Oregon Health Authority

2019 CCO Readiness Review

for

AllCare

September 2019

Interim Report

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Overview

Background

Oregon Health Authority (OHA) contracted with Health Services Advisory Group, Inc. (HSAG), to conduct Coordinated Care Organization (CCO) Readiness Reviews (RRs) in accordance with the federal Medicaid managed care regulations as set forth under 42 Code of Federal Regulations (CFR) §438.66(d). RRs are designed to evaluate a successful applicant's ability to perform the operational requirements of the CCO contract by the contract effective date. The assessment will determine whether the applicant has the resources, capacity, and systems in place to meet federal and State regulations, as well as contractual requirements.

Methodology

The CCO RRs were conducted in two review phases: (1) Critical Areas Readiness Review and (2) Operations Policy Readiness Review. High-priority functions, those that directly impact a member's ability to access healthcare services, were included in the Phase 1 review. Medium-priority functions, those for which a corrective action plan with clear milestones and deadlines would be appropriate for phased implementation and least likely to directly impact member access, are to be included in the Phase 2 review that will be conducted immediately following the Phase 1 review.

Table 1-1—Readiness Review Activities and Timing

Activity	Timing
Readiness Review Instructional Session	July 10, 2019
Documentation Submission	August 5, 2019
Desk review, remote sessions, and reporting of findings from Phase 1—Critical Areas Readiness Review	August 2019 – September 2019
Desk review, follow-up, and reporting of findings for Phase 2—Operations Policy Readiness Review	September 2019 – November 2019
Technical Assistance to CCOs	December 2019

HSAG developed a review process designed to assess the ability and capacity of each CCO to satisfactorily perform the contract requirements applicable to key functional areas, excluding financial management. HSAG's process included a comprehensive desk review of CCO policies, procedures, and processes; key informant interviews; and information system demonstrations. In developing the data collection tools for reviewing documentation related to the standards, HSAG used the Centers for Medicare & Medicaid Services' (CMS') regulations specified by the federal Medicaid managed care

final rule published November 1, 2018, and select OHA CCO 2.0 contractual requirements. RRs do not assume that all processes must be fully implemented at the time of review. Therefore, HSAG assigned one of the following ratings to each element in the RR Tool:

- **Complete**—The CCO has processes defined, documentation developed, roles and responsibilities assigned, and systems in place.
- **Progress Sufficient to Start Operations**—The CCO's management personnel, committees, or other governing bodies have developed or approved strategies, systems, and supporting structures; but processes require further development in order to successfully implement the program by the anticipated start date. (Recommendations may exist.)
- **Incomplete**—The CCO's systems and processes do not exist, and planning or development has been minimal to date. (Action required.)

Phase 1—Critical Areas Readiness Review

The RR for Phase 1 consisted of a policy and procedure review, as well as a review of the program structure and organizational infrastructure. Specifically, Phase 1 of the RR included:

- A thorough desk review of high-priority functions that impact member care.
- An interactive full-day remote session where key management personnel were interviewed.
- A demonstration of the CCOs' health information systems.
- An analysis of the capacity of the CCOs' individual and facility/service provider network.

Below is a summary of the standards reviewed during the Phase 1 RR. Each standard included elements against which the CCOs were reviewed. There was a total of 93 elements reviewed across the Phase 1 standards.

1. Subcontractual Relationships and Delegation—Delegated functions, subcontracts, and oversight procedures.
2. Coverage and Authorization of Services—Key policies and procedures, decision processes and procedures, authorization systems, and monitoring and reporting capabilities.
3. Grievance and Appeal System—Key policies and procedures, decision processes and procedures, grievance systems, and monitoring and reporting capabilities.
4. Enrollment and Disenrollment—Key policies and procedures for processing and managing member enrollment, and enrollment systems.
5. Availability of Services—Key policies and procedures, network monitoring processes, and reporting.
6. Assurance of Adequate Capacity and Services—Preliminary Delivery System Network (DSN) submissions.

7. Health Information Systems—Key policies and procedures and critical information system demonstrations (i.e., authorization, grievance, enrollment, provider, care coordination, claims, and claims processing).
8. Coordination and Continuity of Care—Key policies and procedures, care coordination decision processes, and monitoring and reporting capabilities.

Phase 2—Operations Policy Readiness Review

The RR for Phase 2 consisted of a desk review conducted immediately following completion of the RR Phase 1 review and included an assessment of the CCO's operational readiness. Below is a summary of the standards reviewed during the Phase 2 RR.

1. Administrative Staffing and Resources—CCO staffing plan, organizational charts, and level of resource documentation
2. Member Information—Key member/provider materials (e.g., member handbook, provider directory, and formulary) and processes to meet language and format requirements
3. Member Right and Protections—Key policies and procedures and advanced directives
4. Provider Selection—Key credentialing policies and procedures and contracting processes
5. Confidentiality—Key policies and procedures
6. Program Integrity—Key policies and procedures and monitoring processes
7. Governance and Accountability—Governance structure and responsibilities (e.g., narrative, organizational charts, committee charters, etc.)
8. Practice Guidelines—Key policies and procedures and review of clinical guidelines

Results

This report documents results of the Phase 1—Critical Areas Readiness Review and (pending completion of Phase 2 of the RR) Phase 2—Operations Policy Readiness Review for AllCare, beginning on page 2-1 and 3-1, respectively. Each Results section also contains summaries of the findings relative to the CCO's general readiness to comply with federal and State regulations and CCO contractual requirements.

Detailed findings can be found in appendices A through C. Appendix A includes the completed Phase 1 RR Tool containing reviewer findings as well as recommended and required actions for improvement. Appendix B addresses the CCO's capacity to deliver required services. Appendix C (pending completion of Phase 2 of the RR) includes the completed Phase 2 RR Tool containing reviewer findings as well as recommended and required actions for improvement.

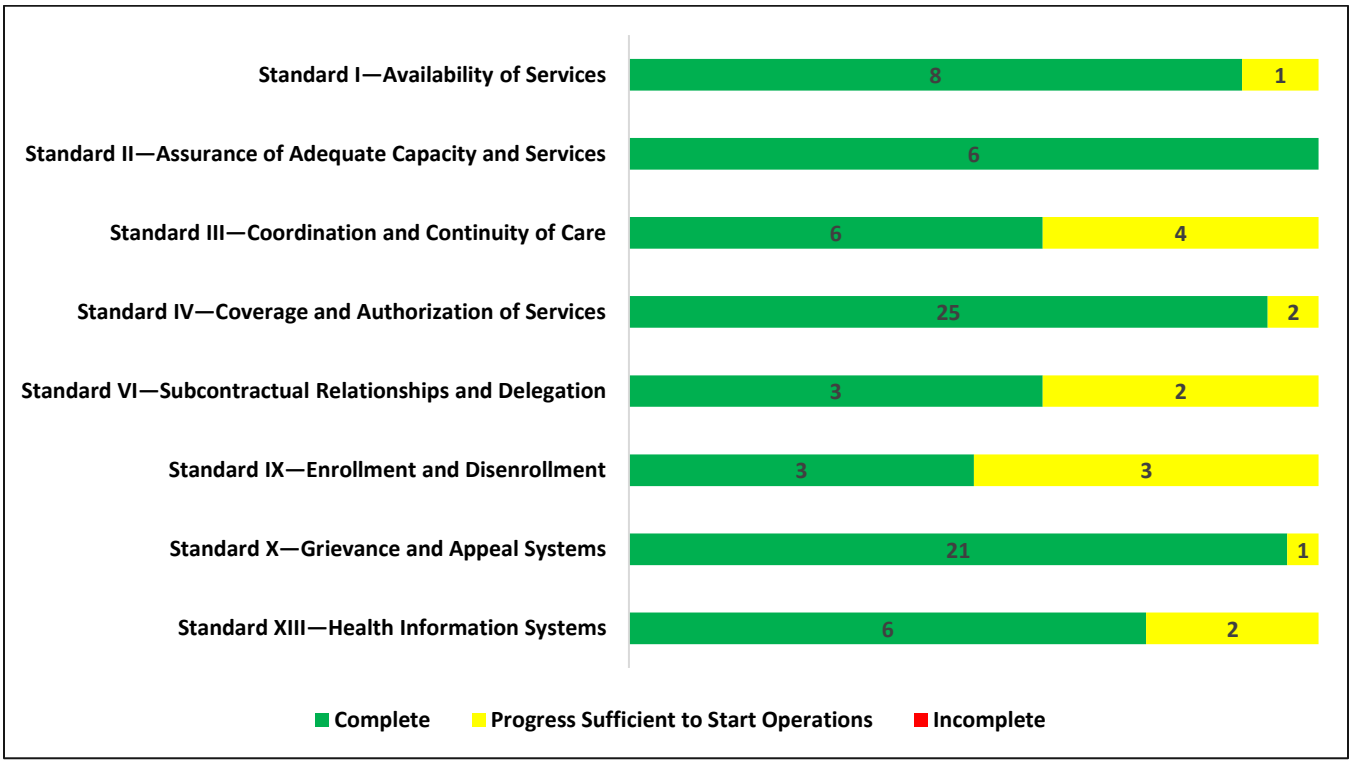
2. Phase 1 Results

Across all eight standards, AllCare's overall percentage of complete elements is 82.8 percent. The CCO demonstrated:

- *Complete* ratings for 77 of the 93 total elements.
- *Progress Sufficient to Start Operations* ratings for 16 elements across eight standards.
- *Incomplete* ratings for zero elements across the eight standards, indicating areas of greater deficiency. These areas *require action* to ensure readiness prior to providing services.

For elements resulting in *Progress Sufficient to Start Operations* or *Incomplete* ratings, HSAG provided guidance to the CCO on specific actions required to fully meet these elements. Required actions are provided in the attached Phase 1 RR Tool under each of the deficient elements.

