Same Day						
Total responses:	595	65	940	123	1038	91
Percent of total:	90.15%	9.85%	88.43%	11.57%	91.94%	8.06%
After Hours Care: Phone Service						
Total responses:	641	19	1,011	52	1127	30
Percent of total:	97.12%	2.88%	94.22%	5.78%	97.41%	2.59%

Additionally, PCS-MP created a task force charged with developing a Medicaid Member Access Survey. The survey aims to monitor members' experience with receiving care, including timeliness, quality, adequacy, and whether providers meet members' Cultural Considerations. Questions aimed at Cultural Considerations include access to interpreter services and whether the member felt their provider treated them fairly regardless of race, ethnicity, sexual orientation, or disability. While we were able to develop the survey, the survey launched later than expected because of competing priorities for our data team, COVID-19, and extended timelines for OHA review. We launched the survey in Q4 2020.

Overall, 2020 proved to be a challenging year for providers due to the pandemic. PCS-MP took steps to offer relief to providers, including temporary suspension of many reporting requirements, including Access to Care surveying. We believe that this disruption and the continuing struggles facing providers have led to a marked decrease in survey responses. In addition, many providers are not able to maintain their customary schedules, creating possible accessibility issues, including an inability to accept new patients. These are all areas of concern and will be monitored closely in 2021.

D. **Project context:**

In 2019, PCS-MP developed a platform for compiling site visit questionnaire results on access to care. The Contract Resource Management (CRM) tool's development and implementation provided the Provider Network Department a central location to house, track, and evaluate information gathered from site visits. The phase-one completion of this platform streamlined our ability to analyze data from site visits, and future enhancements will allow us to identify improvement opportunities for meaningful access measures. PCS-MP deployed the CRM tool in 2020 to collect and compile access data from completed site visits. However, due to COVID-19, PCS-MP decided to implement the Provider Relief Plan for employee safety and reduce providers' administrative burdens during the pandemic. This act suspended site visits for an interim time, ceasing our ability to collect access data through site visits, establish baseline data, or develop and implement our targeted provider education. We have developed a plan for resuming site visits in 2021 through a virtual modality in response to this barrier.

Additional challenges arose when our Provider Access Surveys were suspended by the Provider Relief Plan. These surveys collect provider data specific to accessibility and adherence to access requirements set by OHA, allowing us to assess, educate, and build access recommendations to ensure Medicaid members receive timely care. Our aim for 2020 was to increase the survey frequency from quarterly to monthly, but due to COVID-19, surveys were suspended entirely

from March through September. While we were able to collect survey responses in January 2020, we could not collect sufficient data throughout the year to establish a baseline for improvement targets. Once we can establish baseline access data from the CRM tool, our newly on-boarded Provider Access Analyst will compare the results with OHA and NCQA standards to develop interventions and strategies to improve Timely Access to care and Quality and Adequacy of Services.

Despite challenges resulting from COVID-19, PCS-MP continued the Access to Care Workgroup that includes subject matter experts from Analytics, Grievance & Appeals, Customer Service, Quality, and Population Health Departments. Although formed in the second quarter of 2019, the workgroup did not gain significant traction until the following year. In 2020, the Access to Care Workgroup evaluated existing survey tools for improvements and researched our current population to develop a representative sample size and determine what languages should be included. Through this work, the Access to Care Workgroup contracted with a vendor to develop the Member Access Survey to monitor members' experience receiving care. The workgroup planned on launching the survey in mid-2020, but due to strained resources resulting from COVID-19, it did not deploy until mid-December 2020.

E. **Brief narrative description**:

In 2021, PCS-MP aims to deploy 3,500 Access to Care Surveys per month to reach approximately 15% of its Medicaid membership. SPH Analytics, a national survey organization, will administer the survey, aggregate the data, and provide a quarterly report of findings by provider type (Primary Care, Specialty, Behavioral Health, and Oral Health). The Quality Performance Strategist and Access to Care Analyst will monitor the results every month and share them annually with the Access to Care Workgroup. The Access Analyst will assess members' experience of scheduling an appointment, interacting with office staff and providers, language needs and interpreter services, follow-up care, and satisfaction with non-emergent medical transport (NEMT) services. The Access to Care Analyst and the Access to Care Workgroup will also share opportunities for improvement with other stakeholders who may be impacted or hold subject matter expertise.

In addition to the Member Access Survey, PCS-MP will conduct a monthly Provider Access to Care survey. Our goal is to send out 2,500 surveys per month to all provider types, with the goal of reaching every provider in our network by the end of 2021. Data collected from the survey results in 2021 will set a baseline for Provider Access to Care Survey results in 2022. A comprehensive report of findings will be created by the Access to Care Analyst to identify trends and gaps in access timeliness standards set by OHA and NCQA. The Access Analyst will also set a baseline on survey response rates and develop interventions to increase this rate by the end of the year.

In 2021, the Provider Service Department will resume conducting no less than eight site visits per month for contracted Medicaid providers. Priority will go to newly established providers, and those with issues or concerns escalated to the Provider Service Department. To mitigate the risks posed by COVID-19, the Provider Service Department has developed a virtual site visit format and will utilize this modality until conditions warrant resuming on-site visits. The resumed site visits will allow PCS-MP to continue deploying the CRM system to house the site visit access-to-care data within one data storage system. This process will increase our visibility into member access by determining our baseline data derived at site visits along with the data collected from our Provider Access Surveys.

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

Activity 1 description: Increase data input into the CRM tool to collect actionable data trends on the Quality and Adequacy of Services and Timely access.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: Our target is to enhance analytics to capture member access opportunities. All site visit data will be entered into the CRM tool, and the data output will be used to identify gaps and trends in Medicaid access to care.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
The CRM tool is developed, but no significant data has been entered into the system.	Provider Service Representatives (PSR) will enter site visit results monthly into the CRM tool. The Provider Network Department will analyze each site visit's results regarding access to care to determine if they are meeting the access standards set by OHA and NCQA. If they are not meeting these standards, the PSR will follow-up to provide education and escalation when appropriate.	06/2021	The Provider Service Department will send the Access to Care Analyst a completed log of that month's completed site visit performance collected in CRM on a monthly cadence. Provider Service leadership will implement and develop a plan to increase site visits by provider specialty type to increase our provider network access to care data.	12/2021

Activity 2 description: Compile access data from all monitoring systems into one report to identify gaps and trends related to the Quality and Adequacy of Services and Timely access. Utilize this data to develop interventions for access improvement.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: The Access Analyst will consolidate all access data into the Access Monitoring Review Report to create a baseline for future access improvement opportunities. The Access Analyst will develop interventions to increase response rates on provider surveys.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)

The new Access Analyst has created a spreadsheet for compiling access data from all systems within the organization, but only a limited amount of data has been collected and entered into the spreadsheet.	Collect baseline data from all systems within the organization to identify trends. Develop interventions for increased response rates on provider access to care surveys.	12/2021	Utilize the baseline data collected in 2021 to identify access trends and develop interventions to improve access to care.	12/2022

Activity 3 description: Administer the Member Access to Care Survey to monitor results and develop appropriate interventions for access to care and cultural considerations, such as interpreter services and treatment regardless of race, ethnicity, sexual orientation, or disability.

☐ Short term or ☒ Long term

Monitoring activity 3 for improvement: Increase and monitor Member Access Survey results and develop an action plan for improving access to care and cultural considerations, such as interpreter services and treatment regardless of race, ethnicity, sexual orientation, or disability.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
The Member Access to Care Survey has been developed, but no baseline survey data has been collected.	Collect representative baseline data from the Member Access to Care Survey results.	12/2021	Complete initial assessment of the Member Access to Care Survey data and develop an improvement plan that addresses access to care and cultural considerations.	12/2022

A. **Project short title**: Project 2: PCPCH Enhancement and Financial Support

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

If continued, insert unique project ID from OHA: 188

B. **Components addressed**

i. Component 1: Behavioral health integration
ii. Component 2 (if applicable): PCPCH: Member enrollment
iii. Component 3 (if applicable): PCPCH: Tier advancement
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:**

PCS-MP has worked with supporting clinics to advance Tier levels in Marion and Polk counties, and provided financial support to PCPCH certified clinics (see Table 1 for Tier status.) In 2020, PCS-MP contracted with 67 PCPCH clinics to provide at minimum a base-rate payment to support Advanced PCPCH Standards. Of those, seventeen clinic signed contracts to receive value-based payments (VBP) for Behavioral Health Integration (BHI.) In Marion and Polk counties, 102,358 members receive care at a certified PCPCH clinic, with 13, 760 members receiving care at non-certified clinics.

Table 1: 2020 PCPCH Tier Status for Contracted Clinics is Marion and Polk Counties.

Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
0	1	5	44	15

In summer 2020, PCS-MP executed a contract with Creach Consulting to provide technical assistance (TA) to advance PCPCH standards, Increase Member Enrollment, and help clinics achieve fidelity-based integrated behavioral health services. PCS-MP decided to contract with Creach Consulting for TA because of her expertise in this area, and also to allow its Population Heath Coaches to focus more specifically on quality incentive metrics (QIM) improvement. Despite initial delays in executing the contract and setbacks due to COVID-19, seven clinics are currently receiving TA for BHI.

Due to COVID-19 and the need for social distancing, PCS-MP could not provide in-person TA and learning collaboratives as planned in 2020. In addition, to help relieve provider burden due to COVID-19 and clinic setbacks, PCS-MP released a Provider Relief Memo. As part of the Provide Relief Memo, PCS-MP waived clinics' requirements to increase their population reach metric. Clinics were still encouraged to track and report on this metric by the end of 2020, but results would not negatively affect their program-specific per-member per-month (PMPM) payments.

In addition to the BHI Program, PCS-MP launched Leadership Integration Collaboratives in Marion, Polk, and Lane Counties. The Leadership Integration Collaborative is a sub-group of the Clinical Advisory Panel. The intent of this collaborative is to bring together leaders and prioritize involvement of community partners and members in discussions on the broader system of care serving our community (Behavioral Health, Physical Health, Specialty Care, Dental Health, and Hospital Systems). An integral part of the success of the Leadership Integration Collaborative is shared agenda-setting, ongoing discussion, creating action plans toward continued improvement in the service delivery system, service delivery representation, and using data to guide this work.

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

PCS-MP executed contracts for VBPs for Behavioral Health Integration (BHI) in all regions. PCS-MP achieved its target for expanding the BHI program. In Marion and Polk Counties, 17 clinics signed VBP contracts for BHI, and will begin to receive TA to increase their population health reach. As part of the provider relief for COVID-19, PCS-MP changed its population health reach targets. All participating clinics will only have to maintain 5% population health reach in 2021.