Figure 2-1—AllCare Phase 1—Critical Areas Readiness Review Results



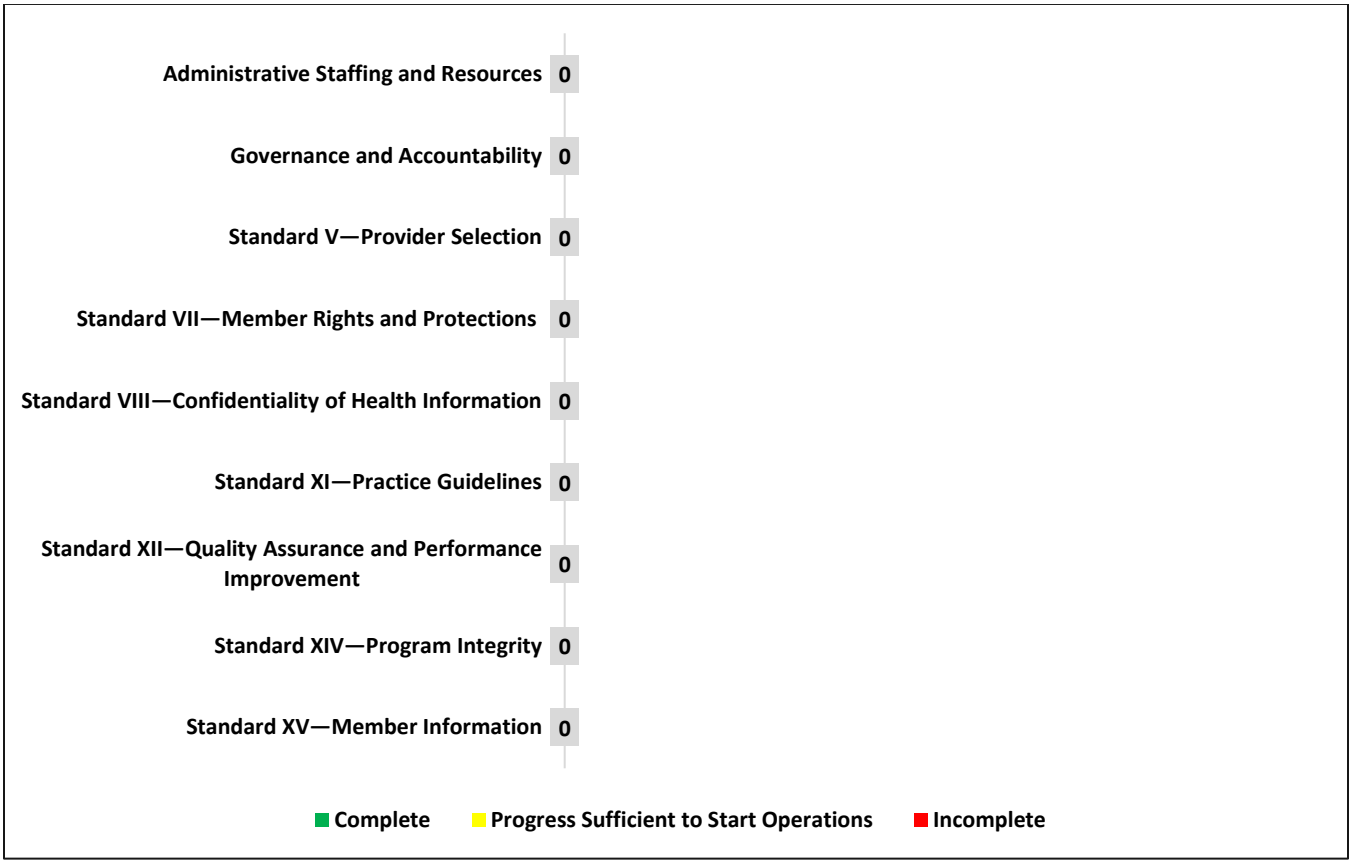
3. Phase 2 Results

At the time of this report, Phase 2 of the RR is still in progress.

Across all eight standards, AllCare's overall percentage of complete elements is XX.X percent. The CCO demonstrated:

- *Complete* ratings for the XX of the XX total elements.
- *Progress Sufficient to Start Operations* ratings for XX elements across nine standards.
- *Incomplete* ratings for XX elements across nine standards, indicating areas of greater deficiency. These areas *require action* to ensure readiness prior to providing services.

Figure 3-1—AllCare Phase 2—Operations Policy Readiness Review Results



Appendix A. Phase 1 Evaluation Tool

Following this page is the completed readiness review Phase 1 tool HSAG used to evaluate AllCare's performance for each requirement.

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. The CCO provides all covered services specified in the contract and as required by 42 CFR §438.206: a. The CCO has written policies and procedures to ensure that all services covered under the State plan are available and accessible to members in a timely manner. *42 CFR §438.206(a)* *Contract: Exhibit B Part 4 (2)*	AllCare CCO currently and will continue to provide all OHP covered services to our members. AllCare CCO's written policies and procedures ensure that all covered services are available and accessible to members in a timely manner, as outlined in the UM CCO 134 benefit policy- attached here as **Q1-UM CCO 134 Benefit policy-ACCCO.docx**, page 2. Per the **Q1-Delivery Service Network Policy CCO – ACCCO.PDF** page 2, to comply with State and Federal requirements for oversight and monitoring of services, the AllCare CCO contracts department will submit to each subcontracted partners the templated form for submitting provider data. Though this spreadsheet is based upon the OHA Delivery Service Network (DSN) form, AllCare CCO will have additional criteria added that is required of the subcontracted partners to comply with other contract requirements. The additional criteria are related to hours of operation, appointment wait times, and ADA accessibility. AllCare CCO will submit changes to delegates with a 30 day notice of changes to the report. To comply with State and Federal requirements, a 30 days' notice may not always be given. The DSN form is to be sent to contracts@allcarehealth.com and credentialing@allcarehealth.com no later than 5:00 pm on the first Friday of each month.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	AllCare CCO uses the information to cross reference this data with the current population in each zip code to show the Providers per 1,000 members for each specialty. See **Q1-Network Adequacy Policy, -ACCCO.** Page2, Paragraph 2 (ii). Evidence of these reviews is provide in the agenda **Q1-Agenda 4272018-ACCCO.pdf** and minutes **Q1-Minutes 4.27-ACCCO.pdf** this set of minutes and agenda was selected specifically for the documentation of opening and closing panels from previous meetings. AllCare has a sufficient Network of Providers in the entire service area. Some zip codes have an over saturation of specific provider types. As seen in these reviews it is related to Ancillary Services. Sample reports presented to the committee: **Q1-Quarter2-2019-Network Capacity-PCP-File-JXCO.xlsx,** "Network Tab" is evidence for Jackson County. 99.35% of Jackson County members are within 10 miles of a PCP. 20,000 additional lives can be added to AllCare's panel and still meet the CCO's requirement of 1.7 providers per 1,000. **Q1-Quarter2-2019-Network Capacity-PCP-File-JOCO.xlxs**,"Network Tab" is evidence for Josephine County. 91.534% of Josephine County members are within 10 miles of a PCP. 15,000 additional lives can be added to AllCare's panel and still meet the CCO's requirement of 1.7 providers per 1,000. **Q1-Quarter2-2019-Network Capacity-PCP-File-CUCO-xlxs**,"Network Tab" is evidence for Curry	

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	County. 93.04% of Curry County members are within 10 miles of a PCP. 2,000 additional lives can be added to AllCare's panel and still meet the CCO's requirement of 1.7 providers per 1,000.	
2. The CCO maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract (inclusive of non-emergent medical transportation, alternative therapies [e.g., acupuncture, chiropractic medicine, massage, yoga], and access to traditional health care workers) for all members, including those with limited English proficiency, physical or mental disabilities, or special health care needs. *42 CFR §438.206(b)(1)* *Contract: Exhibit B Part 4 (3)(a)(1)*	Per the **Q2-Delivery Service Network Policy CCO ACCCO.pdf,** page 2, to comply with State and Federal requirements for oversight and monitoring of services. The AllCare contracts department will submit to each delegated entity, and facility the templated form for submitting provider data. Though this spreadsheet is based upon the OHA Delivery Service network form, AllCare will have additional criteria added that is required of the delegate or facility to comply with other contract requirements. AllCare will submit changes to delegates with a 30 day notice of changes to the report. To comply with State and Federal requirements, 30 days' notice may not always be given. This is to be sent to contracts@allcarehealth.com and credentialing@allcarehealth.com no later than 5:00 pm on the first Friday of each month. AllCare uses the information to cross reference this data with the current population in each zip code to show the Providers per 1,000 members for each specialty. See **Q2-Network Adequacy Policy, -ACCCO.pdf**, Page2, Paragraph 2 (ii). Evidence of these reviews: **Q2-Agenda 4272018-ACCCO.pdf** and **Q1-Minutes 4.27-ACCCO.pdf**. This set of minutes and agenda was	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	selected specifically for the documentation of opening and closing panels from previous meetings. AllCare has a sufficient Network of Providers in the entire service area. Some zip codes have an over saturation of specific provider types. As seen in these reviews it is related to Ancillary Services. Sample reports presented to the committee: **Q2-Quarter2-2019-Network Capacity-PCP-File-JXCO,xlxs** "Network Tab" is evidence for Jackson County. 99.35% of Jackson County members are within 10 miles of a PCP. 20,000 additional lives can be added to AllCare's panel and still meet the CCO's requirement of 1.7 providers per 1,000. **Q2-Quarter2-2019-Network Capacity-PCP-File-JOCO.xlxs,** "Network Tab" is evidence for Josephine County. 91.534% of Josephine County members are within 10 miles of a PCP. 15,000 additional lives can be added to AllCare's panel and still meet the CCO's requirement of 1.7 providers per 1,000. **Q2-Quarter2-2019-Network Capacity-PCP-File-CUCO.xlxs,** "Network Tab" is evidence for Curry County. 93.04% of Curry County members are within 10 miles of a PCP. 2,000 additional lives can be added to AllCare's panel and still meet the CCO's requirement of 1.7 providers per 1,000. For the purposes of this analysis, AllCare estimates that the maximum visits per year that an Interpreter can provide is 960. The industry standard for the billable time that it takes an Independent Interpreter to provide	

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	services is a two (2) hour minimum. It was also assumed that Interpreter worked an eight (8) hour day and was able to take four (4) weeks of vacation in the year. AllCare's Median Visits per year for a Limited English Proficient (LEP) speakers was 3.8 per year. These two factors were used to develop the standard of 3.96 interpreters per 1,000 LEP individuals. Please see **Q2-Interpreter FTE calculation-ACCO.xlxs** for these calculations. To ensure that members with physical disabilities have access ADA accessibility is also reviewed as part of these calculations. <u>Non-Emergent Medical Transportation</u> AllCare CCO maintains a contract with its NEMT provider to ensure AllCare CCO members have access to NEMT services **Q2-SupportingDocument_NEMT_Contract_ACCCO.pdf**. The duration of this contract will be amended to parallel the duration of AllCare CCO's contract with the Oregon Health Authority (contract amendments to extend the contract duration are not included). Due to the nature of this service, it is not feasible to contract with more than one direct provider. It is imperative to look at past records and patterns to project expected transportation (capacity) needs. Thus, AllCare CCO will continue to monitor its NEMT provider monthly, quarterly, and annually based on the above mentioned contract in particular Exhibit C, section 14 and 15 to ensure adequate capacity. AllCare CCO continually monitors utilization numbers and	

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	requires the NEMT provider – if warranted – to adjust its fleet or arrangements with subcontractors accordingly. AllCare CCO will continue using the following utilization metric to ensure future capacity needs are met. Please note in the Operations Summary Graphs **Q2-SupportingDocument_Operations Summary_Graph_2018-2019-ACCCO.pdf** on page two, the lines titled: % Utilization Rate. The NEMT provider has a robust infrastructure in place and has the capacity to serve any increase in ridership as needed. The NEMT provider has its own fleet of vehicles and also has ready access to numerous specialized NEMT subcontractors with amble capacity. Pressures due to increased utilization are mitigated since almost 50% of all rides are provided through public transportation and mileage reimbursements to members who either use their own vehicle or obtain rides from a friend or family member. The NEMT provider also entertains a relationship with a not-for-profit organization that utilizes volunteers to provide rides to AllCare CCO members. The operations summary functions as the annual capacity report **Q2-SupportingDocument_Operations Summary_2018-ACCCO.pdf**. The monthly operations summary report **Q2-SupportingDocument_Operations Summary_June-2019-ACCCO.pdf** and the operations summary graph **Q2-SupportingDocument_Operations Summary_Graph_2018-2019-ACCCO.pdf** are	

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	received by AllCare CCO monthly and assist with the ongoing monitoring of capacity and access. During the quarterly quality meetings the team reviews stats and trends (the above mentioned reports) **Q2-SupportingDocument_Minutes 04242019-ACCCO.pdf.** Every month, AllCare CCO receives audit reports comprised of a myriad data points **Q2-SupportingDocument_NEMT_Audit_Report_ACCCO.pdf**, which provide oversight on how the NEMT provider renders services to AllCare CCO members (due to instructions with regard to PHI, only the column titles are provided in the above mentioned report). The comment section (last column) of this report shows how the NEMT provider accommodates members, including those with limited English proficiency, physical or mental disabilities, or special health care needs. E.g., mbr is blind, call her to let her know you are there; mbr has special needs and cannot get in/out of small car; women driver only – put in front seat – do not ask any questions at all …; mbr needs to sit in front – gets carsick; mbr is deaf; mbr has seeing eye dog (Howie); **minor** father is blind will be the attendant, travels with guide dog.	
3. The CCO provides female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the female member's designated	AllCare CCO allows female member's choice without restriction to directly access an AllCare's network of women's health providers. AllCare CCO Claims Department policy includes a monitoring process to ensure this benefit is appropriately applied. This is AllCare CCO's current process and will continue	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
source of primary care if that source is not a woman's health specialist. *42 CFR §438.206(b)(2)* *Contract: Exhibit B Part 4 (2)(m)*	through 2020 and beyond. This is outlined in these policies: • The AllCare CCO Claims Department Specialty Providers authorization and referral policy. Attached **Q3-Speciality Providers Authorization and Referral Policy-ACCCO.DOCX**, page 1; • The AllCare CCO Utilization Management UM CCO 134 OHP Benefit Policy. Attached as **Q3-UM Benefit Policy-ACCO.docx**, pages 4, 5; • Please see our attached General Care Coordination Policy- **Q3-General Care Coordination Policy-ACCCO.docx**, Pages 4 and 7; • Please see our attached Care Coordination Policy: Maternal Child and Health Policy-**Q3-Maternal Child Policy-ACCCO.docx**, Pages 2-4. Information for direct access to care for female health is also included in the current Member Handbook as well as our 2020 draft. • Screen shot attached as Q3-Female Access-Member Handbook 2020-ACCCO.png	☐ NA
HSAG Findings: The CCO's Specialty Providers Authorization and Referral policy indicated that routine women's health and preventive healthcare services do not require a referral or authorization; however, the member handbook stated that follow-up services for women's health and preventive healthcare services require a primary care provider referral. During the interview, AllCare staff members confirmed that the policy correctly identifies its approach to providing women's health and preventive healthcare services.		

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Required Actions: HSAG recommends that the CCO revise its member handbook to ensure consistency with its Specialty Providers Authorization and Referral policy.		
4. The CCO has a mechanism to allow members to obtain a second opinion from a network provider or arrange for the member to obtain one outside the network, at no cost to the member. *42 CFR §438.206(b)(3)* *Contract: Exhibit B Part 4 (2)(n)*	AllCare CCO allows members to obtain a second opinion from in-network or out-of-network at no cost to the member. This is AllCare CCO's current process and will continue through 2020 and beyond. This is outlined in these policies: • The AllCare Utilization Management policies: UM CCO 105 Enrollee Rights – Second Opinion, attached as **Q4-UM Second Opinion Policy-ACCCO.docx** pages 1 & 3 and UM CCO 106 Out of Network, attached as **Q4-UM Out Of Network Policy-ACCCO.docx** page 1 • Also attached are training and sign-in sheet for the UM Second opinion policy. Attached as **Q4-Second Opinion UM Training-ACCCO.pdf** and **Q4-Second Opinion UM Training sign-in sheet-ACCCO.pdf** • Please see our attached Care Coordination policy: Special Needs Policy. **Q4-Special Needs Policy-ACCCO.docx** Policy Section 9 (page 4), Desk Procedure 3iii (page 6) • Please see our attached General Care Coordination Policy**. Q4-General Care Coordination Policy-ACCCO.docx** Policy Section 10b. Second opinion access is included in the current Member Handbook as well as our 2020 draft.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• See attached Q4-Second Opinion Member Handbook 2020 screenshot-ACCCO.png	
5. If the CCO is unable to provide medically necessary covered services to a particular member using contract providers, the CCO shall adequately and timely cover these services for that member using non-contract providers for as long as the CCO's provider network is unable to provide them. a. The CCO shall coordinate payment with out-of-network providers and ensure that the cost to the member is no greater than it would be if services were provided within the network. *42 CFR §438.206(b)(4-5)* *Contract: Exhibit B Part 4 (4)(g)*	It is the policy of AllCare CCO, to ensure adequate and equitable coverage to members enrolled in AllCare. That all services covered under the OHA plan are available and accessible to members in a timely manner. This policy applies to all AllCare First Tier, Downstream, and related entities. If the provider network is unable to provide necessary services, covered under the contract, to a particular Member. AllCare shall adequately and timely cover these services out of network for the Member. AllCare's Contracting team will establish Letters of Agreement in these cases and ensure the cost to the Member is no greater than it would be if the services were furnished within the network. **Q5. AllCare Network Adequacy Policy-ACCCO.pdf**, section 5. Please see **Q4-LOA_template_11.doc**, page 1, as it is standard language in AllCare's template that "Per OAR 410-120-1280, member cannot be billed for services or treatments that have been denied due to provider error (i.e. required documentation not submitted)." The provider is to look solely to AllCare for payment. Also see the UM out-of-network policy AllCare CCO provides out of network services at no cost to the member. Attached as **Q5-UM Out Of Network Policy-ACCCO.doc** pages 1-3	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
6. The CCO demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services: a. In accordance with 42 CFR §431.51(b)(2), members shall not be restricted in freedom of choice of providers of family planning services. b. Therefore, members are permitted to self-refer to any provider for the provision of family planning services, including those not in the CCO's network. *42 CFR §431.51(b)(2)* *42 CFR §438.206(b)(7)* *Contract: Exhibit B Part 2 (6)(b)*	AllCare CCO covers self-referring for family planning services to in and out of network Providers. This is AllCare CCO's current process and will continue through 2020 and beyond. Policies as outlined below: • The AllCare CCO Claims Department Specialty Providers authorization and referral policy. Attached **Q6-Speciality Providers Authorization and Referral Policy-ACCCO.DOCX** page 1 • The AllCare CCO Utilization Management UM CCO 134 OHP Benefit Policy. Attached as **Q6-UM CCO 134 Benefit Policy-ACCCO.docx** pages 1,4,5 • Please see our attached General Care Coordination Policy- **Q6-General Care Coordination Policy-ACCCO.docx** Policy Section #10 (page 4), Desk Procedure #1 (#7) (page 7). • Please see our attached Care Coordination Policy: Maternal Child and Health Policy- **Q3-Maternal Child Policy-ACCCO.docx** Section 5(a)i, Desk Procedure 3g (pages 2-3) Information for direct access to care for family planning services is also included in the current Member Handbook as well as our 2020 draft. • Screen shot attached as Q6 Family Planning-Member Handbook.png	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
7. The CCO ensures its provider network observe the timely access to services provisions and complies with the following requirements: a. Meet and require its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. b. Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid Fee for Service (FFS), if the provider serves only Medicaid enrollees. c. Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary. d. Establish mechanisms to ensure compliance by network providers. e. Monitor network providers regularly to determine compliance. f. Take corrective action if there is a failure to comply by a network provider. *42 CFR §438.206(c)(1)* *Contract: Exhibit B Part 4 (2)(a)* *Contract: Exhibit B Part 4 (13)(b)(3), (4)*		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		
8. The CCO demonstrates that its network includes sufficient specialty behavioral health providers to ensure timely access to covered specialty behavioral health services for the following priority populations in accordance with the timeframes below,	Narrative answers with documentation: • AllCare currently reviews and will continue to review and assess all policies and procedures pertaining to Access, Prioritized	☒ Complete ☐ Progress Sufficient to Start Operations

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
with access prioritized in accordance with OAR 309-019-0135 and 410-141-3220. a. If a timeframe cannot be met due to lack of capacity, the member must be placed on a waitlist and provided interim services within 72 hours of being put on a waitlist. Interim services should be as close as possible to the appropriate level of care and may include referrals, methadone maintenance, compliance reviews, HIV/AIDS testing, outpatient services for substance use disorder, risk reduction, residential services for substance use disorder, withdrawal management, and assessments or other services described in OAR 309-019-0135. b. Pregnant women, veterans and their families, women with children, unpaid caregivers, families, and children ages birth through five years, individuals with HIV/AIDS or tuberculosis, individuals at the risk of first episode psychosis and the I/DD population: Immediate assessment and intake. If interim services are necessary due to capacity restrictions, treatment at appropriate level of care must commence within 120 days from placement on a waitlist. c. IV drug users: Immediate assessment and intake. Admission required within 14 days of request, or, if interim series are necessary due to capacity restrictions, admission must commence within 120 days from placement on a waitlist. d. Opioid use disorder: Assessment and intake within 72 hours. e. Medication assisted treatment: No more than 72 hours for assessment and induction, with efforts to do such as soon as possible.	Populations and/or Provision of Culturally and Linguistically appropriate services at time of all contracted behavioral health provider reviews. (See **Q10-BH Review Outline-ACCCO.pdf**, pages 1). • AllCare CCO created a new policy to better outline these prioritized populations and timelines to share with BH providers so they are aware of AllCare's expectations around ensuring access for these members. See **Q10-BH Access Policy-ACCCO.pdf** , pages 2-5. • Furthermore, AllCare conducts an onsite interview with providers and their staff at time of review where we request additional information about how they operationalize and internally monitor these access and triage processes. (See **Q10-BH Review Outline-ACCCO.pdf**, pages 3). • AllCare CCO will continue the above interventions and will also work to develop new processes and/or tools to assess whether specialty BH providers have screening mechanisms in place to identify, prioritize, provide timely service and report to the CCO on these specified populations. This will also include development of a new process for notifications from providers when members are added to a waitlist for specialty behavioral health services.	☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
f. Children with serious emotional disturbance: Any limits that the Authority may specify in the contract or in guidance. g. Routine behavioral health care for other populations: Seen for an intake assessment within seven days from date of request, with second appointment within 14 days and 4 appointments (including the second appointment) within 48 days. Appointments must be therapeutic in nature and expand beyond administrative activities. *Contract: Exhibit B Part 4 (2)* *Contract: Exhibit M*	Please also see the AllCare CCO Care Coordination policies: • General Care Coordination Policy. Attached as **Q8-General Care Coordination Policy-ACCCO.docx** Section Desk Procedure #5 (page 7). • Maternal Child Health Policy. Attached as **Q8-Maternal Child Policy Policy-ACCCO.docx** Section Desk Procedure 3d (page 4). • Special Needs Policy. Attached as **Q8-Special Needs Policy-ACCCO.docx** Section Desk Procedure 3c (page 6).	
9. The CCO has written policies and procedures that ensure scheduling and rescheduling of member appointments are appropriate to the reasons for and urgency of the visit. The member shall be seen, treated, or referred within the following timeframes: a. *Well care:* Within four (4) weeks from the date of a patient's request. b. *Urgent care:* Within seventy-two (72) hours or as indicated in the initial screening for urgent care. c. *Emergency care:* Immediately or referred to an emergency department depending on the member's condition. d. *Emergency oral care:* Seen or treated within twenty-four (24) hours. e. *Urgent oral care:* Within one (1) to two (2) weeks or as indicated in the initial screening.	AllCare CCO has no barriers to Well Care. We monitor Primary Care access through our quarterly surveys that populate our Directories. In that survey, we ask for Time to Next Appointment. We then monitor those responses for outliers. We reach out to those providers who have longer than acceptable wait times. AllCare CCO has no barriers to urgent or emergency care. Treatment in an Urgent or Emergency Care Facility does not require any authorization from AllCare CCO. The treating provider and/or facility does not need to be part of the AllCare CCO network for coverage. AllCare CCO does not place any limit on what constitutes an emergency medical condition. • Please see attachment **Q9b & c- UM Emergency and Post Stabilization Services-**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
f. *Routine oral care:* Within eight (8) to twelve (12) weeks, or the community standard, whichever is less. g. *Non-urgent behavioral health treatment:* Seen for an intake assessment within two (2) weeks of the request. *42 CFR §438.206(c)(1)(i)* *Contract Exhibit B Part 4 (2)(a)*	**ACCCO.docx** for our policy around urgent and emergent services for 9b, 9c, and 9d. We have no barriers to Emergency or Urgent Oral Care. We have some barriers to Routine Oral Care. We reach out to our oral health providers on a routine basis to partner in improving wait times for members. If barriers are identified, we work with the dental organization to recruit more oral health providers, work with the organization to improve access or engage the organization in a corrective action plan. • Please see attached policy: Q9-Oral Health Timely Access to Care-ACCCO.docx We have no barriers for Non-Urgent Behavioral Health Treatment. We actively work with our providers to ensure access for all levels of urgent and non-urgent care. • Please see attached Policy: **Q9g-BH Access-ACCCO,** Page 3. Please also see the AllCare CCO Care Coordination policies: • General Care Coordination Policy. Attached as **Q9-General Care Coordination Policy-ACCCO.docx** Section Desk Procedure #1 (#5) page 7. • Maternal Child Health Policy. Attached as **Q9-Maternal Child Policy Policy-ACCCO.docx** Section Desk Procedure 3d page 4.	