PCS-MP continues to offer and provide TA to clinics to reach their population health metric, and offers TA in targeted focus areas. Last year, PCS-MP piloted TA with One Community Health and began discussions on analyzing its population health data with a health equity lens. These discussions will continue through 2021, with the aim to helping clinics to identify and address disparities within their populations. In addition, Creach Consulting will hold virtual learning collaboratives to increase coordination between behavioral health and primary care providers To decrease provider burden, PCS-MP changed reporting and attestation requirements from quarterly to twice a year. Creach Consulting will continue to offer TA for BHI to help clinics achieve their population health reach measures and meet the requirements of PCPCH Standard 5C3, which entails collaborating with diverse populations to develop individualized care plans for complex medical or social concerns. TA for BHI aims to increase awareness and benefits of the Collaborative Care Model. In 2021, PCS-MP will offer TA to clinics that are below Tier 3 to help them achieve a higher tier status. PCS-MP plans to increase PCPCH Member Enrollment by offering TA to clinics that are not currently certified.

In 2020, PCS-MP also worked to support clinics in achieving advanced Tier levels by offering scaled incremental payment rates specific to each PCPCH Tier recognition and participation level in the PCS-MP's Programs. To date, 14 PCPCH clinics have signed contracts to receive some level of financial support. Six PCPCHs are currently receiving a base payment (OHA certified, but not attesting to any PCS-MP Program). Eight clinics are receiving an enhanced PCS-MP PCPCH Program rate (for Tier 3 and above). Clinics who are above Tier 3 can qualify to receive an additional PMPM increase for fidelity-based behavioral integration as outlined in PCPCH Standard 5C3. Clinics participating in the PCS-MP PCPCH Program received attestation forms to report progress on three identified PCPCH measures: electronic health information exchange capabilities, quality improvement and population health management metrics, and CAHPS domain scores and improvement plans for Access and Care Coordination and documented plan for improvement. In order to receive the PCS-MP Program rate, clinics must show their most recent OHA Tier recognition letter in addition to showing documentation for the four identified PCPCH standards. Creach Consulting closely monitors all reporting for BHI and PCPCH. As a part of Provider Relief, PCS-MP waived reporting requirements in 2020. In 2021, clinics will continue to receive either the base-rate, PCS-MP PCPCH Program rate, and/or the BHI rate.

E. **Brief narrative description**:

PCS-MP will provide financial support and TA to implement high-value BHI elements in PCPCHs that serve our members. In order for clinics to participate in the fidelity-based BHI program, they must be a Tier 3 PCPCH or higher. PCS-MP provides financial support via a PMPM tied to a VBP model. Each participating clinic is required to submit quarterly reports consisting of three metrics, including the population reach metric. The population health reach metric measures the percentage of patients who see a behavioral health clinician in primary care. The program provides multi-year assistance to help clinics improve utilization of Behavioral Health Clinicians (BHCs) and increase the number of members receiving integrated services.

- Clinics in the first year of the program must achieve 5% population reach.
- Clinics in the second year of the program must achieve a 5% population reach (adjusted down from 10% for COVID-19 Provider Relief).
- Clinics in the third year of the program must achieve a 10% population health reach.
- Clinics in the 4th year of the program must achieve and maintain a 15% population health reach.

Clinics that participate in the contracts receive support through site visits, learning collaboratives, training, meetings, individual clinic support, and facilitation of community of practice meetings. Longitudinally, concurrent provision of

physical and behavioral health will help assure access to services by other members of this region. TA will also address discussing the benefits of the Collaborative Care Model.

In 2021, PCS-MP will begin offering TA to clinics below Tier 3 to help clinics achieve a higher tier status. PCS-MP plans to increase member enrollment to certified PCPCH clinics by offering TA to clinics that are not currently certified. PCS-MP is also currently preparing and building the capacity to offer TA to PCPCHs to increase awareness and value of using Community Health Workers (CHWs) within their patient population.

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

Activity 1 description: PCS-MP will offer continued and expanded support for the implementation of fidelity-based BHI in PCPCHs using a VBP strategy, which requires a minimum population reach of 5% for the first and second years of participation, 10% in the third, and 15% for clinics in their fourth year of participation in the program.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: We will monitor (1) fidelity of program and expansion of the program model through clinic attestations with follow-up site visits and/or documentation reviews, and (2) bi-annual data reporting on population reach, with targets that are commensurate with the clinic's maturity in the program.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
17 PCPCH clinics signed VBP contracts for fidelity-bases BHI.	>2 additional PCPCH enrolls in VBP arrangements for BHI.	12/2021	20% increase in the number of contracted PCPCHs enrolled in VBP arrangements for BHI.	12/2022
PCPCHs that participated in the BHI Program in 2020 will maintain a 5% population health reach in 2021.	100% of clinics receive TA to maintain a 5% population health reach.	12/2021	50% of participating clinics enrolled in 2022 will achieve a 10% population health reach.	12/2022
PCPCHs that are new to the BHI Program in 2021 will achieve a 5% population reach.	100% of clinics receive TA to maintain a 5% population health reach.	12/2021	50% PCPCHs that are new BHI Program in 2021 will achieve 10% population reach in 2022.	12/2022

Activity 2 description: PCS-MP will offer support to PCPCHs by providing virtual learning collaboratives and TA to increase collaboration between primary care and specialty behavioral health and increase access and coordination. PCS-MP will explore TA options to ensure they support clinics to achieve advanced measures.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: We will monitor progress in TA through offering virtual learning collaboratives between PCPCHs and specialty behavioral health providers to include discussions and education around using the Collaborative Care Model. In addition, PCS-MP will develop plans to begin providing TA to PCPCHs to increase awareness and value of using Community Health Workers within their patient population.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
No Virtual Learning Collaboratives occurred in 2020.	Plan 2 annual Learning Collaboratives.	12/2021	The utilization of BHCs in primary care establishes consistency with fidelity of population-reach and core clinical practices.	12/2022
PCS-MP does not offer TA to PCPCHs to utilize Traditional Health Workers (THWs) within the clinic's patient population.	>1 clinic will be offered TA to discuss value of using THWs in a clinic setting.	12/2021	PCS-MP will establish goals for increasing THW engagement in PCPCHs.	12/2022

Activity 3 description: PCS-MP will offer TA to clinics who are not currently PCPCH recognized to increase member enrollment in PCPCH's as outlined in the CCO 2.0 Contract requirements.

☐ Short term or ☒ Long term

Monitoring activity 3 for improvement: PCS-MP will contract with Creach Consulting to offer TA to clinics that are not certified PCPCHs. TA will focus on assisting clinics with the PCPCH application process and targeted assistance with ensuring clinics select PCPCH measures best suited for their patient population.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
88% of PCS-MP members are assigned to a PCPCH.	PCS-MP will identify clinics who are not recognized as PCPCHs and offer TA.	12/2021	95% of PCS-MP members are assigned to a PCPCH recognized clinic.	12/2022

A. **Project short title**: Project 3: Advancing CLAS Standards with a focus on Language Access and use of preferred language.

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

If continued, insert unique project ID from OHA: 189

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

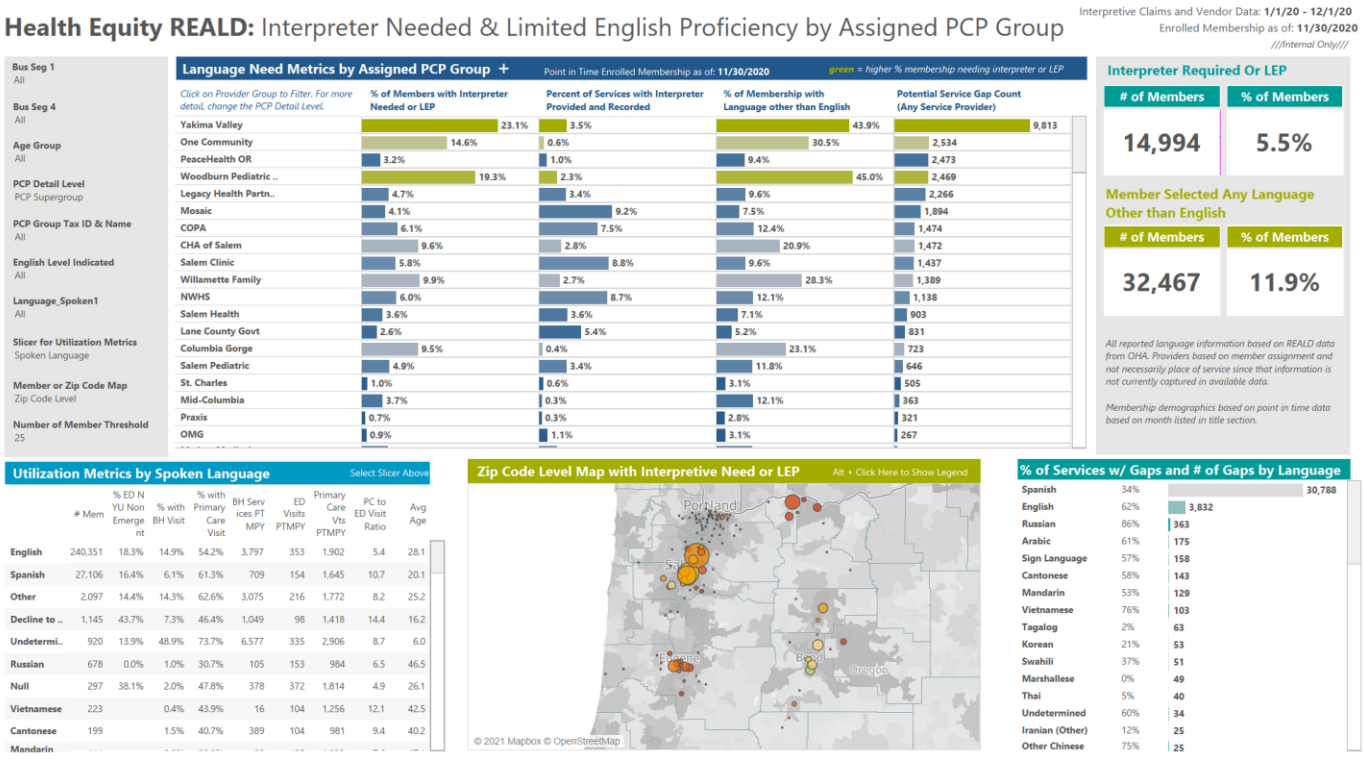
C. **Component prior year assessment**:

In 2020, PCS-MP made organizational improvements to promote Health Equity: Cultural Responsiveness and ensure that members receive effective, understandable, and respectful care from all CCO staff by offering Implicit Bias Training to PCS-MP employees. 100% of leadership and 97% of employees participated in the training, including Customer Service staff, Case Management (CM) staff, and Member Support Specialists (MSSs). We followed the online training with a series of discussions that helped deepen the employees' understanding of the topic. In a follow-up survey, 97% of participants reported interest in additional training on this topic. PCS-MP also integrated CLAS standards into a continuous improvement process and embedded this strategic work into the CCO by adopting a new corporate value related to equity and social justice. In addition, we developed an anti-racism action plan and created a Resources and Training Facilitation Program to support educational initiatives on a permanent basis. In 2021, this project will address Health Equity: Data as a component since PCS-MP has created Health Equity Interpreter Dashboards with REAL+D data instead of Health Equity: Cultural Responsiveness.

Last year, PCS-MP also made developments in Access: Cultural Considerations by promoting the delivery of services in a culturally competent manner to members. PCS-MP achieved this by creating and distributing the Language Access Plan (LAP) to providers in all regions. The LAP promotes access and delivery of services in a culturally competent manner by providing oral interpretation guidelines, translation of materials, additional language support for providers, and requirements for attestations on policies and procedures. In addition, PCS-MP sent surveys to members who received interpretation services to assess the services' quality and accessibility. PCS-MP has standardized this process and integrated it as part of a standard workflow.

Additional work included elevating implementation of CLAS Standards in our company and system-wide. We implemented improvements for CLAS Standards number: 4, 5, 6, 9, 10, 11, 12, and 13. PCS-MP advanced CLAS Standard 11 by developing four dashboards that incorporate REAL+D and claims information to identify gaps in interpretation services. In 2021, PCS-MP will focus on improving CLAS Standard 5: Offering 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.

Below is an image of one of the four dashboards: Health Equity REAL+D: Interpreter Needed & Limited English Proficiency by Assigned PCP Group:



D. **Project context:**

In 2020, PCS-MP achieved its target to distribute the LAP to providers and subcontractors through two channels. We distributed the document to providers on our website and an Oregon-specific provider bulletin. PCS-MP requires that providers attest to policies and procedures in the CCO provider manual. The Diversity Equity and Inclusion (DEI) team successfully deployed the member access survey and completed a qualitative assessment of language access and language services quality. The DEI team analyzed the results from the qualitative assessment, and used the data to help build the LAP and Health Equity Plan. They used the data from the assessment to ensure that members filed a grievance and appeal when dissatisfied with an interpreter service.

PCS-MP also developed four Health Equity Interpreter Gap Dashboards that utilize data received from REAL+D and claims for interpreter needs. PCS-MP identified one provider per region where technical assistance needs were evident and offered them technical assistance. Based on provider feedback PCS-MP provided the LAP and information on interpreter services available for reimbursement and how to request interpreters through the PCS-MP approved vendor list. In 2021, PCS-MP will expand the Health Equity Interpreter Gap Dashboards to include behavioral health and dental health. PCS-MP will also create a workflow to identify thresholds, capacity, and additional technical assistance needs. This will help establish the ongoing processes as we move beyond 2022.

Last year, PCS-MP shifted its focus from developing new materials for "I-Speak" cards to supporting and promoting existing OHA materials. This activity allowed us to identify process improvement opportunities within the OHA portal, such as ordering issues and printing formats and languages not yet available. PCS-MP reported these findings to OHA, and work is currently underway to explore improvements in 2021. Although the DEI team did not develop new materials, they were able to promote the I-Speak cards poster as part of the LAP promotion process. The work to improve access and promotion of the I-Speak Cards will continue into 2021.

Lastly, in 2020, PCS-MP offered Implicit Bias Training to all its employees with a more than 97% participation rate. In addition, PCS-MP provided additional support through a series of post-training discussions to deepen employees'

understanding of the topics. We learned that our employees are eager to have more discussion opportunities and continue engaging in this work. Although restrictions due to COVID-19 limited our ability to provide in-person training, we overcame this challenge by successfully implementing online learning techniques. This online training (Quality Interactions) was made available to providers and subcontractors through the provider web portal, targeted email invitations, and via PCS-MP's Provider Service Representatives. We learned that the process, capacity, and relationships to make this happen needed to be built in and supported. In response to this, PCS-MP created a new Training and Facilitation Program to support continuous education to providers and sub-contractors.

Brief narrative description:

This project outlines new activities within CCO 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-MP created Health Equity Interpreter Gap Dashboards to analyze interpreter gaps amongst primary care providers. These dashboards will be utilized to collect REAL+D data and claim codes (CLAS Standard #11.)

In 2021, PCS-MP will utilize the Health Equity Interpreter Gap Dashboards to establish data workflows for ongoing monitoring of interpreter service claims and technical assistance requirements to determine language access needs and quality of services (CLAS Standard #5). We will leverage the Health Equity Interpreter Dashboards to help implement processes and procedures to improve culturally and linguistically appropriate services, including behavioral health and oral health. Secondly, PCS-MP will develop a multimedia approach for technical assistance on interpretation services for the PCS-MP provider network. This project will address *Access: Cultural Considerations* by assisting providers with identifying their patients' cultural and linguistic needs and engaging them in their care plan (CLAS Standard #5). We will also use the Health Equity Interpreter Gap Dashboards to identify language assistance needs and address the I-Speak card distribution challenges to members and providers.

Activities will focus on:

- **Health Equity: Data**: Establishing a data workflow for ongoing monitoring and technical assistance needs assessment to support providers and inform annual updates of PCS-MP's LAP (CLAS Standard # 11.)
- **Access: Cultural Considerations**: We will develop technical assistance strategies using a multimedia approach to accessing interpretation services for the provider network (CLAS Standard #5.)
- **CLAS Standards:** We will integrate the use of our REAL+D Dashboard to identify members' language assistance needs and address challenges and barriers to utilizing I-Speak Cards. This will help us to ensure seamless distribution to providers and members (CLAS Standard #8.)

E. Activities and monitoring for performance improvement:

Activity 1 description: Health Equity Data: PCS-MP will establish a data workflow for ongoing monitoring, and technical assistance needs assessment to support providers and inform annual updates of PCS-MP' LAP.
☐Short term or ☒ Long term

Monitoring activity 1 for improvement: PCS-MP will monitor the technical assistance needs using the Health Equity dashboards. Information in the dashboards will be disseminated to provider groups by 1) creating a form for Provider Representatives to assess gaps, and 2) outreaching to provider groups on a quarterly basis.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
The *Health Equity: REAL+D Language, Race, and Ethnicity* dashboards are not	Create a form for Provider Service Representatives to assess interpreter	06/2021	Conduct outreach to a least 10 provider groups on a quarterly basis to identify	12/2022

currently available to Provider Contracting Representatives.	gaps with the provider groups.		technical assistance needs.	
The *Health Equity: REAL+D Language, Race and Ethnicity* dashboards only represent data for primary care providers.	PCS-MP expands the *Health Equity: REAL+D Language, Race, and Ethnicity* dashboard to behavioral and oral health providers.	09/2021	Conduct outreach to oral health providers and DCOs to share findings from dashboards and provide technical assistance.	12/2021

Activity 2 description: Access: Cultural Considerations: We will develop technical assistance strategies using a multimedia approach on how to access interpretation services for the provider network.

☒ Short term or ☐ Long term

Monitoring activity for improvement: PCS-MP will monitor interpreter services by distributing an FAQ about accessing interpreter services and creating one additional tool to assist providers in billing for interpreter services.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
PCS-MP printed an FAQ about accessing interpreting services. We do not currently have any other educational tools or training developed in this area.	PCS-MP creates at least one additional tool to assist providers in accessing CCO interpreter vendors/or billing for on-site interpreter services.	08/2021	Distribute tools through at least two channels to 75% of providers.	12/2021

Activity 3 description: CLAS Standards: PCS-MP will use the REAL+D Dashboards created to identify member's language assistance needs and address challenges and barriers to utilizing I-Speak Cards. This will help ensure seamless distribution to providers and members.

☒ Short term or ☐ Long term

Monitoring activity for improvement: PCS-MP will monitor the success of distributing I-Speak cards to providers through using REAL+D dashboards to identify members who have language assistance needs.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
I-Speak cards developed by OHA have challenges and are not ready for distribution to providers.	PCS-MP addresses I-Speak card challenges and distributes cards to providers.	06/2021	I-Speak cards are promoted to providers through at least two channels.	12/2021

A. **Project short title**: Project 4: Monitoring of CCO and Subcontractor Grievance and Appeals Data

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

If continued, insert unique project ID from OHA: 190

B. **Components addressed**

i. Component 1: Grievance and appeal system
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:**

PCS-MP utilizes a Grievance and Appeal System that compiles complaint data from customer service calls, during which each complaint is entered and subsequently categorized. The Grievances and Appeals (G&A) Department log complaints using Dynamo software, and notify providers whenever they are the subject of a member complaint. The grievance process ensures that PCS-MP members have an avenue to request a grievance resolution by the plan. Pertinent information is gathered, reviewed, and completed in a confidential and timely manner, in accordance with applicable rules and regulations. A resolution is issued to the member by written notice, with direct follow-up to entities affected by the issue. Reports are provided to the Quality Assurance Utilization Management Pharmacy & Therapeutics (QAUMPT) Committee, the Division of Medical Assistance Programs (DMAP), and to the Addictions and Mental Health Division (AMH) on a quarterly basis.

In 2020, PCS-MP developed and implemented a monitoring tool to enhance its Grievance and Appeal System. This tool analyzes and trends grievance and appeals (G&A) data from internal and subcontractor sources. In addition, due to the need to formalize more frequent and routine monitoring of member complaints and complaint-resolution by subcontractors, PCS-MP increased its grievance and appeals monitoring from quarterly to monthly.

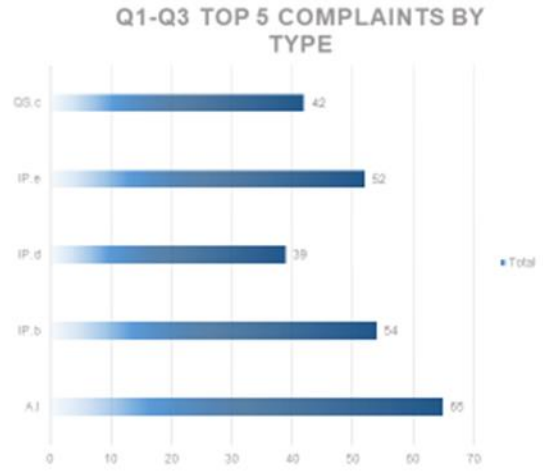
Based upon the data collected and analyzed from this tool, PCS-MP initiated interventions to improve processes or services to support timely, accurate, and compliant responses to appeals and grievances. The Medicaid Regulatory and Reporting Specialist utilized monthly logs submitted by subcontractors and internal data to assess process requirements and opportunities for improvement. The Specialist used month over month trended data, to collaborate with subcontractors and internal staff on improvement activities.

The results of this enhanced system highlighted areas for focused improvement efforts. Although the complaint rate in this region remained relatively low overall in 2020, the graph below shows NEMT as an outlier, with a significantly higher complaint rate compared to other grievance categories.