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Special Needs Policy. Attached as **Q9-Special Needs Policy-ACCCO.docx** Section Desk Procedure 3c page 6	
10. The CCO participates in the State's efforts to promote the delivery of services 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. These efforts must ensure that members have access to covered services that are delivered in a manner that meet their unique needs. *42 CFR §438.206(c)(2)* *Contract: Exhibit B Part 4 (4)(e)*	Per **Q10-Equity Training and Education Policy-ACCCO.pdf** Yearly the Health Equity Manager will work with the Training and Education Work Group to develop a training and education plan with community input on: (a) Implicit bias/addressing structural barriers and systemic structures of oppression; (b) Language access (including the use of plain language) and use of Health Care Interpreters, including without limitation, the use of Certified or Qualified Healthcare and American Sign Language interpreters. (c) The use of CLAS Standards in the provision of services. (d) Adverse childhood experiences/trauma informed care practices that are culturally responsive and address historical trauma; (e) Uses of REAL+D data to advance health equity, (f) Universal access and accessibility in addition to compliance with the ADA; and (g) Health literacy. All AllCare employees, including directors, executives, are required to participate in all such trainings. Before a training is approved it must reviewed by The Training and Education Work Group shall review to be aligned with the components of a cultural competence	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	curriculum set forth by OHA's Cultural Competency Continuing Education criteria listed on OHA's website. AllCare's current scoring tool is provided **Q10-Weighted-Scoring-Sheet-ACCCO.xls** AllCare is currently in the process of finalizing the 2020 trainings and cannot submit the completed training and education plan until September 1st. Evidence of training activities that the 2020 plan will be modeled after are outlined in the following attachments: **Q10 2017-18 Health Equity Training Schedule-ACCCO.pdf**, **Q10 2018-19 Health Equity Training Schedule-ACCCO.pdf**, **Q10-Barriers to care-ACCCO.pptx**, **Q10-ACHHC-Health Equity Training Flyer-WEB-ACCCO.pdf, Q10-Social determinants of health-ACCCO.pptx, Q10-Health Literacy new-ACCCO.pptx** Examples of how AllCare has used REAL+D data to advance health equity is made public in each years Health Equity Strategic Plan. AllCare's Quality Measures are stratified by REAL+D identifiers **Q10-2019ACHHC-HealthEquityPlan-Final-ACCCO.pdf,** Appendix G. To access Interpreter services please see **Q10-2019ACHHC-Accessing Interpreter Services-FINAL-ACCCO.pdf** and the **Q10-ACHHC-Medical Interpreters Directory List-4.24.19-PQACCCO.pdf** this is also outlined in **Q10-Barriers to care-ACCCO.pptx**	

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Q10-DIRECT PROVIDER AGREEMENT TEMPLATE-C.Section 33-ACCCO.docx, Outlines the contract requirement of this.	
11. The CCO ensures that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities. *42 CFR §438.206(c)(3)* *Contract: Exhibit B Part 4 (3)(a)(2)(e)*		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		

Standard I- Availability of Services	
	Total #
Complete	**8**
Progress Sufficient	**1**
Incomplete	**0**
Not Applicable (NA)	**2**

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. The CCO submits documentation to the State, in a format specified by the State, to demonstrate that it complies with the following requirements: a. Offers an appropriate range of preventive, primary care, specialty services, that is adequate for the anticipated number of enrollees for the service area. b. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. *42 CFR §438.207(b)(1-2)* *Contract: Exhibit G*	Answers for both a and b: AllCare CCO, currently complies with federal and state Provider network Standards by submitting a DSN Provider Capacity Report on July 1st of every year, and every year thereafter. We also provide a new DSN report when there is a significant change to our network. Participating Providers, whether employed by or under subcontract with AllCare CCO, or paid fee-for-service, must have agreed to provide the described services, or items, to Medicaid and Fully Dual Eligible CCO members to be included in the DSN Provider Capacity Report. An inventory of the provider and facility types that must be included in the DSN Provider Capacity Report is in the **Q1-Delivery Service Network Policy-ACCCO.PDF** pages 2-16. Proof of AllCare's network adequacy is also attached (see Q1-2019 DSN Report Final Allcare(7312019Update)-ACCCO.XLSX). Per the Delivery Service Network Policy (see **Q1-Delivery Service Network Policy-ACCCO.PDF**, page 2), to comply with State and Federal requirements for oversight and monitoring of services, the AllCare Contracts Department submits to each delegated entity and facility, a form that mirrors the State Delivery Service Network form required for submitting provider data. Though this form is based upon the State form, AllCare will include additional	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	criteria that is required of the delegate or facility to comply with other contract requirements. AllCare will submit changes to delegates with a 30 day notice of changes to the report. However, to comply with State and Federal requirements, 30 days' notice may not always be given. The delegates will send their DSN reports to contracts@allcarehealth.com and credentialing@allcarehealth.com no later than 5:00 pm on the first Friday of each month. AllCare uses both internal data and provider provided data to reconcile with our records. We then cross-reference the current member population within each zip code. This is to show the Providers per 1,000 members for each specialty by region (see **Q1-Network Adequacy Policy-ACCCO.PDF** Page2). Based on the Network Adequacy report, the Contracts Manager makes a Quarterly recommendation to AllCare's Medical Directors to close/open new contracts for specific specialties within each zip code. Sample reports that are presented to the committee: **Q1-Quarter2-2019-Network Capacity-PCP-File-JXCO-ACCCO.XLSX** "Network Tab" is evidence for Jackson County. 99.35% of Jackson County members are within 10 miles of a PCP. 20,000 additional lives can be added to AllCare's panel and still meet the CCO's requirement of 1.7 providers per 1,000.	

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Q1-Quarter2-2019-Network Capacity-PCP-File-JOCO-ACCCO.XLSX "Network Tab" is evidence for Josephine County. 91.534% of Josephine County members are within 10 miles of a PCP. 15,000 additional lives can be added to AllCare's panel and still meet the CCO's requirement of 1.7 providers per 1,000. Please note that the zip codes in Douglas County are part of the service area because those members seek care in Josephine County and thus are covered under the Josephine county DSN report. **Q1-Quarter2-2019-Network Capacity-PCP-File-CUCO-ACCCO.XLSX** "Network Tab" is evidence for Curry County. 93.04% of Curry County members are within 10 miles of a PCP. 2,000 additional lives can be added to AllCare's panel and still meet the CCO's requirement of 1.7 providers per 1,000. Evidence of these reviews is provided in the agenda (see **Q1-Agenda 4272018-ACCCO.PDF**) and minutes (see **Q1-Minutes 4.27-ACCCO.PDF**). The provided example of minutes and agenda was selected specifically to demonstrate the documentation of opening and closing panels from previous meetings. As proven by our Delivery Service Network report, AllCare CCO has a broad network of providers to provide care and services to our enrollees. The network encompasses all required provider type as well as fulfilling the geographic requirements in our OHA contract.	

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
2. The CCO submits the documentation described above as specified by the State, but no less frequently than the following: a. At the time it enters into a contract with the State. b. On an annual basis. c. At any time there has been a significant change (as defined by the State) in the CCO's operations that would affect the adequacy of capacity and services, including: i. Changes in the CCO's services, benefits, geographic service area, composition of or payments to its provider network; or ii. Enrollment of a new population. *42 CFR §438.207(c)(1-3)* *Contract: Exhibit G*	Answers for all questions: AllCare CCO, currently complies with federal and state Provider network Standards by submitting a DSN Provider Capacity Report on July 1st of every year, and every year thereafter. We also provide a new DSN report when there is a significant change to our network. Participating Providers, whether employed by or under subcontract with AllCare CCO, or paid fee-for-service, must have agreed to provide the described services, or items, to Medicaid and Fully Dual Eligible CCO members to be included in the DSN Provider Capacity Report. An inventory of the provider and facility types that must be included in the DSN Provider Capacity Report is in the **Q2-Delivery Service Network Policy-ACCCO.PDF**, pages 2-16. Evidence of AllCare's most recent DSN submission is also attached (see **Q2-2019 DSN Report Final Allcare(7312019Update)ACCCO.xlsx**). Per the Delivery Service Network Policy (see **Q2-Delivery Service Network Policy-ACCCO.PDF**, page 2), to comply with State and Federal requirements for oversight and monitoring of services, the AllCare Contracts Department submits to each delegated entity and facility, a form that mirrors the State Delivery Service Network form required for submitting provider data. Though this form is based upon the State form, AllCare will include additional	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	criteria that is required of the delegate or facility to comply with other contract requirements. AllCare will submit changes to delegates with a 30 day notice of changes to the report. To comply with State and Federal requirements, 30 days' notice may not always be given. The delegates will send their DSN reports to contracts@allcarehealth.com and credentialing@allcarehealth.com no later than 5:00 pm on the first Friday of each month. AllCare uses both internal data and provider provided data to reconcile with our records. We then cross-reference the current member population within each zip code. This is to show the Providers per 1,000 members for each specialty by region (see **Q2-Network Adequacy Policy-ACCCO.PDF** ,Page2,Paragraph2 Based on the Network Adequacy report, the Contracts Manager makes a Quarterly recommendation to AllCare's Medical Directors to close/open new contracts for specific specialties within each zip code. Sample reports presented to the committee: **Q2-Quarter2-2019-Network Capacity-PCP-File-JXCO-ACCCO.XLSX** "Network Tab" is evidence for Jackson County. 99.35% of Jackson County members are within 10 miles of a PCP. 20,000 additional lives can be added to AllCare's panel and	

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	still meet the CCO's requirement of 1.7 providers per 1,000. **Q2-Quarter2-2019-Network Capacity-PCP-File-JOCO-ACCCO.XLSX**"Network Tab" is evidence for Josephine County. 91.534% of Josephine County members are within 10 miles of a PCP. 15,000 additional lives can be added to AllCare's panel and still meet the CCO's requirement of 1.7 providers per 1,000. Please note that the zip codes in Douglas County are part of the service area because those members seek care in Josephine County and thus are covered under the Josephine county DSN report. **Q2-Quarter2-2019-Network Capacity-PCP-File-CUCO-ACCCO.XLSX,**"Network Tab" is evidence for Curry County. 93.04% of Curry County members are within 10 miles of a PCP. 2,000 additional lives can be added to AllCare's panel and still meet the CCO's requirement of 1.7 providers per 1,000. Evidence of these reviews is provide in the agenda **Q2-Agenda 4272018-ACCCO.PDF** and minutes **Q1-Minutes 4.27-ACCCO.PDF** this set of minutes and agenda was selected specifically for the documentation of opening and closing panels from previous meetings. AllCare has a sufficient Network of Providers in the entire service area. Some zip codes have an over saturation of specific provider types. As seen in these reviews it is related to Ancillary Services.	

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
3. Adult & Pediatric Primary Care, PCPCH, OB/GYN, Behavioral Health, Oral Health Access Standards—Time and Distance: a. In urban areas - Thirty (30) minutes or thirty (30) miles from the personal residences of members. b. In rural areas – Sixty (60 minutes) or sixty (60) miles from the personal residence of members. *42 CFR §438.68* *42 CFR §438.206(c)(1)(i)* *Contract: Exhibit B (2)(a)*	Per AllCare **Q3-Network Adequacy Policy-ACCCO.PDF** page 3 section 7.a. AllCare will always strive to meet a ten (10) minute, ten (10) mile time and distance standard for all service areas. In the event that this standard cannot be met AllCare will notify OHA if more than 90% of the service area cannot meet any of the following: a. Adult & Pediatric Primary Care, PCPCH, OB/GYN, Behavioral Health, Oral Health Access Standards—Time and Distance: i. In urban areas - Thirty (30) minutes or thirty (30) miles from the personal residences of members. ii. In rural areas – Sixty (60 minutes) or sixty (60) miles from the personal residence of members. **Q3-Quarter2-2019-Network Capacity-PCP-File-JXCO-ACCCO.XLSX** "Network Tab" is evidence for Jackson County. 99.35% of Jackson County members are within 10 miles of a PCP. 20,000 additional lives can be added to AllCare's panel and still meet the CCO's requirement of 1.7 providers per 1,000. **Q3-Quarter2-2019-Network Capacity-PCP-File-JOCO-ACCCO.XLSX** "Network Tab" is evidence for Josephine County. 91.534% of Josephine County members are within 10 miles of a PCP. 15,000 additional lives can be added to AllCare's panel and still meet the CCO's requirement of 1.7 providers per 1,000. Please note that the zip codes in Douglas County are part of the service area because those members seek	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	care in Josephine County and thus are covered under the Josephine county DSN report. **Q3-Quarter2-2019-Network Capacity-PCP-File-CUCO-ACCCO.XLSX** "Network Tab" is evidence for Curry County. 93.04% of Curry County members are within 10 miles of a PCP. 2,000 additional lives can be added to AllCare's panel and still meet the CCO's requirement of 1.7 providers per 1,000. Recently, AllCare identified a gap in process for our Oral and Behavioral Health vendors. Vendors have been providing capacity at the organizational level while we need the data broken down at the provider level. We will monitor this on an ongoing basis. Subcontracted delegates of AllCare will be monitored in this same manner. For those providers that Medicare does not provide a providers per 1,000 calculation (e.g. Interpreters, Licensed Clinical Social Workers, and Dentists), the Contracts Manger will work with the Medical Director team to calculate the provider capacity for each specialty area. FTE calculations may need to be developed instead of a provider per 1,000 count. This will be completed by 9/1/2019 and the policy will be amended to reflect the process. Current Behavioral Health review demonstrating adequacy **Q3-BHAdequacy2019Qtr1JXCUJOCO-ACCCO.XLSX**	

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
4. Adult & Pediatric Specialty Care Access Standards— Time and Distance: a. In urban areas - Thirty (30) minutes or thirty (30) miles from the personal residences of members. b. In rural areas – Sixty (60 minutes) or sixty (60) miles from the personal residence of members. *42 CFR §438.68* *42 CFR §438.206(c)(1)(i)* *Contract: Exhibit B (2)(a)*	Per **Q4-AllCare Network Adequacy Policy-ACCCO.PDF** page 3 section 7.a. AllCare will always strive to meet a ten (10) minute, ten (10) mile time and distance standard for all service areas. In the event that this standard cannot be met AllCare will notify OHA if more than 90% of the service area cannot meet any of the following: 4. Adult & Pediatric Specialty Care Access Standards— Time and Distance: a. In urban areas - Thirty (30) minutes or thirty (30) miles from the personal residences of members. b. In rural areas – Sixty (60 minutes) or sixty (60) miles from the personal residence of members. **Q4-Quarter2-2019-Network Capacity-Specialty-File-JXCO-ACCCO.XLSX** "Network Tab" is evidence for Jackson County. To understand the capacity of a specialty an individual would select the count of a specialty and enter this into the provider count field. For this example Orthopedic Surgery was selected which currently has a 1.01 Provider per 1,000 capacity. The goal being .23, this is still met with the addition of 20000 lives at .579. **Q4-Quarter2-2019-Network Capacity-Specialty-File-JOCO-ACCCO.XLSX** "Network Tab" is evidence for Josephine County. To understand the capacity of a specialty an individual would select the count of a specialty and enter this into the provider count field. For this example Chiropractor was selected	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	which currently has a .51 Provider per 1,000 capacity. The goal being .12, this is still met with the addition of 15000 lives at .28. Douglas County is combined with Josephine County because of serving a partial portion of the county. **Q4-Quarter2-2019-Network Capacity-Specialty-File-CUCO-ACCCO.XLSX** "Network Tab" is evidence for Curry County. To understand the capacity of a specialty an individual would select the count of a specialty and enter this into the provider count field. For this example Physical Therapist was selected which currently has a 6.9 Provider per 1,000 capacity. The goal being .31, this is still met with the addition of 2000 lives at .4.44.	
5. Hospital and Emergency Services Access Standards—Hospitals—Time and Distance: a. In urban areas - Thirty (30) minutes or thirty (30) miles from the personal residences of members. b. In rural areas – Sixty (60 minutes) or sixty (60) miles from the personal residence of members. *42 CFR §438.68* *42 CFR §438.206(c)(1)(i)* *Contract: Exhibit B (2)(a)*	Per **Q5-AllCare Network Adequacy Policy-ACCCO.PDF** page 3 section 7.a. AllCare will always strive to meet a ten (10) minute, ten (10) mile time and distance standard for all service areas. In the event that this standard cannot be met AllCare will notify OHA if more than 90% of the service area cannot meet any of the following: a. In urban areas - Thirty (30) minutes or thirty (30) miles from the personal residences of members. b. In rural areas – Sixty (60 minutes) or sixty (60) miles from the personal residence of members. **Q5-Quarter2-2019-Network Capacity-Hospital-File-JXCO-ACCCO.XLSX** "Network Tab" is evidence for Jackson County review currently there is	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	99.35% of the membership within 30 miles of a hospital **Q5-Quarter2-2019-Network Capacity-Hospital-File-JOCO-ACCCO.XLSX** "Network Tab" is evidence for Josephine County review currently there is 100% of the membership within 30 miles of a hospital Douglas County is combined with Josephine County because of serving a partial portion of the county. **Q5-Quarter2-2019-Network Capacity-Hospital-File-CUCO-ACCCO.XLSX** "Network Tab" is evidence for Curry County review currently there is 99.117% of the membership within 30 miles of a hospital	
6. Pharmacy—Time and Distance: a. In urban areas - Thirty (30) minutes or thirty (30) miles from the personal residences of members. b. In rural areas – Sixty (60 minutes) or sixty (60) miles from the personal residence of members. *42 CFR §438.68* *42 CFR §438.206(c)(1)(i)* *Contract: Exhibit B (2)(a)*	AllCare CCO utilizes a pharmacy network through its pharmacy benefit manager (PBM) MedImpact. The network is nationwide and contains all major chains with the exception of Walgreens. The pharmacy network also contains smaller regional chain and local independent pharmacies. One hundred percent of our members who live in urban and suburban communities are within 30 miles of network pharmacy provider. Please see attachment **Q6- Pharmacy GeoAccess Report Urban-ACCCO.PDF** pages 3 and 7. One hundred percent of our members who live in rural communities are within 60 miles of network pharmacy provider. Please see attachment **Q6- Pharmacy GeoAccess Report Rural-ACCCO.PDF** page 14.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	AllCare CCO will be completing oversite of this process the same way that AllCare oversees all other delegates by 1/1/2020. Per the **Q6-Delivery Service Network Policy CCO-ACCCO.PDF** page 2**,** to comply with State and Federal requirements for oversight and monitoring of services. The AllCare contracts department will submit to each delegated entity, and facility the templated form for submitting provider data. Though this spreadsheet is based upon the State Delivery Service network form. AllCare will have additional criteria added that is required of the delegate or facility to comply with other contract requirements. AllCare will submit changes to delegates with a 30 day notice of changes to the report. To comply with State and Federal requirements, 30 days' notice may not always be given. This is to be sent to contracts@allcarehealth.com and credentialing@allcarehealth.com no later than 5:00 pm on the first Friday of each month.	

Standard II—Assurance of Adequate Capacity and Services	
	Total #
Complete	**6**
Progress Sufficient	**0**
Incomplete	**0**
Not Applicable (NA)	**0**