Region	Complaint Rate/1000 members
Marion Polk	4.81

Q1-Q3 2020: Marion Polk

- 521 complaints received between January 1st and September 30th
- Top 5 complaints per type:
  1. A.I – Access: NEMT not provided, late pick up w/missed appointment, no coordination of services
  2. IP.b – Interactions with Plan or Provider: Provider rude or inappropriate comments or behavior
  3. IP.e – Interactions with Plan or Provider: Plan explanation/instruction inadequate/incomplete
  4. QS.c – Quality of Service: Benefits not covered
  5. IP.d – Interactions with Plan or Provider: Provider explanation/instruction inadequate/incomplete



D. **Project context:**

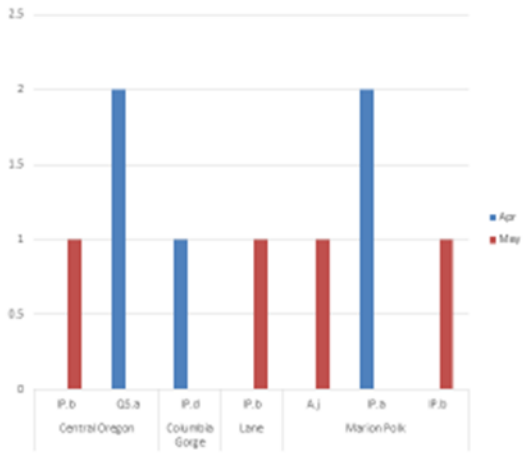
In 2020, PCS-MP successfully established a standardized tool for monitoring internal G&A data from PCS-MP and all subcontractors performing complaint resolution. This process allows PCS-MP to evaluate delegated functions and review for appropriateness of response to an appeal and grievance, the timeliness of responding to member complaints, and whether the CCO and subcontractor followed the proper appeals and grievances processes and criteria.

The data gathered in 2020 helped us identify a trend of grievances related to member interactions with dental providers. In response, PCS-MP utilized this 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 resulted in developing proactive outreach mechanisms, which included written communication about programs, information about available providers, and a potential text messaging system. The agenda for these discussions also centered on member impacts due to COVID-19 and wildfires. Due to quarantine requirements and office closures from COVID-19, dental care utilization drastically declined. These quarterly discussions helped raise awareness of the service complaint trends and foster communication to strengthen member and provider relationships.

Below is an example of our monthly trend report:

April – May 2020 Grievance Review

- Timely Submission of Monthly Grievance Logs: April and May (not reporting June)
  - Slight decrease in complaints in Central Oregon and Marion/Polk
  - The Gorge increased over this quarter
  - Lane remains steady at 1
  - General trend is related to the interactions with provider/plan
  - Rate/1000 comparison:
    - Advantage: 0.16
    - ODS: 0.06
    - Capitol: 0.03



E. **Brief narrative description**:

In 2021, our goal is to reduce the overall rate of member grievances from 4.81 per 1,000 members to 4 per 1,000. We will achieve this through targeted interventions aimed at Non-Emergent Medical Transportation (NEMT) member pick-ups and member communications.

Results from the 2020 Grievance Report show NEMT had the highest complaint rate among PCS-MP's subcontractors. In response, the G&A Department will monitor overall complaint rates monthly and develop mitigation efforts to reduce missed NEMT member pick-up. PCS-MP will continue quarterly discussions with dental subcontractors and will initiate similar meetings with NEMT subcontractors. The first quarterly meeting with NEMT subcontractors will focus on a root cause analysis of late pick-up occurrences. Subsequent discussions will initiate 1-3 proactive interventions to ensure timely pick up to reduce complaint volumes.

In addition, PCS-MP will review complaints directly related to member communications. The G&A Department will update the language in these templates to focus on the members' perspective, education, cultural background, and language needs to reduce member frustration with the G&A process. They will also engage with the Community Advisory Council (CAC) to provide training on the G&A process.

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

Activity 1 description: PCS-MP will improve the Grievance and Appeals System by working with NEMT subcontractors to initiate interventions to ensure timely member pick-up. Activities 1 and 2 combined will result in a complaint rate reduction to 4 complaints per 1000 members overall in the PCS-MP-Marion and Polk (MP) region.

☐ Short term or ☒ Long term

Monitoring activity 1 for improvement: PCS-MP will use the monitoring tool and quarterly report to trend complaint rates from quarter to quarter. Data that will inform this trend will be complaint volumes categorized as: *A.l- Access* – NEMT not provided, late pick-up with a missed appointment, or no coordination of services. PCS-MP will target a 2% reduction in overall complaint volume each quarter.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
2020 baseline: 4.81 complaints per one thousand members. (Measurement includes all PCS-MP-MP member complaints, not just those related to NEMT.)	Conduct root cause analysis and implement interventions to address NEMT complaints and reduce the complaint rate per 1000 members.	06/2021	4 complaints per 1000 members (Measurement includes all PCS-MP-MP member complaints, not just those related to NEMT.)	04/2022

Activity 2 description: PCS-MP will improve the Grievance and Appeals System by reviewing member communications that result in grievances and initiate changes to the language in G&A templates. These changes will focus on member perspective, education, cultural background, and language needs to reduce member frustration with the appeals and grievance process.

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: PCS-MP will use current letter auditing and monitoring activities to elevate findings and initiate improvements. The G&A Department will evaluate improvement efforts monthly, based upon complaint volumes related to the following pre-existing category: *I.p- Interaction with Provider or Plan*: Plan explanation/ instruction inadequate/incomplete.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
2020 baseline: 4.81 complaints per 1000 members. (Measurement includes all PCS-MP member complaints, not just those related to member communications.)	Improved letter language that increases member understanding of appeals and grievance process Execute participation in community advisory council meetings and appeals and grievance training	06/2021	4 complaints per 1000 members (Measurement includes all PCS-MP-MP member complaints, not just those related to NEMT.)	12/2021

A. **Project short title**: Project 5: 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 or program

If continued, insert unique project ID from OHA: 191

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:**

Diabetes prevalence and its impact on health is an on-going concern in the Columbia Gorge region. Data presented in the 2019 Columbia Gorge Community Health Assessment indicates that "11% of Columbia Gorge adults are diabetic (2% higher than Oregon and Washington state rates)." Optimal disease management and prevention remain a top priority for PCS-MP, given the continued impact of diabetes across the state and in the Columbia Gorge.

A promising strategy for improving oral health for members with diabetes is through Oral Health Integration. One way to achieve this is to deliver dental services where the patient is receiving their primary care via teledentistry. Teledentistry is the coordination and delivery of dental care (diagnostic, preventative, and some treatment) using electronic, video, and audio technologies that transmit patient data to the remotely located treating dentist via a dental hygienist, who is physically with the patient. Using video conferencing and other live communication technologies, a live virtual visit between the patient, hygienist, and dentist can occur. Alternatively, dental providers can view patient information later in a "store-and-forward" visit.

This model has many benefits, such as reducing patient burden and abrasion, increasing care utilization, and reducing delivery system burden. In Oregon, comprehensive care delivery via co-located teledentistry is still emerging but is delivering promising results at piloted physical health locations treating diabetic patients. PCS-MP plans to continue working with Dental Care Organizations (DCOs) to expand the co-location of teledentistry to primary and specialty care clinics as a strategy for increasing dental utilization and interprofessional collaboration for the diabetic population.

In the latter part of the first quarter and during much of the second quarter of 2020, the COVID-19 pandemic led to access restrictions for most dental care offices. This significantly impeded PCS-MP Oral Health Integration Component activities. Efforts to increase dental care for diabetic members fell short of the 26.8% target, with just 22.9% of diabetic members receiving the qualifying dental exam.

CCO	MEASURE	NUM	DEN	RATE	Target	DIFF
Marion/Polk	Oral Evaluation - Diabetic	1,094	4,782	22.9	26.8	-3.9

Efforts to deploy the HIT technologies survey and initiate and increase co-located dental services to serve diabetic members were also not successful due to COVID-19 and other partner stakeholder challenges. However, PCS-MP created several assets to facilitate provider awareness and understanding of teledentistry, mobile dentistry, co-location, and integration that include:

- *Teledentistry FAQ for Physicians and Behavioral Health Providers*

- *Mobile Dentistry and Teledentistry Explained – a training slide deck for physicians and other care providers*
- *Oral Health Integration for Physicians FAQ*

In addition, PCS-MP successfully disseminated the *Dental Care for Diabetics* report to primary care providers. We also reconfigured the report for accuracy to address issues with continuous enrollment filters.

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

In 2020, PCS-MP aimed to leverage Value-Based Payment (VBP) strategies, dashboards, and monthly monitoring to increase the percentage of diabetic members who receive a comprehensive or periodontal exam. While PCS-MP completed the dashboard revision efforts, COVID-19 led to several dental clinic closures, which impeded progress towards dental exams for people with diabetes. As a result of COVID-19's impact on all care-related measures, OHA suspended the quality withhold arrangement with CCOs. Despite this, PCS-MP continued updating and sharing dashboards with DCOs, discussing the deployment of strategies for resuming care for people with diabetes through teledentistry and co-location and encouraging DCOs to continue member outreach to deliver care via telehealth or in clinic settings.

PCS-MP-MP also began disseminating the *Dental Care for Diabetics* report to primary care providers who receive the *Member Insight* Report to advance the integration of care and coordination. PCS-MP re-tooled this report to remove the continuous enrollment filter to include membership in new regions and programmed it for delivery alongside other reports via PCS-MP' provider portal.

Other efforts in promoting dental care delivery to the diabetic population via teledentistry and co-location with physical health provider clinics were successful. In 2020, PCS-MP created and deployed a dental integration activities log, which provided a baseline for current state diabetes co-location efforts. Additionally, PCS-MP created several informational guides on teledentistry, mobile dentistry, co-location, and Oral Health Integration to facilitate provider awareness and increase understanding. However, COVID-19 impacted progress on achieving at least one or more co-locations to serve diabetic members in the Marion-Polk region. DCOs are committed and ready to implement co-location programs given readiness and willingness by physical health providers. PCS-MP plans to include discussions about dental integration in meetings with physical health providers to promote interest in more specific conversations with DCOs about co-location possibilities.

Lastly, in 2020, PCS-MP-MP planned to survey providers across the region to understand the HIT technologies currently used to inform new technology adoption strategies supporting health information exchange and closed-loop referrals. However, the OHA suspended the deployment of this survey because of COVID-19. Regardless, PCS-MP has worked closely with the OHA to draw from currently available data to identify current-state baselines for adoption. PCS-MP has met with DCOs to discuss these baselines, the HIT Roadmap, OHA requirements, and strategies moving forward.

E. **Brief narrative description**:

In an effort to implement and improve Oral Health Integration, PCS-MP will continue using a VBP model to incentivize the delivery of dental care to members with diabetes. This work aligns with the quality incentive measure (QIM) addressing oral evaluations for diabetic members. It also continues tracking with the 2020 TQS strategy to use VBPs to incentivize each DCO to achieve performance improvement targets and, ultimately, the region's performance benchmark on this measure. The VBP strategy, in combination with monthly monitoring and sharing of measure dashboards and gap lists, will help drive continued progress.

PCS-MP will also promote the establishment and expansion of co-located teledentistry programs within physical health clinics to increase dental care utilization in the diabetic population. We support this endeavor by facilitating regular conversations with DCOs, sharing resources, hosting discussions encouraging integration (including co-location as appropriate) with physical health providers, and connecting interested physical health providers with DCOs to explore further options when needed.

Finally, PCS-MP will promote community HIE and HIT systems' adoption to enable interprofessional collaboration and care coordination between physical and dental providers. PCS-MP recently entered into a significant partnership with Unite Us (Connect Oregon) that over time will phase in access to PCS-MP' entire provider network across all CCO regions. The Unite Us platform offers closed-loop referral functionality to support social determinants of health (SDOH) service coordination. Throughout 2021, PCS-MP plans to collaborate with Unite Us to evaluate options for provider to provider closed-loop referrals. We desire to leverage our investment and partnership with Unite Us to solve provider care coordination and referral needs. Depending on what we discover, PCS-MP will shift efforts to support the DCOs and dental providers in adopting the Unite Us platform for SDOH and health care coordination referrals. PCS-MP will also research and evaluate other options such as Fast Healthcare Interoperability Resources (FHIR), Activate care, and Epic's Care Everywhere to best support existing, preferred provider to provider communication systems.

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

Activity 1 description: 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 activity 1 for improvement: 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 region overall: 22.9%	The CCO meets the CCO improvement target set by OHA.	12/2021	The CCO meets the CCO benchmark set by OHA.	12/2022

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 activity 2 for improvement: PCS-MP-MP will continue to utilize a regional DCO survey to capture co-located teledentistry programs in each region. Improvements to baseline will be monitored 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)

Baseline availability of co-located teledentistry programs serving the diabetic population is established using the tracking log data. Currently, there are 0 co-located teledentistry programs serving the diabetic population.	One or more co-located teledentistry programs are serving the diabetic population.	12/2021	Two or more co-located teledentistry programs are serving the diabetic population.	12/2022

Activity 3 description: Work with various internal and external regional stakeholders to research and explore platforms such as Unite Us, FHIR, Epic's Care Everywhere, and Activate Care that enable provider to provider care coordination and interprofessional collaboration. Depending on what is discovered, facilitate product awareness and connectivity by arranging demonstrations (as needed) of the platform to DCOs and interested dental providers.

☐ Short term or ☒ Long term

Monitoring activity 3 for improvement: The CCO will research and identify referral platform options best suited to meet the region's provider to provider communication needs. The CCO will track DCO adoption of platforms.

Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
0 platforms identified as suitable and capable options for dental provider/DCO to physical health provider referrals in the region.	One or more platforms identified as suitable and capable options for dental provider/DCO to physical health provider referrals in the region.	12/2021	Two or more platforms identified as suitable and capable options for dental provider/DCO to physical health provider referrals in the region.	12/2022
0 DCOs have adopted a referrals platform.	1 DCO has adopted a referrals platform.	12/2021	2 DCOs have adopted a referrals platform.	12/2022

A. **Project short title**: Project 6: Connect Oregon

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

If continued, insert unique project ID from OHA:

B. **Components addressed**

i. Component 1: Social determinants of health & equitySocial determinants of health & equitySocial determinants of health & equity

ii. Component 2 (if applicable): Health equity: Cultural responsivenessHealth equity: Cultural responsivenessHealth 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 itemChoose an itemChoose an item

C. **Component prior year assessment:**

The health care industry is reaching a tipping point of awareness on how social determinants influence a person's overall health, yet these social needs continue to remain largely undetected and unaddressed. In an effort to close this gap, a growing number of health centers, emergency departments, and health plans are beginning to screen their patients for Social Determinants of Health and Equity (SDOH-E). From this movement, models are emerging to support community-based referrals and navigation to help meet the health-related social needs of individuals and communities. PCS-MP aims to support this momentum by promoting standardized SDOH-E screening processes at a systems level and advancing infrastructure to reinforce connections between healthcare and community social needs services. To achieve this, we will focus our efforts on supporting a shared framework through screening tools, information sharing between clinical and social service agencies with shared populations, and utilizing best-practice methods for stratifying social risk.

In prior years, the Social Determinants of Health and Equity (SDOH-E) TQS project aimed to standardize SDOH-E screening processes at a systems level and advance infrastructure to reinforce connections between healthcare and community social needs services. Since the onset of this project, screening for SDOH-E has increased and become part of the standard process for Care Management (CM) staff and Member Support Specialists (MSSs). PCS-MP also collaborated with the CMS Accountable Health Communities (AHC) Study to share screening data and analyzed results to determine insights into members' needs.

In 2020, PCS-MP continued its work to address the SDOH-E by standardizing and increasing screenings, referral, and navigation services. PCS-MP has engaged in efforts to increase the number of members screened since 2019 and paired its results with the AHC Study's collective efforts. The MSS team received training from the OHSU Oregon Rural Practice-Based Research Network (ORPRN) on Clara Vistalogic platform. The Clara Vistalogic platform system provided MSSs with a screening tool, community resource summary, and navigation functionality. Throughout this pilot, we have seen a slight upward trend in screenings. In Marion and Polk counties, screenings increased by 2% since the pilot with AHC started in May. Nearly twelve hundred (1,177) members have been screened organization-wide. Of those, 176 screenings occurred through the pilot using Clara Vistalogic. The table below provides regional screening data:

Region	**2020 Total Results**	**Percent Increase with Clara Pilot**
Central Oregon	297	7.4%

Columbia Gorge	72	80%
Lane	481	24%
Marion Polk	327	2%
Total Screenings	1,117	14.9% (organization wide)

As part of the Clara Vistalogic pilot, MSSs provided members with a copy of a "Community Resource Summary." All members who screened positive for a social need received a Community Resource summary in Clara Vistalogic. In addition, if members indicated having two or more emergency department visits in the prior year, they were eligible for navigation services provided by our CM and MSS team. Across all regions, 25% of screened members were eligible for navigation services, and 63% of those members received navigation to a community resource.

Health Equity: Data was another component of our 2020 SDOH-E TQS. The tables below from the AHC Study show aggregated screening data and disparities in access to SDOH-E resources. In comparing our smaller sample of PCS-MP screenings with the larger AHC findings, we can see similarities in reported needs. PCS-MP analyzed internal screening, referral, and navigation data by demographic and risk strata. In addition, we collaborated with the OHSU's ORPRN to look at statewide trends in disparities related to social needs to inform Health Equity planning across all of PCS's CCO regions. AHC's screening data has been integrated into our Care Programs Initiation Algorithm, and is being used to develop data staging and integration with member risk profiles to inform case management workflows. In addition, "SDOH Dashboards" are being built into members profiles where MSSs and CM staff can see members' needs and associated REAL+D data. SDOH data is limited and work will continue to be done in this area for years to come.

Table 1: Unmet Needs by Race

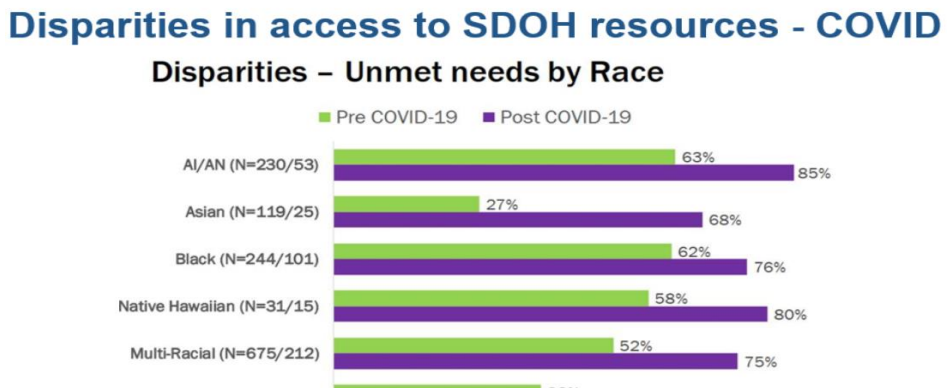
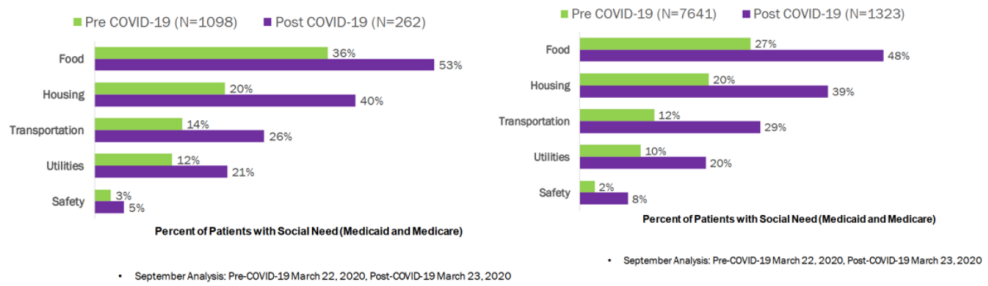


Table 2: Disparities in Hispanic Populations



- September Analysis: Pre-COVID-19 March 22, 2020, Post-COVID-19 March 23, 2020

In 2020, PCS-MP purchased Unite Us (aka Connect Oregon) as a Community Information Exchange (CIE) platform to implement within all PCS-MP regions. The shift to Unite Us will allow statewide coordination to connect members with community resources. Due to this change, resources shifted from connecting Clara Vistalogic to the preexisting Dynamo platform to planning and implementing Unite Us in 2021. PCS-MP plans to close out the previous SDOH-E TQS project and begin a new project focused on developing the provider network and onboarding community partners into Unite Us.

D. **Project context:**

Healthy People 2020 strategies to address SDOH-E include: 1) use of a health impact assessment to review needed, proposed, and existing policies, and 2) application of a "health in all policies" strategy, which introduces *improved health for all* and *closing of health gaps* as goals to be shared across all areas of government. In order to successfully implement a "health in all policies" approach, Healthy People 2020 goals promote working together to: 1) explore how programs, practices, and policies in these areas affect communities, 2) establish common goals, complementary roles, and ongoing constructive relationships between health sectors, and 3) maximize opportunities for collaboration among local-level partners related to social determinants of health.[1]

Connect Oregon advances and transforms the work that PCS-MP accomplished within the previous TQS project. It will allow PCS-MP to address systemic gaps with infrastructure by adopting a holistic approach to connect providers and community partners to an integrated statewide closed-loop referral system and Community Information Exchange (CIE.) Information is stored and transferred through a secure HIPAA- and CFR-compliant platform, allowing a secure way to share PII and PHI. This approach allows PCS-MP to embrace the 2020 Healthy People strategy "to maximize opportunities for collaboration among local-level provider and community partners."