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. The CCO ensures that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member. a. The member must be provided information on how to contact their designated person or entity. b. The CCO implements a standardized approach to effective transition planning and follow-up. *42 CFR §438.208(b)(1)* *Contract: Exhibit B Part 4 (2)(k)*	Care Coordination services are available to all of our CCO members. The AllCare CCO website also provides information on Care Coordination. This includes what Care Coordination services are available and how to contact intensive case management and care coordination staff. The above information will be updated in the 2020 Member Handbook. Also, beginning this year, members are provided an introductory letter for Care Coordination services in the new member packet which details what Care Coordination services entails and how to contact our intensive case management and care coordination staff. This will continue into 2020 and beyond. In addition, our traditional health worker (THW) staff outreach by phone to all new members for an initial health risk survey (HRS) within 30 days of enrollment for members with special needs and 90 days for all other members. Members are able to enroll into one or more care coordination programs after completing the HRS. Once enrolled in Care Coordination services the member works one on one with a Care Coordinator, Chronic Disease Coordinator, or Intensive Case Manager and w to formulate a patient-centered treatment plan. The member is then provided and connected with an AllCare Health Care Coordination team. The team has various staff whom have expertise based on the member's healthcare needs. A member's	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	team could include but is not limited to an RN, LCSW, Addictions Specialist, CNA or THW. Members are mailed a welcome to Care Coordination letter to confirm their participation and enrollment with Care Coordination. Members who are transitioning from FFS or another CCO are outreached in the same manner as above with an HRS conducted as soon as possible to coordinate between the member, the prior plan and their current providers. Members who are in a transitioning settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays or from home to health care settings are contacted for transition of care case management services. When we are unable to reach a member after multiple attempts, AllCare CCO Care Coordination send the member a letter letting them know we attempting to connect with them and providing detail on how to contact us in the future. Please see attachment **Q1-General Care Coordination policy-ACCCO.docx** section "Policy" #7, 8, 10, 17, 18 and section "Desk Procedure" #1 (1-3). Pages 3-7; Please see attachment **Q1-Special Needs policy-ACCCO.docx**, Section "Desk procedure" #2, 3, 4. Pages 4-6; Please see attachment **Q1-HRS policy-ACCCO.docx** for our HRS process. Pages 2-3;	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Please see attachment **Q1b-TOC-ACCCO.docx** for our transition process settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays or from home to health care settings: **sections "Overview and Purpose", "Policy" #5, 6, and "Desk Procedure" #1-6 and #8, Pages 1-5;** Please see attachment **Q1b-New Member Transition of Care-ACCCO.docx** (pages 1-2) for how members transitioning from another CCO or FFS are contacted by Care Coordination. Please see attachment **Q1a-CC Website Snippet-ACCCO.pdf** showing one way our members are able to identify how to contact their entity for care coordination needs. And attachments **Q1a-General Welcome Letter for New Member Packet-ACCCO.docx and Q1a-Special Needs Welcome Letter for New Member Packet-ACCCO.docx** for the letters that go out in our new member welcome packets. Please see attachment **Q1-Example Program Welcome Letter-ACCCO.pdf** for an example of the letter we send member who consent to enroll in Care Coordination. Please see attachment **Q1-Unable to Reach Letter-ACCCO.pdf** for an example of the letter we send when cannot reach the member.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
2. The CCO coordinates the services it furnishes to the member: a. Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays; b. With the services the member receives from any other MCO, PIHP, or PAHP; c. With the services the member receives in FFS Medicaid; and d. With the services the member receives from community and social support providers. *42 CFR §438.208(b)(2)* *Contract: Exhibit B Part 4 (1)(c)*	AllCare Care Coordination has created a policy and procedure in place to identify, track and coordinate care when new members join AllCare from another FFS or CCO to ensure no interruption in services. This work has always occurred but was not previously formalized in policy and procedure. During the HRS process, the THW identifies any prior authorized services the member may have had at their former CCO or while on FFS. This triggers a referral to our Utilization Management department to ensure the services are reviewed for continuation beyond the transition period. Members who are in a transitioning setting of care, including appropriate discharge planning for short term and long-term hospital and institutional stays or from home to health care settings are contacted for transition of care case management services. TOC staff coordinates with the member, discharge planning staff and providers to ensure safe transitions of care. Our Care Coordination department works with all providers including community and social support providers as well as with the member in creating a patient-centered care plan. Providers are contacted by fax, secure email and/or telephone. Initial care plans are communicated and depending on the treatment course, the provider(s) is asked to collaborate on the care plan and provide assessments or other necessary information to coordinate the member's health care needs. AllCare CCO continues to update the provider	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	of changes or follow up on the member's care plan per their preferred method of communication. Please see attachment **Q2-TOC-ACCCO.docx** for our transition process settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays or from home to health care settings: **sections "Policy" #5-9 and "Desk Procedure" #2, 3 and #8-10, Pages 1-5;** Please see attachment **Q2-New member Transition of Care Policy-ACCCO.docx** highlighted sections "Purpose" and "Desk Procedure" for our policy on new member transitions. Pages 1-2; Please see attachment **Q2-General Care Coordination policy-ACCCO.docx** section "Policy" #7, 8, 17, 18 and section "Desk Procedure" #5 (pages 3-6 and 8) and attachment **Q2-Special Needs policy-ACCCO.docx s**ections "policy" #2 and 7 "Desk procedure" #2, 3, 4 (pages 2-6) for more information on working with other CCOs, FFS and community partners. Please see attachment **Q2-HRS policy-ACCCO.docx** for our HRS process for ensuring continuity of services for member's transitioning between CCOs or from FFS to AllCare CCO: section "Desk Procedure" #5 (pages 2 and 4); Please see **Q2-Scope of Practice Policy-ACCCO.docx** page 3 for more information on how Case Owners work with members to help with transitions of care.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
3. The CCO conducts an initial screening of each member's needs, within 30 days of the effective date of enrollment for all new members, including documentation of subsequent attempts if the initial attempt to contact the member is unsuccessful. *42 CFR §438.208(b)(3)* *Contract: Exhibit B Part 4 (1)*	For our initial screening, our traditional health worker (THW) staff outreach by phone to all new members for an initial health risk survey (HRS) within 30 days of enrollment for members with special needs and 90 days for all other members. The HRS process includes to make two phone call attempts on two different days and two different times. If still no contact then an Unable to Reach Letter is mailed out with information on how to request Case Management Services. Please see attachment **Q3-HRS policy-ACCCO.docx** section Policy #2. Pages 2 and 3; **Q3- Special Needs Policy- ACCCO.docx** sections Policy #2, Desk Procedure #2. Pages 2 and 4-5; **Q3- General Care Coordination Policy-ACCCO.docx**. See sections Policy #2, 7 and 11, and Desk Procedure #1 (#1 and #3). Pages 2-7; **Q3-Unable to Reach Letter-ACCCO.pdf** Please see **Q3-Health Risk Survey Printout-ACCCO.pdf.** This is a printout of our HRS program.	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: AllCare's Health Risk Survey (HRS) policy stated that the AllCare Health Care Management Team will complete an initial HRS on every newly enrolled member and document it in the member's electronic health record. Traditional health workers contact each newly enrolled member by phone to complete the survey. Two call attempts are made to reach the member and then an unable-to-reach letter is mailed if the member is unreachable. AllCare prioritized outreach phone calls to members already identified on the enrollment file as having a special healthcare need. The HRS template provided by the CCO was very thorough and more consistent with a comprehensive assessment tool. During the remote interview session, staff members confirmed that the current process is to use the HRS as both the initial screening and comprehensive assessment. Staff members also stated that they are planning on revising the current HRS to be a shorter, more general screening that can be mailed to each member upon enrollment.		
Required Actions: While AllCare has processes to conduct an initial screening, HSAG recommends that the CCO revise its policies and procedures once the HRS has been finalized and processes have been implemented.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
4. The CCO's service agreements with specialty and hospital providers must: i. Address the coordinating role of patient-centered primary care; ii. Specify processes for requesting hospital admission or specialty services; and iii. Establish performance expectations for communication and medical records sharing for specialty treatments: – At the time of hospital admission; or – At the time of Hospital discharge for the purpose of facilitating after-Hospital follow up appointments and care. *Contract: Exhibit B Part 4 (9)*	Please see attachment **Q4-Contract Policy-ACCCO page 2 paragraph 6.** As of January 1st 2020, all Specialty and Hospital provider agreements will be updated with language to be compliant with the OHA Contract: Exhibit B Part 4 (9). The language will include the following: • Address the coordinating role of patient-centered primary care; • Specify processes for requesting hospital admission or specialty services; and • Establish performance expectations for communication and medical records sharing for specialty treatments – At the time of hospital admission; OR At the time of Hospital discharge for the purpose of facilitating after-Hospital follow up appointments and care.	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: AllCare's Contract policy stated that all provider agreements will be updated by January 1, 2020, to include the language required by the OHA contract in Exhibit B, Part 4 (9). During the remote interview session, AllCare staff members stated that they are on track to have the provider agreements updated prior to January 1, 2020.		
Required Actions: While it is clear that AllCare understands the requirements, HSAG recommends that the CCO provide evidence that the hospital and specialty provider contracts have been updated to include the coordination role of patient-centered primary care, processes for requesting hospital admission or specialty services, and performance expectations for communication and medical record sharing at the time of hospital admission and discharge.		
5. The CCO has processes in place to ensure that: a. Hospitals and specialty service providers are accountable for achieving successful transitions of care.	AllCare CCO Utilization Management staff review all inpatient and skilled nursing facility stays to ensure appropriate management/utilization of services, quality	☒ Complete ☐ Progress Sufficient to Start Operations