Joining the Connect Oregon statewide network also improves continuity of care and services for transient members. The 2020 Oregon wildfires forced many community members to relocate and led to an increase in social needs. Connect Oregon is currently being implemented in thirteen Oregon counties and launching in ten more in 2021. Users can seamlessly support members across all regions. Connect Oregon also allows regional stakeholders, such as CCOs, to identify priority resources in building the local network. This contrasts with other CIEs that focus on statewide resources and do not lean upon local community leaders to build the local network. Connect Oregon gives a voice to regions in developing the local network and addresses buy-in and engagement barriers. It also promotes Health Equity: Cultural Responsiveness by ensuring that resources are truly available in the local service area and supports members with unique cultural and linguistic needs. Long term, Connect Oregon will allow regional network partners to identify redundancies and gaps in community service offered to inform future policy and funding opportunities.

The COVID-19 pandemic highlighted the need for referral systems to respond and evolve to address changing social needs rapidly. Connect Oregon allows local network partners to update their available resources in real-time, add programs as they become available (such as temporary COVID-19 assistance), and remove discontinued programs. Through statewide monitoring of health equity data, PCS-MP learned that social needs have increased across the board during the COVID-19 pandemic, but communities of color have been disproportionately affected (see Table 1). In particular, Hispanic and Latinx populations show an increased need for food security, housing, transportation, utilities, and safety (see Table 2). As we build the Unite Us regional network, we will address racial and ethnic health inequities by prioritizing resources that offer culturally and linguistically appropriate services. Our 2021 roadmap includes plans to

[1] Office of Disease Prevention and Health Promotion, (2020). Healthy People 2020-Social Determinants of Health. https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health

enhance Connect Oregon's reporting capabilities to include demographics such as race, ethnicity, and gender to enhance our ability to identify and address social need inequities.

E. **Brief narrative description**:

PCS-MP will work in partnership with community stakeholders to build the Connect Oregon network in each of its CCO regions to facilitate social need screenings, closed-loop referrals, and navigation to advance Social Determinants of Health and Equity. PCS-MP is exploring options on how to best incorporate screening and navigation for social needs into Connect Oregon. PCS-MP aims to build partnerships with organizations that meet its diverse membership's needs and promote *Health Equity: Cultural Responsiveness* by reaching out to local culturally responsive organizations and inviting them to join the network.

This project will address the community engagement requirements for the SDOH-E component in the following ways:

In 2020, PCS-MP educated members of the Community Advisory Committee (CAC) and Clinical Advisory Panel (CAP) on TQS requirements and provided information about all TQS projects. Both groups survey completed a survey and selected three projects of interest to focus on. Both CAP and CAC members selected the SDOH-E project. Since then a SDOH-E workgroup comprised CAP and CAC of members formed in Marion and Polk counties. This group will provide quarterly consultation on the Connect Oregon network build out.

The network build out is also informed by Kaiser Permanente's Community-Clinic Integration Initiative (CCI) grant. Recipients include: Catholic Community Services, Centro Latino Americano, Family Building Blocks, Farmworkers Housing Development Corporation, Marion-Polk Food Share, Boys & Girls Club of Salem, Mid-Willamette Valley Community Action Agency, Northwest Senior and Disability Services, and the Oregon Marshallese Community Association.

Unite Us hosts Community Strategy Sessions each month for local community-based organizations to learn more about joining Connect Oregon. Organizations are invited to a quarterly Community of Practice meeting to share experiences, network, and learn with other Connect Oregon users from around the state. Unite Us and PCS-MP will be hosting bi-weekly introductory presentations and onboarding sessions for in-network providers interested in joining the network.

PCS-MP also worked to incorporate community feedback into TQS projects for *Health Equity Cultural: Responsiveness* and *Social Determinants of Health: Equity*. In fall 2019 and winter 2020, PCS-MP conducted targeted listening sessions, one-on-one interviews, and public forums to collect qualitative data from the community to inform our health equity efforts. OHP members, health care providers, social service providers, local health departments, and community members attended the listening sessions. The feedback we gathered helped inform our CIE planning, including the need for providers and the CCO to offer:

- Support for members experiencing housing instability, food insecurity, transportation needs, and other social needs. The Connect Oregon platform is designed to support SDOH-E by facilitating referrals to existing community resources.
- Increase access to culturally and linguistically responsive resources. As we build the network, PCS-MP will make focused efforts on inviting community-based organizations that support specific cultural groups.
- Support trauma-informed care. Connect Oregon supports a trauma-informed approach by focusing on members' consent and offering a PHI-secure, HIPAA- and CFR-compliant portal. This reduces the need for members to repeat their story, which can be re-traumatizing.

At the local level, two advisory boards guide this work:

	Community Network Advisory Board (CNAP)	**Local Network Implementation Advisory Board**
Launch	2021	2020
Purpose	• Represent the voice of the community in network decision-making • Provide input on network health, network standards, assessment tools, and quality or performance issues.	• Build the network by identifying community resources • Support community engagement and implementation activities • Provide input on initial network configurations
Membership	The CNAP is comprised of key community-based organizations representing social service needs.	The Local Network Implementation Advisory Board is comprised of funding partners, Unite Us staff, and at least one representative from the CNAP (once this body forms.) Current partners include: **Marion and Polk** Unite Us, PCS-MP, the Willamette Health Council, Kaiser Permanente and Samaritan Health.

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

Activity 1 description Social Determinants of Health & Equity: PCS-MP will work with community partners to expand a regional community information exchange (CIE) network made up of providers, CCO CM and MSS staff, local health departments, and community based organizations (CBOs.) Connect Oregon will allow closed-loop referrals across sectors to meet the SDOH needs of CCO members.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: PCS-MP will monitor CIE network growth through the Connect Oregon dashboard and tableau reporting.

Baseline or current state	**Target/future state**	**Target met by (MM/YYYY)**	**Benchmark/future state**	**Benchmark met by (MM/YYYY)**
2020: 11 Marion and Polk CBOs joined the Connect Oregon network.	Promote the value of joining Connect Oregon with CBOs.	12/2021	An additional 20 CBOs will join the network.	12/2021
2020: 2 Marion and Polk providers joined the Connect Oregon network.	Promote the value of joining Connect Oregon with provider partners.	9/2021	20 additional providers will join the network.	12/2021

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

☒ Short term or ☐ Long term

Monitoring activity 2 for improvement: PCS-MP will monitor the number of CBOs that offer culturally and linguistic services, and join the Connect Oregon network through connected dashboards and tableau reporting.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
2 Marion/Polk CBOs joined the Connect Oregon network and specialize in supporting members with culturally and diverse needs (in the Micronesian community.) In 2020, the Oregon Marshallese Community Association made 6 referrals in the Connect Oregon network. In 2020, no Marion/Polk based CBOs in Connect Oregon specialized in supporting the Latinx community.	Establish additional partnerships with organizations that serve the social needs of cultural and linguistic members. PCS-MP will make efforts to prioritize partnerships with organizations that support the Latinx community.	3/2021	20 clients are referred for services to or from organizations that supports members' cultural and linguistic needs.	12/2021

A. **Project short title**: Project 7: Utilization of Direct Access to Care

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

If continued, insert unique project ID from OHA: 193

B. **Components addressed**

i. Component 1: Utilization review
ii. Component 2 (if applicable): Special health care needs
iii. Component 3 (if applicable): Serious and persistent mental illness
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:**

The 2020 project for Direct Access to Care aimed to identify opportunities to enhance support for members with Serious and Persistent Mental Illness (SPMI) and better understand the under- and over-utilization of direct access to specialty care for members with Special Health Care Needs (SCHN). PCS- made advancements to monitor, track, and trend under- and over-utilization by creating an algorithm to identify members with Intensive Care Coordination (ICC) needs, including members with SPMI and SCHN by creating flags in its medical platform.

Historically, there is a significant overlap in our prioritized populations identified for Intensive Care Coordination (ICC) services among members with SHCN and SPMI. As outlined in OAR 410-141-3870, a prioritized population includes members identified as having complex or high health care needs, multiple or chronic conditions, SPMI, or receiving Medicaid-funded Long-term Care Services and Supports (LTSS). Therefore, PCS-MP uses the prioritized population definition, and more broadly, the ICC population, to evaluate the utilization of specialty care services for members with SHCN and SPMI.

PCS-MP data indicates that behavioral health (BH) utilization has increased year over year. A higher percentage of members receive BH services each year, and they receive more services on average than prior years. This increase has been driven by several factors, including removing referral requirements to move toward an open access model. While this increased utilization is positive, it does not conclude that all BH needs are currently being met. There could still be unmet needs in each region, and continued monitoring of BH services in combination with member input on access to BH care will be important.

Additionally, when filtering down the Emergency Department utilization rate to members with at least one behavioral health condition, we see that they have a much higher rate compared to members without a diagnosed behavioral health condition. More than 40% of members with a BH condition tend to have an ED visit each year, compare to 20 to 25% of members without a BH condition. On average, the ED utilization rate among members with a BH condition has been approximately 190% higher than the rate among members without a BH condition. This warrants further monitoring to determine if access to BH care among members with BH conditions plays any role in increased rate of ED utilization.

PCS-MP aims to increase equitable access to skilled and coordinated care between specialty care and the broader health system while decreasing barriers to ensure adequate care and positive health outcomes for those we serve. Members who belong to prioritized populations, such as those with SHCN or SPMI, often fail to receive the proper specialized health care they need to manage their conditions. PCS-MP is currently working on a mechanism to track the utilization of specialty care services specific to the ICC population. Until this is complete, the Care Management Department attempts to contact all members identified for ICC services via letter and telephonically to engage in services. In doing so, members receive education on the benefits of ICC, including direct access to specialty services.

D. **Project context:**

In 2019, PCS-MP focused on working directly with clinics to enhance workflows to reduce Emergency Department (ED) utilization among members with Serious and Persistent Mental Illness (SPMI). In the Columbia Gorge, we identified the Mid-Columbia Center for Living (MCCFL) and One Community Health (OCH), which is a fully integrated primary care clinic, to pilot workflows using Health Information Technology (HIT) to impact ED utilization among the SPMI population. PCS-MP made considerable progress in fulfilling the goals identified in this project. Though we did not fully complete all of the objectives by the end of 2019, we were able to accomplish our goal to support MCCFL and OCH in developing a shared workflow and standardizing how they respond to the information they receive from HIT.

In 2020, PCS-MP partnered with the Eliza Health Engagement Management system to provide initial outreach to ICC members, while the PCS-MP Care Management (CM) team developed workflows to enhance care coordination and outreach. When CM identifies SPMI or SHCN members during the Utilization Management (UM) Review process for Behavioral Health Acute Inpatient Stay, the Behavioral Health Utilization Management (BH UM) team provides a referral to the Behavioral Health Care Management team (BH CM.) The BH UM team also provides a referral for new members (and re-triggered members) to the BH CM Team.

PCS-MP also developed the ICC Report to identify Medicaid members with SPMI and SHCN and generate a gap list for automated member outreach through Eliza. PCS-MP first sends the gap list to Eliza, which triggers an automated call to all ICC members, followed by an option of a warm hand-off to Member Support Services (MSS) for case management services. MSS completes ICC intake screenings and then determines a member's ICC score based on SDOH needs, ED utilization, substance use, and identified ICC flags. PCS-MP uses this score to determine the level of care a member needs. If the member's needs are significant, CM and MSS can connect members to a Behavioral Health Clinician (BHC).

PCS-MP intended to use the ICC Report to monitor members' utilization of direct access to specialists. However, challenges arose with defining members with SPMI and SHCN because of complexities when integrating multiple data sources. Further analysis showed that PCS-MP could not use the ICC Report for analytical purposes to track, trend, or monitor under- and over-utilization or data comparison against other sources.

Additional project barriers arose with the onset of COVID-19, which affected members' ability to access specialty providers due to office closures. The COVID-19 Provider Relief Plan from PCS-MP also removed all referral requirements for members' access to specialty care. The goal was to increase equitable access to skilled and coordinated specialty care by removing the barrier of referrals. However, this action forced the project team to re-assess how to continue monitoring direct access to specialists.

E. **Brief narrative description**:

In January 2021, PCS-MP created a direct access benefit that removed the requirement for members to obtain referrals prior to accessing specialty care services. Although this initially posed a barrier to the project's measurement, the change has provided an opportunity to pivot our approach to measure the impact direct access has on specialty care and Emergency Department (ED) utilization. This project proposes that removing the referral requirement will create a quicker and more efficient process for members to seek specialty care, leading to increased specialty care utilization. Furthermore, we anticipate that higher utilization of specialty care services amongst SPMI and SHCN populations will reduce ED utilization.

To track and analyze the ED and specialty care utilization ratio amongst SPMI and SHCN members, PCS-MP will develop an improved reporting system to identify members with SPMI and SHCN accurately. The Analytics team will then develop a retrospective report that shows the ratio of ED visits to specialty care visits amongst members identified as SPMI or SHCN. After creating enhanced reporting, we will identify high ED utilization members specifically. High ED utilization is defined as three visits in the past three months or six visits in the past six months. PCS-MP will use this enhanced reporting to monitor the ratio of ED and specialty care utilization over time among members with SPMI or SHCN who are traditionally high ED utilizers.

Once the ratio reporting is complete, the Analytics team will create a list of members identified as SPMI or SHCN that also show under-utilization of specialty care services. Our Care Management (CM) team will use this list to provide direct

outreach to members in order to identify any barriers they are experiencing and assist them in accessing care. Through this effort, we hope to increase specialty care utilization and improve the quality of care for the SPMI and SHCN population.

Lastly, in an effort to improve the under-utilization of specialty care services, PCS-MP will create a multi-media campaign to educate members and providers on the new direct access benefit that enables members to schedule specialty care visits without needing to obtain a referral.

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

Activity 1 description: To address the under-utilization of specialty care services for SPMI and SHCN, PCS-MP will educate members and providers on the direct-access benefit that removes the referral requirement for members to access specialty care.

☒ Short term or ☐ Long term

Monitoring activity 1 for improvement: PCS-MP will ensure that members have increased access to specialty services by educating members and providers on the direct access benefit. CM and UM teams will monitor feedback from providers to determine if the benefit change helps increase access to specialty services.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
A multi-media approach has not been created to educate providers on the new direct access benefit	Provider communication will be sent through multiple media channels to educate providers on the new direct access benefit	05/01/2021	PCS-MP will document provider feedback with the referral process and identify barriers and action steps toward process improvement	12/31/2021
A multi-media approach has not been created to educate members on the new direct access benefit	Care Management and other member-facing departments will be trained to educate members about the new direct access benefit	05/01/2021	PCS-MP will identify and execute additional multi-media opportunities for educating members on the new direct access benefit	12/31/2021

Activity 2 description: To address over-utilization of the ED and improve the quality of care for members with SPMI or SHCN, PCS-MP will develop an improved reporting system to track, trend, and analyze the relationship between ED and specialty care utilization for this population.

To address the under-utilization of specialty services, PCS-MP will create a list of SHCN and SPMI members with low specialty care utilization and high ED utilization to provide direct member outreach and assistance.

☐ Short term or ☒ Long term

Monitoring activity 2 for improvement: PCS-MP will identify members with SPMI and SCHN flags to monitor ED utilization trends in relation to members' utilization of specialty care visits. PCS-MP will also create a list of members with SPMI or SHCN to monitor the under-utilization of specialty care services and provide patient outreach from CM.

Baseline or current state	Target/future state	Target met by (MM/YYYY)	Benchmark/future state	Benchmark met by (MM/YYYY)
CCO does not currently have a ratio report showing ED and specialty care utilization for members with SPMI or SHCN	A retrospective report is created for ED and specialist office visit utilization for the defined population.	06/30/2021	CCO reviews YTD reporting to establish a baseline and improvement targets to increase specialty care utilization and decrease ED utilization.	12/30/2021
CCO does not have a list of SPMI and SHCN members with low specialty care utilization who may be experiencing barriers to access	CCO identifies a list of members with SPMI and SHCN with low specialty care utilization who may be experiencing barriers to access	06/30/2021	CM will utilize list to provide direct member outreach to assist members in accessing specialty care.	12/30/2022

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: SDOH Screening Referral and Navigation
B. Project unique ID (as provided by OHA): 192
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 2020, PCS-MP purchased Unite Us, referred to as Connect Oregon at the state and local level, as the Community Information Exchange (CIE) platform to implement within all its CCO regions. The shift to Unite Us will allow more coordinated statewide efforts to connect members with community resources. Due to this change, resources shifted from connecting Clara Vistalogic to the preexisting Dynamo platform to planning and implementing Unite Us in 2021. PCS-MP plans to retire the previous SDOH-E TQS project and begin a new project focused on implementing and developing the provider network and community partners for Unite Us. PCS-MP also acknowledges the feedback from the 2020 project and the importance of having an SDOH-E project that is community informed. Connect Oregon embraces a more holistic approach to patient engagement, and allows more opportunities to address needs at the community level.

Section 3: Required Transformation and Quality Program Attachments

A. REQUIRED: Attach your CCO's Quality Improvement Committee documentation (for example, strategic plan, policies and procedures as outlined in TQS guidance).
B. OPTIONAL: Attach other documents relevant to the TQS components or your TQS projects, such as policies and procedures, driver diagrams, root-cause analysis diagrams, data to support problem statement, or organizational charts.
C. OPTIONAL: Describe any additional CCO characteristics (for example, geographic area, membership numbers, overall CCO strategy) that are relevant to explaining the context of your TQS: Add text here.

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 (PCS) CCO members' rights, to discuss the methods PCS 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), PCS 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;
- PCS 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;
- PCS 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;

- PCS 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). PCS 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.
- PCS will notify members of their responsibility for paying a Co-Payment for some services as specified in OAR 410-120-1230;
- PCS 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 PCS receives notice of the member's enrollment from OHA or for members who are Fully Dial Eligible, within the time period required by Medicare. PCS 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; PCS 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 PCS, 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 PCS or 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 PCS 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 PCS employees. PCS 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

PCS 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. PCS sends the member the PCS Member Handbook, which includes the member rights. The member rights are also available on the PCS 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, PCS 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

PCS 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:** 7/1/2021

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
06/19/20	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*

Admin Policy

This Policy outlines the requirements and actions of PacificSource Community Solutions (PCS) 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, PCS 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) PCS 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) PCS 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. PCS 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 PCS's health promotion or education activities may not constitute an attempt by PCS to influence a client's enrollment.

(4) PCS 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 PCS to influence client enrollment:

(a) Communication to notify dual-eligible members of opportunities to align PCS 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) PCS 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) PCS 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 PCS 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 PCS's member/customer service unit;

(c) Be made available in alternative formats upon request of the member at no cost. Auxiliary aids and services must also be made available upon request of the member at no cost.

(9) Electronic versions of member materials, including provider directories, formularies, and handbooks shall be made available prominently on PCS's 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 PCS's website, the member is informed that the information is available in paper form without charge upon request, and PCS shall provide it upon request within five business days.

(10) PCS provider directories shall include:

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

(b) Street address;

(c) Telephone number;

(d) Website URL, as appropriate;

(e) Provider Specialty, as appropriate;

(f) Whether the provider will accept new members;

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

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

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

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

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

(h) The provider directory must include the information for each of the following provider types covered under the contract, as applicable to PCS's 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 PCS receives updated provider information. Updated materials shall be available on PCS's 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) PCS 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 PCS receiving notice of a member's enrollment, PCS shall mail a welcome packet to new members and to members returning to the PCS 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 PCS members, PCS shall notify members annually of the availability of a member handbook and provider directory and how to access those materials. PCS shall send hard copies upon request within five days.

(13) PCS shall facilitate materials as follows:

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

(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 PCS. Written and spoken language preferences are indicated on the Oregon Health Plan application form and reported to plans in 834 enrollment updates. PCS 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) PCS 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) PCS 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) PCS'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 PCS'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 PCS'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 PCS 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 PCS's 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) PCS'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 PCS 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) PCS's confidentiality policy;

(bb) How and where members may access any benefits that are available under OHP but are not covered under PCS's contract, including any cost sharing;

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

(dd) PCS 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 PCS's internal changes. If changes affect the member's ability to use services or benefits, PCS shall offer the updated member handbook to all members;

(ee) The "Oregon Health Plan Client Handbook" is in addition to PCS's member

handbook, and PCS 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 self-care, and disease and accident prevention. PCS providers or other individuals or programs approved by the PCS may provide health education. PCS 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 PCS 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) PCS 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) PCS 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 PCS participating providers. PCS 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 PCS 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 PCS develops 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) PCS 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 PCS, members, and providers.

Appendix

Policy Number: [Policy Number]

Effective: [Effective Date] **Next review:** [Next Review Date]

Policy type: **Admin**

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

Medicaid Grievance and Appeal System – Notice of Adverse Benefit Determination

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

Admin Policy

This policy outlines the requirements and actions of how PacificSource Community Solutions (PCS) 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) PCS'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 PCS has made an adverse benefit determination, PCS shall notify the requesting provider and give the member and the member's representative a written notice of adverse benefit determination (NOABD). The notice shall:

(a) 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 PCS'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.