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
b. Primary care teams are responsible for transitioning members out of hospital settings into the most appropriate, independent, and integrated care settings, including home and community-based as well as hospice and other palliative care settings. *Contract: Exhibit B Part 4 (9)*	and appropriateness of care, and assist in discharge planning and preparing for services needed at discharge to promote successful transitions of care. The regular UM Nurse staff communication with the hospital and skilled nursing providers assists in holding them accountable for positive transitions. Care Coordination's Transition of Care Nurse (TOC) targets cases requiring additional assistance and focuses on working with the member's primary care team that may include but is not limited to: the primary care provider, the specialty providers, social workers, case managers, discharge planners, nurses, and caregivers. The TOC nurse is involved in the member's case without restriction on facility, and remains involved throughout the transition until considered stable. Assistance in scheduling following up appointments, medication reconciliation, assurance that ordered and covered services are received, education on resources, are some of the TOC nurse responsibilities that will occur in conjunction with the members primary care team. The TOC nurse has access to view the member's current claims, prescriptions, authorizations, and documentation to assist in successful transitions as well as to provide to the members primary care team as needed and allowed. Please see attachments **Q5-Concurrent inpatient review-ACCCO.docx** (page 1) and **Q5-SNF-ACCCO.docx (**highlighted pages 2-6).	☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Please see attachment **Q5-TOC policy-ACCCO.docx** Section Policy #2, 5, 6 and Desk Procedure #1-4 and #7-10 Pages 1-5 In addition, please see attachment **Q5-Contract Policy-ACCCO.pdf,** page 2 paragraph 6. As of January 1st 2020, all Specialty and Hospital provider agreements will be updated with language to be compliant with the OHA Contract: Exhibit B Part 4 (9). The language will include the following: • Address the coordinating role of patient-centered primary care; • Specify processes for requesting hospital admission or specialty services; and • Establish performance expectations for communication and medical records sharing for specialty treatments – At the time of hospital admission; OR At the time of Hospital discharge for the purpose of facilitating after-Hospital follow up appointments and care.	
6. The CCO shares with the PCP, State or other MCOs, PIHPs, and PAHPs serving the member the results of any identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR §438.208(b)(4)* *Contract: Exhibit B Part 4 (2)(f)(3)*	The Care Coordination case owner completes an assessment on all members enrolled in Care Coordination to identify other agencies involved in a member's treatment plan. The case owner then coordinates with these other agencies to ensure there is no duplication of services. The case owner will provide the assessment information including any identified needs to all entities involved in the care of the member. This maybe done in	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	several ways, including secure e-mail, fax, or by telephone. The goal is to ensure treatment plans are coordinated between agencies and prevent duplication of services. This may include Health-Related Services (Flex) spending requests, Care Coordination services, treatment plans, social determinates of health services, transportation, and any other barriers to care. AllCare CCO is working with our partner agencies such as DHS and APD to schedule regular group meetings to discuss and coordinate care for our shared members. AllCare CCO has a goal for these meetings to be in place for all service area counties by 1/1/2020. • **Q6-Scope of Practice- ACCCO.docx,** please see highlighted area page 3, Desk Procedure paragraph 2,3; • **Q6-General Care Coordination Policy-ACCCO.docx**, Sections Policy #11, Desk Procedure #1 (#3) Pages 4-7; • **Q6-Chronic Conditions Policy-ACCCO.docx**, Sections Policy 7 and Desk procedure #2b Pages 3-4; • **Q6-Maternal Child Policy-ACCCO.docx**, Section Policy #4 Page 2; • **Q6- Special Needs Policy-ACCCO.docx,** Section Policy #5 and 7 and Desk Procedure #2b., Pages 2-5.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
7. The CCO ensures that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards. *42 CFR §438.208(b)(5)* *Contract: Exhibit B Part 8 (1)(d-f)*		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		
8. The CCO ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable. *42 CFR §438.208(b)(6)* *Contract: Exhibit B Part 4 (1)(a)*	AllCare takes the privacy of our members very serious and we have standards of practice built into our policies to protect the member's rights to privacy. AllCare also has mandatory HIPPA compliance training yearly for current employees and within 90 days of the hire date for new employees. Please see attached policies with highlights: • **Q8-PHI Policy-ACCCO.docx,** for our PHI policy. See Pages 1, 5-7 for Policy and Procedure; • **Q8-HRS Policy-ACCCO.docx**, Policy #1; • **Q8-Chronic Conditions Policy-ACCCO.docx,** Policy 31; • **Q8-General Care Coordination Policy-ACCCO.docx,** Policy #1; • **Q8- Hep C Policy-ACCCO.docx**, Policy #5; • **Q8- Maternal child Policy-ACCCO.docx**, Policy 1;	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• **Q8-Special Needs Policy-ACCCO.docx**, Policy #1; • **Q8- TOC Policy-ACCCO.docx**, Policy #1. Please also see the attached attendance for our June 2019 HIPAA Compliance training: • Q8-2019 Mandatory Compl. Empl Attendance - Population Health-ACCCO.xlsx	
9. The CCO implements mechanisms to comprehensively assess each member identified as needing LTSS or having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. *42 CFR §438.208(c)(2)* *Contract: Exhibit B Part 4 (10)(a)(4)*	AllCare identifies special needs members using the state's eligibility file and Program Eligibility Reporting Code (PERC) definition. These members have an initial health risk screening within 30 days of the effective date of enrollment for new members, or within 30 days when the member is referred or is receiving Medicaid LTC or LTSS, or as quickly as the member's health condition requires. Traditional health worker (THW) staff provide this outreach by phone. All other new members are contacted within 90 days of enrollment. Members may also be classified as having complex or special needs during the HRS due to medical or social situation complexity that is revealed during the HRS process. These members may not have a PERC that would identify them as special needs. All members are able to enroll into one or more care coordination programs after completing the HRS. Once enrolled in Care Coordination services the member works one on one with a Care Coordinator, Chronic Disease Coordinator, or Intensive Case Manager to formulate a patient-centered treatment plan.	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Members with special health care needs, including members receiving LTC or LTSS that are determined through a health assessment to need a course of treatment or regular care monitoring, have their treatment plans developed with any providers caring for the member, including any community-based support services and LTSS providers. AllCare CCO Care Coordination also includes consultations with any specialist caring for the member and department long-term care or long-term services and supports, providers, or case managers. In addition, AllCare CCO works with Collective Medical's PreManage HIE program to communicate important elements of our care plans with other providers. We successfully communicate and exchange care plan information with multiple provider partners and agencies around Emergency Room Utilization for our members with severe and persistent mental illness enrolled in Care Coordination programs and for our pregnant members working with our Maternal Child Care Coordination team. AllCare CCO plans to expand use with this HIE tool going forward into 2020 to our other Care Coordination programs. AllCare CCO is working with our partner agencies such as DHS and APD to schedule regular group meetings to discuss and coordinate care for our shared members. AllCare CCO has a goal for these meetings to be in place for all service area counties by 1/1/2020.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Please see attached highlighted policies • **Q9- HRS Policy-ACCCO.docx**, Section Policy #2-3, Pages 2-5; • **Q9- Special Needs Policy-ACCCO.docx**. Sections Policy #2, #7-8, Desk Procedure 2e. Pages 2-3; **Q9-General Care Coordination Policy-ACCCO.docx** Section Policy #6 and 7, Desk Procedure #1 (#3) Pages 3-4 and 6-7.	
HSAG Findings: Based on the policies, procedures, and remote interview session, AllCare's current processes involved using the HRS as both the initial screening and the comprehensive assessment. CCO staff members stated that they plan on using the telephonic HRS for assessing members with special healthcare needs and implementing a shortened HRS for the initial screening of all newly enrolled members.		
Required Actions: HSAG recommends that the CCO revise its policies and procedures to describe the process for conducting the comprehensive assessment on members identified as needing LTSS or with a special healthcare need, with a delineation from the initial health risk screening of all members.		
10. The CCO has written policies and procedures for identifying, assessing and producing a treatment plan for each member identified as having a special healthcare need. *Contract: Exhibit B Part 4 (10)(a)(4)*	AllCare identifies special needs members using the state's eligibility file and Program Eligibility Reporting Code (PERC) definition. These members have an initial health risk screening within 30 days of the effective date of enrollment for new members, or within 30 days when the member is referred or is receiving Medicaid LTC or LTSS, or as quickly as the member's health condition requires. Traditional health worker (THW) staff provide this outreach by phone. All other new members are contacted within 90 days of enrollment. Members may also be classified as having complex or special needs during the HRS due to medical or social situation complexity that is revealed	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	during the HRS process. These members may not have a PERC that would identify them as special needs. All members are able to enroll into one or more care coordination programs after completing the HRS. Once enrolled in Care Coordination services the member works one on one with a Care Coordinator, Chronic Disease Coordinator, or Intensive Case Manager to formulate a patient-centered treatment plan. In addition, AllCare CCO works with Collective Medical's PreManage HIE program to communicate important elements of our care plans with other providers. Through this tool we can exchange care plan information with multiple provider partners and agencies. We currently use this program for some of our Care Coordination Programs and plan to expand use with this HIE tool going forward into 2020 to our other Care Coordination programs. Please see attached highlighted policies **Q10 Special Needs Policy-ACCCO.docx,** Sections Policy 2a, 7a, Desk Procedure 2c, e., Pages 2-5;	
HSAG Findings: AllCare provided policies and procedures that explain the process for identifying members with special healthcare needs. However, the policies and procedures for the comprehensive assessment and treatment planning processes lacked specificity as to the timelines used by the CCO to complete the assessment and treatment plan, timelines for updating the care plan consistent with the OHA contract, how the comprehensive assessment is completed (face-to-face, telephonically), and how the CCO monitors staff members to ensure care coordination activities are being conducted accurately and timely.		
Required Actions: HSAG recommends that the CCO revise policies and procedures to include more specificity and to align with the final care coordination processes implemented by the CCO.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
11. The CCO responds to requests for Intensive Care Coordination services with an initial response by the next business day following the request. *Contract: Exhibit B Part 2 (8)(a)(4)*		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		
12. For members with physical and/or behavioral special health care needs determined to need a course of treatment or regular care monitoring, the member's Intensive Care Coordinator develops an Intensive Care Coordination Plan (ICCP) or treatment plan in consultation with any specialists caring for the member and with member participation. The ICCP or treatment plan must: a. Be approved by the CCO in a timely manner (if approval is required; b. Revised upon assessment of the members functional need or at the request of the member; c. Revised at least every three months for member receiving intensive care coordination and every 12 months for other members; and a. Be developed in accordance with State quality assurance and utilization review standards. *42 CFR §438.208(c)(3)* *Contract: Exhibit B Part 4 (2)(f)(1))*		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element was not applicable for the readiness review.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Required Actions: None.		
13. For members with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, the CCO must have policies or procedures in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. *42 CFR §438.208(c)(4)* *Contract: Exhibit B Part 4 (2)(f)(2)*	AllCare identifies special needs members using the state's eligibility file and Program Eligibility Reporting Code (PERC) definition. These members have an initial health risk screening within 30 days of the effective date of enrollment for new members, or within 30 days when the member is referred or is receiving Medicaid LTC or LTSS, or as quickly as the member's health condition requires. Traditional health worker (THW) staff provide this outreach by phone. All other new members are contacted within 90 days of enrollment. Members may also be classified as having complex or special needs during the HRS due to medical or social situation complexity that is revealed during the HRS process. These members may not have a PERC that would identify them as special needs. All members are able to enroll into one or more care coordination programs after completing the HRS. Once enrolled in Care Coordination services the member works one on one with a Care Coordinator, Chronic Disease Coordinator, or Intensive Case Manager to formulate a patient-centered treatment plan. If during the creation or follow up in the treatment plan the member with special needs requires direct access to a specialist, the Case Owner works with our Utilization Management (UM) group to facilitate the service. Contracted Specialist referrals are approved for an initial 6 visits per year, unless otherwise noted in UM	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	policy, to allow for direct access. Additional visits for those with special health care needs may be added to a Specialist to allow for continued direct access based upon the member's condition and identified needs. Please see highlighted policies: • **Q13- Special Needs Policy-ACCCO.docx.** Sections Policy #2, 6, and 8, Desk Procedure 2d Pages 1-5; • Q13-UM Decision Making Process for Service Requests policy-ACCCO.docx. page 5 #15.	

Standard III—Coordination and Continuity of Care	
	Total #
Complete	**6**
Progress Sufficient	**4**
Incomplete	**0**
Not Applicable (NA)	**3**

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. In accordance with 42 C.F.R. §438.210, the CCO has processes in place to provide covered services outlined in the Contract that is no less than the amount, duration, and scope of the same services to beneficiaries under FFS Medicaid, as set for in 42 C.F.R. §440.230, and for members under the age of 21, as set forth in 42 C.F.R. subpart B of part 441. The CCO: a. Must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. b. May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary. *42 CFR §438.210(a)(3)(i-ii)* *Contract: Exhibit B Part 2 (2)(a-b)*	AllCare CCO provides OHP covered services that are no less than the amount, duration, and scope of the same services to members under FFS, as outlined in the attached policies. AllCare CCO will ensure that services are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the service is ordered by reviewing claims and utilization data on service requests. AllCare CCO has created a workgroup called the Utilization Management Clinical Practice Guideline and Utilization Review Committee (UMCPGURC) which is mandated to review utilization data. This work has occurred prior through our Population Health Utilization Management (UM) department in conjunction with our Medical Directors but was not previously formalized. This new committee is made up of our UM, Pharmacy and Medical Director staff including our Behavioral Health and Oral Health internal experts and subcontracted partners. The committee will review utilization trends to ensure that services the CCO provides are in alignment with appropriate durations, scope, amount, and that over- and under-utilization trends are identified. The work from this committee is meant to inform and improve benefit configuration for our members. Findings from this committee are reported to external healthcare provider committees such as the Clinical Advisory Panel (CAP) and/or the Pharmacy and Therapeutics (P&T) Committee.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	The first UMCPGURC meeting is scheduled for 8/5/19. This committee and its work will continue going forward into 2020 and beyond. AllCare CCO has policies in place that do not allow denial or limitation of services related to diagnosis, type of illness, or condition of the member. AllCare CCO is currently refining monthly monitoring process for all clinical reviewers. Randomly selected cases will be selected to review service determinations by the RN Supervisor and Medical Director that will assist in identification of deficiencies and training needing. AllCare CCO has also attached audit tools used for our oral and behavioral health subcontractors to show how policies are implemented, how oversight is provided, and issues of quality, appropriateness of services and over and under-utilization are reviewed. The audit tools allow AllCare CCO to look at the decision making of our subcontracted partners to ensure that our members are receiving covered services at the appropriate scope, amount and duration and that services are not being arbitrarily denied. The information identified with the audit tool is shared in the UMCPGURC meeting. Please see attached documents for further clarification: • Q1- UM CCO 133 UMCPGURC-ACCCO.docx, page 1;	