(b) 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 PCS Service Authorization or otherwise specified in this rule;

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

(A) Date of the notice;
(B) PCS'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 PCS has made or intends to make, including whether the PCS 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 PCS 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 PCS's adverse benefit determination with PCS, including information on exhausting PCS'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 PCS's Appeal Notice of Resolution or where PCS 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 PCS 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) PCS shall provide copies of the following forms when PCS 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, PCS 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) PCS may mail the notice no later than the date of adverse benefit determination if:

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

(B) PCS receives notice that the services requested by the member stating are no longer desired or PCS 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 to a member under this section shall be in writing, clearly indicated so 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 PCS 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) PCS can verify that the member has been admitted to an institution where the member is no longer eligible for OHP services from PCS;

(D) PCS is unaware of the member's whereabouts and PCS 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) PCS 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) PCS must mail the notice five days before the adverse benefit determination when PCS:

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

(B) PCS 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, PCS 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 PCS up to 14 additional days, if:

1) The member, member's representative or provider requests an extension; or
2) PCS justifies to OHA upon request a need for additional information and how the extension is in the member's best interest. PCS 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 PCS 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, PCS 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) PCS 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) PCS justifies to OHA upon request a need for additional information; and
3) How the extension is in the member's interest.
PCS must provide its justification for any request to OHA, via Administrative Notice, upon request.

(8) If PCS meets the criteria to extend the 14 calendar day NOABD timeframe for expedited 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], PCS 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 PCS's adverse benefit determination is upheld; or if PCS fails to adhere to the notice and timing requirements in 42 CFR 483.408, the Authority may consider PCS appeals process exhausted.

Timing of NOABD for Outpatient Drugs

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

Participating Providers and Subcontractors

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

PCS 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 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.

PCS 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

PCS 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

Effective: [Effective Date] **Next review:** [Next Review Date]

Policy type: **Admin**

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

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 (PCS) 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 PCS, 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) PCS’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 PCS 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 PCS to make an authorization decision;
(f) “Member.” With respect to actions taken regarding grievances and appeals, 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 PCS 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) PCS 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 PCS 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 PCS adverse benefit determination once the plan has issued a written notice of appeal resolution under the Administrative Procedures Act;
(d) An explanation of how PCS 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 PCS’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) PCS 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) PCS 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 PCS (or at the direction of PCS) 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 PCS that complies with OAR 410-141-3915 and is consistent with contractual requirements.

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

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

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

(a) OHP Complaint Form (OHP 3001);
(b) PCS 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 Authority's Ombudsperson or hearing representatives, PCS, 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.

(13) If at the member's request PCS 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.

A) The member withdraws the appeal or request for state fair hearing.

B) The member does not request a state fair hearing and continuation of benefits within 10 calendar days from the date the MCE sends the Notice of Appeal Resolution letter.

C) A state fair hearing decision adverse to the member is issued.

(14) Adjudication of appeals in a member grievance and appeals process may not be delegated to a subcontractor. If PCS delegates any other portion of the grievance and appeal process to a subcontractor, PCS 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 PCS or the Authority. If the grievance is filed with the Authority, it shall be promptly forwarded to PCS.

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

(a) Within five business days from the date of PCS'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 PCS's receipt of the grievance, notify the member in their preferred language that there shall be a delay in PCS's decision of up to 30 days. The written notice shall specify why the additional time

is necessary.

(3) PCS 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 PCS's decision, PCS:

(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, PCS 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 Department of Human Services (Department) Client Services Unit or the Authority's Ombudsperson.

(5) In compliance with Title VI of the Civil Rights Act and ORS Chapter 659A, PCS 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 PCS 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, PCS shall log the grievance and work with the receiving or sending MCE to ensure continuity of care during the transition.

(7) PCS must allow Members to file a grievance (after receiving notice that an adverse benefit determination is upheld). PCS 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) PCS 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) PCS shall not discourage any Member from using any aspect of the Grievance and Appeal System. Nor shall PCS:

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, or a subcontractor or provider with the member's written consent, may file an appeal with PCS to:

(a) Express disagreement with an adverse benefit determination; or

(b) Contest PCS'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, subject to the following requirements:

(a) PCS shall ensure the member is informed that they must file in writing unless the individual filing the appeal requests expedited resolution.

(b) PCS is considered to have satisfied this duty if PCS has already made attempts to assist the member in filling out the necessary forms to file a written appeal

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

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

(a) If PCS fails to adhere to the notice and timing requirements in 42 CFR § 438.408, the member is considered to have exhausted PCS's appeals process. In this case, the member may initiate a contested case hearing;

(b) PCS may extend the timeframes from section (3) of this rule by up to 14 days if:

(A) The member requests the extension; or

(B) PCS 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 PCS extends the timeframes but not at the request of the member, PCS 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 PCS for review of a notice.

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

(a) PCS shall ensure oral requests for appeal of a notice are treated as appeals to establish the earliest possible filing date, and unless the member requests an expedited resolution, the member shall follow an oral filing with a written, signed, and dated appeal;
(b) The member shall file the appeal with PCS no later than 60 days from the date on the notice.

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

(a) PCS and the member; or
(b) PCS and the member's provider.

(8) PCS shall resolve each standard appeal in time period defined above in section (4). PCS 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 PCS or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, PCS 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 PCS 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, PCS 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 PCS 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 PCS'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) PCS 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) PCS 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, PCS shall complete the review of the expedited appeal in a timeframe that is no longer than 72 hours after PCS receives the appeal. PCS 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) PCS 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 PCS extends the timeframes not at the request of the member, PCS 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.
C) Resolve the appeal as expeditiously as the member's health condition requires and no later than the date the extension expires.

(4) If PCS provides an expedited appeal but denies the services or items requested in the expedited appeal, PCS 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.

(5) If PCS denies a request for expedited resolution on appeal, PCS shall:

(a) Transfer the appeal to the timeframe for standard resolution in accordance with OAR 410-120-1860;
(b) Make reasonable efforts to give the member and requesting provider prompt oral notice of the denial and follow up within two days with a written notice.

Contested Case Hearings Requirements

(1) PCS shall have a system in place to ensure its members and providers have access to appeal for PCS'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 PCS'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 PCS and receiving written notice that PCS 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 PCS'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, PCS shall submit the required documentation to the Authority's Hearings Unit within two business days of the Authority's 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 PCS, and if the request does not satisfy section (3) below, the Authority shall transfer the request to PCS and provide notice of the transfer to the member. PCS shall:

(A) Review the request immediately as an appeal of PCS'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 PCS after PCS has already completed the initial plan appeal, PCS shall:

(A) Date-stamp the hearing request with the date of receipt; and
(B) Submit the following required documentation to the Authority within two business days:

(i) A copy of the hearing request adverse benefit determination, and notice of appeal resolution;
(ii) All documents and records PCS 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, PCS fails to adhere to the notice and timing requirements in 42 CFR § 438.408, the Authority may consider the member to have exhausted PCS's appeals process for purposes of requesting a contested case hearing, as provided in OAR 410-141-3890(3). The Authority shall notify PCS 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 PCS member contested case hearing requests.

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

(a) PCS and the member; or
(b) PCS and the member's provider.

(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 PCS receives the member's request for appeal. The 90-day count does not include the days between the date PCS 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 PCS or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, PCS 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 PCS 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, PCS or the state shall pay for those services in accordance with the Authority policy and regulations

Expedited Contested Case Hearings

(1) PCS shall have a system in place to ensure its members and providers have access to expedited review for PCS'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 PCS, subject to the exception in OAR 410-141-3900(3). When a member files a hearing request prior to completion of a PCS 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) PCS shall submit relevant documentation to the Authority within two working days. The Authority shall decide within two working days 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 PCS, and PCS 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 shall complete a PCS 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) In determining timeliness, delay for good cause as defined in OAR 137-003-0528 is not counted;
(c) The benefits shall continue until:

(A) Unless the member requests a contested case hearing with continuing benefits, no later

than 10 days following the date of PCS notice of appeal resolution, a final appeal resolution resolves PCS appeal;
(B) A final order resolves the contested case;
(C) The time period or service limits of a previously authorized service have been met; or
(D) 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 PCS or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, PCS 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 PCS 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, PCS or the Authority shall pay for those services in accordance with the Authority policy and regulations.

Grievance and Appeals System Recordkeeping

(1) PSCPCS 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) PSCPCS 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.

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

(4) PSCPCS 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 PCS contract.

(5) The PSCPCS 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 PSCPCS's 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

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: [Effective Date] **Next review:** [Next Review Date]

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

Member Responsibility Policy

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

Government Policy

Member Responsibilities

PacificSource Community Solutions (PCS) 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 PCS member handbook, and OAR 410-141-3590:

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

• To choose a primary care provider (PCP).

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

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

• To treat PCS 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 PCS 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

PCS 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 PCS plan.

Procedure: Marketing and Communications and Regulatory Communications

PCS 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 PCS website. Not less than once a year, PCS 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:** 3/15/2020

Policy type: Government

Author(s): i:0#.w|pacificsource\e1003

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
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 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 TQS Steering Committee, 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 is a means by which PacificSource Community Solutions (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 Transformation and Quality Strategy (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 Transformation and Quality Strategy (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) and Medicaid Leadership Team (MLT) 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. Through this process, a TQS Steering Committee was chartered to include a diverse group of people from multiple departments with specific expertise. Starting in 2019, each appointee to the steering committee holds a defined role, including project manager, project development coordinator, state liaison, component manager, IT/analytics feasibility manager, and TQS report compliance manager. Each project within the TQS has an assigned project lead who is responsible for the planning, design, and implementation of the project.

   ii. The TQS is composed of projects that are representative of the CCO's activities related to health care transformation and quality. The TQS Steering Committee utilized 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
      8. 2019 TQS Progress Report

   Utilizing these sources, the TQS Steering Committee identifies a short list of potential projects for inclusion in each year's TQS. This list, including 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. The TQS Steering Committee synthesizes the information gathered from these internal and external stakeholders and begins working with project leads to fully define each project. Once drafted, the projects undergo thorough review by the TQS Steering Committee, MLT, and the EMG 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 Steering Committee 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 the development and implementation of 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. MLT oversees the TQS Steering Committee and provides 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, with a progress report due in September. The progress report is an evaluation of progress on individual project goals and activities, reflecting the time from January to June of the plan year. In addition to this mid-year evaluation, PacificSource completes a year-end report to evaluate the effectiveness in meeting project outcomes and deliverables. The progress report and year-end report is a way for PacificSource to evaluate its effectiveness in areas of transformation and quality improvement. Performance on the progress report and the year-end report inform the following year's TQS projects and quality initiatives.
   ii. The QIC and the CQUM Committee review and approve the TQS progress and year-end reports annually, and offer guidance on improvement strategies and defining the following year's goals. The TQS Steering Committee meets to review the progress and year-end reports 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, all CCOs are expected to participate in a statewide Performance Improvement Project 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, two PIPs of the CCO's choosing, and one focus study. 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, internal QIM Steering Committee and QIM Improvement Team 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 Facilitators 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, PCS 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:** 8/31/2021

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 410-141-0200; OAR 410-141-3200

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 citings and updated processes.