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• Q1-UM CCO 108 Decision Making Policy-ACCCO.docx, Page 1; • Q1-UM CCO 134 Benefit Policy-ACCCO.docx, Pages 2-5 highlighted sections; • Q1-AllCare Dental Audit Tool Revised-ACCCO.docx; • Q1-BH Review Outline-ACCCO.pdf; • Q1- Chart Review Form AllCare-ACCCO.docx;	
2. The CCO is permitted to place appropriate limits on a service: a. On the basis of criteria applied under the State plan, such as medical necessity; or b. For the purpose of utilization control, provided that: i. The services furnished can reasonably achieve their purpose, as required in paragraph (a)(3)(i) of this section; ii. The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the member's ongoing need for such services and supports; and iii. Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with §441.20 of this chapter.	AllCare CCO permits appropriate limits on services, based on criteria, medical necessity, and utilization control. AllCare CCO is not more restrictive than criteria applied under FFS Medicaid. Please see attached policy UM CCO 108 Decision Making Policy for instruction on how and who may make service determinations on authorization requests. Attached is an example of how outpatient therapy requests are processed and when limitations are appropriate for the specific services listed in the policy. Please see **Q2-UM CCO 226 Therapy-ACCCO.pdf**. • **Q2-Appropriate Limits Family Planning (CLM-ALCR-0037)-ACCCO.docx** • **Q2-Appropriate Limits Family Planning - Member Handbook.pdf-ACCCO.PNG** • **Q2-UM CCO 108 Decision Making Policy-ACCCO.docx** Page 1 and 5 section #15;	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
42 CFR §438.210(a)(4)(i-ii) *Contract: Exhibit B Part 2*	• **Q2-UM CCO 226 Therapy-ACCCO.pdf** • **Q2-UM CCO 134 Benefit Policy-ACCCO.docx** page 2, 3 and 4-please see highlighted sections;	
3. The CCO has processes to ensure that utilization or prior authorization standards for mental health or substance used disorder benefits and access to both in-network and out-of-network providers providing these benefits are no more stringent then the standards that are applied to medical/surgical benefits. *Contract: Exhibit E (22)*	Providing Documentation & Narrative: • **Q3-Mental Health Parity Policy-ACCCO. pdf**, Page 2-3; • **Q3-UM CCO 134 OHP Benefit Policy-ACCCO**.docx Page 3; AllCare CCO completed an extensive Parity Analysis in 2018 performed by OHA and Mercer. Attachment **Q3-AllCare NQTL Analysis_final Parity Report-ACCCO.pdf** is AllCare CCO's final analysis. The highlighted **pages 2-3** outline the method for the analysis. It included review of all AllCare CCO mental health and substance use disorder benefits and compared utilization, prior authorization standards and access to that of our Medical/Surgical benefits to ensure they are no more restrictive. Going forward, AllCare CCO will use this worksheet or an updated OHA provided report to complete the review of Mental Health Parity annually.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
4. The CCO has processes to ensure that any financial requirements or treatment limits to mental health or substance use disorder benefits in any classification are no more restrictive then the financial requirements or treatment limits to medical/surgical benefits in the same classification (whether or not the benefits are furnished by the CCO).	Providing Documentation & Narrative: • **Q4-Mental Health Parity Policy. ACCCO.pdf** Pg 2-3; • AllCare CCO completed an extensive Parity Analysis in 2018 performed by OHA and Mercer. **Attachment Q3-AllCare NQTL**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Contract: Exhibit E (22)	**Analysis_final Parity Report-ACCCO.pdf** is AllCare CCO's final analysis. The highlighted **pages 2-3** outline the method for the analysis. It included review of all AllCare CCO mental health and substance use disorder benefits and compared utilization, prior authorization standards and access to that of our Medical/Surgical benefits to ensure they are no more restrictive. Going forward, AllCare CCO will use this worksheet or an updated OHA provided report to complete the review of Mental Health Parity annually.	
5. The CCO must furnish medically necessary services as defined in the Contract and in a manner that: a. Is no more restrictive than that used in the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and b. Addresses: i. The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability. ii. The ability for a member to achieve age-appropriate growth and development iii. The ability for a member to attain, maintain, or regain functional capacity.	AllCare CCO covers medically necessary services, and in a manner required that is no more restrictive than that used in FFS Medicaid. OHA publishes the Prioritized List of Health Services prior to the effective date. AllCare CCO is signed up for OHA notifications of Prioritized List of Health Services changes. Upon notification of a new published list, the UM Service Operations Manager reviews the list to identify all changes. These changes are reviewed by the UMCPGURC and Medical Directors. Changes that require implementation, such as system updates to benefit rules or prior authorization requirements, are coordinated by the UM Service Operations Manager. AllCare CCO's prior authorization review process requires clinical staff to make medically necessary	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
42 CFR §438.210(a)(5)(i-ii) *Contract: Exhibit B Part 2 (2)(b)*	coverage determinations. Inter-rater reliability is conducted annually to ensure service determinations and use of medical necessity is used consistently and appropriately among all UM Analyst, RN, Medical Director and Pharmacist staff. AllCare CCO is currently refining monthly monitoring process for all clinical reviewers. Randomly selected cases will be used to review service determinations by the RN Supervisor and Medical Director that will assist in identification of deficiencies and training needing. Please see the attached policies for additional detail. • **Q5-UM CCO 134 Benefit Policy-ACCCO.docx** pages 1-3 highlighted sections; • **Q5-Mental Health Parity Policy ACCCO.pdf,** Pages 2-3; • **Q5-UM CCO 108 Decision Making Policy-ACCCO.docx,** pages 1-4 highlighted sections; • **Q5-Medical Director Decision Desk Procedure-ACCCO.docx**, page 2; • **Q5-UM CCO 136 Inter Rater Reliability-ACCCO.docx**, page 1-policy, page 5-tool.	
6. The CCO establishes and adheres to written policies and procedures for both the initial and continuing service authorization requests consistent with utilization control requirements of 42 CFR Part 456. Policies and procedures must include:	AllCare CCO has policies and procedures for both initial and continuing service authorization requests, as outlined in the attached policies. The decision making process policy guides UM service determinations to ensure consistent	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
a. Mechanisms to ensure consistent application of review criteria for authorization decisions; b. Consultation with the requesting provider for medical services when appropriate. c. A process to ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs. *42 CFR §438.210(b)(1-3)* *Contract: Exhibit B Part 2 (3)(a & f)* *Contract: Exhibit B Part 2 (2)(c)*	application of criteria. AllCare CCO may consult with the requesting provider during a service determination and this is supported by multiple policies. AllCare CCO also conducts inter-rater reliability on an annual and as needed basis for staff to confirm that consistent application of criteria and processes are used for service determination. Job descriptions of all staff able to make service determinations are also included to support appropriate expertise for decision making. An example includes that a registered nurse or analyst I-III may not deny any service for medical necessity. In addition to the decision making process policy we have attached the decision making scope which includes the scope of the AllCare CCO analyst and registered nurse. The scope outlines specific service processes and is consistently updated as new OHA rules, criteria, and utilization reports become available. Also attached is our prior authorization grid to assist in showing services that require PA and those without restrictions. Please see the following policies for detail. • **Q6-2019ACCCO-PA Grid 2019-ACCCO.pdf** • **Q6-UM CCO 03 Decision Making Scope-ACCCO.pdf** • **Q6a-UM CCO 108 Decision Making Process-ACCCO.docx,** Pages 1-4 highlighted sections;	☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• **Q6a-UM CCO 136 Inter-Rater Reliability –ACCCO.docx,** Page 1; • **Q6b- UM CCO 110 Expedited Service Determinations-ACCCO.docx,** Pages 2-5 highlighted sections; • **Q6b-UM CCO 111 Standard Service Determinations-ACCCO.docx** Pages 2-5 highlighted sections; • **Q6b-UM CCO RX 100 Expedited Standard OP RX_PAD Service Determination-ACCCO.docx** Pages 2-4 highlighted sections; • **Q6c-UM CCO 108 Decision Making Process-ACCCO.docx,** Pages 1-2 highlighted sections; Job Descriptions: • **Q6-Clinical Pharmacist job description-ACCCO.docx** • **Q6-Medical Director of Oral Health-ACCCO.docx** • **Q6-Medical Director-ACCCO.docx** • **Q6-Utilization Management (UM) Analyst I-ACCCO.docx** • **Q6-Utilization Management (UM) Analyst II-ACCCO.docx** • **Q6-Utilization Management (UM) Analyst III-ACCCO.docx**	

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• **Q6-Utilization Management RN-ACCCO.docx** • **Q6-Behavioral Health Director-ACCCO.docx**	
7. The CCO's utilization management policies are not structured in a way to provide incentives for its provider network, employees or other utilization reviewers to inappropriately deny, limit or discontinue medically appropriate services to any member. *42 CFR §438.210(e)* *Contract: Exhibit B Part 2 (2)(d)*	AllCare CCO does not provide incentives to inappropriately deny, limit or discontinue medically appropriately services to any member. This is addressed in the UM Decision Making Process policy, for utilization reviewers. AllCare CCO contracts do not provide incentives to inappropriately deny, limit or discontinue medically appropriately services to any member in our Provider Contracts. As part of the planned updates for the 2020 contracts AllCare's agreements prohibit providers from denying or limiting care to assigned members or providers not receiving incentives. AllCare CCO informs our members through the Member Handbook that we do not incentivize our Providers to deny, limit or discontinue services. • **Q7-UM CCO 108 Decision Making Process policy-ACCCO.docx** page 5 • **Q7-Provider Incentive (Member Handbook 2020)-ACCCO.PNG** • **Q7-Contract_Provider Incentive (DIRECT PROVIDER AGREEMENT TEMPLATE)-ACCCO.docx** page 5	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: The documentation submitted by the CCO was limited to a description of how it ensures employees and utilization reviewers are not incentivized to inappropriately deny, limit, or discontinue medically appropriate services to members. The documentation did not address how these practices are accomplished for its provider network.		
Required Actions: HSAG recommends that the CCO ensure its utilization management policies are not structured and define the mechanisms to ensure they do not provide incentives for its provider network to inappropriately deny, limit, or discontinue medically appropriate services to members.		
8. The CCO operates a drug utilization review program that complies with the requirements described in section 1927(g) of the Act and 42 CFR part 456, subpart K. *42 CFR §438.3(s)(4)* *Contract: Exhibit B Part 2 (4)(g)(2)*	AllCare CCO, in conjunction with the Oregon Health Authority's Pharmacy Programs Division, conducts a drug use review (DUR) program for its members, providers and pharmacies. The intent of the program is to ensure covered outpatient prescriptions are appropriate, medically necessary, and not likely to result in adverse medical results, as specified in CFR 438.3 and OAR 410-121-0100. The DUR program encompasses both prospective and retrospective drug utilization review, as well as education for the CCO's providers and pharmacies. AllCare CCO requires pharmacies that serve AllCare members comply with prospective DUR (ProDUR) requirements as defined in 42 CFR § 456.705 as well as the applicable Oregon administrative rules. AllCare CCO delegates ProDUR to our pharmacy benefit manger MedImpact. MedImpact contracts with network pharmacies and provides detailed information for compliance with prospective DUR requirements, including guidelines on counseling, profiling, and documentation of prospective DUR activities by pharmacists. AllCare CCO conducts a retrospective DUR program for ongoing periodic examination (no less frequently	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	than quarterly) of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and members, or associated with specific drugs or groups of drugs. This examination includes pattern analysis of physician prescribing practices, drug use by individual patients and, where appropriate, dispensing practices of pharmacies, using predetermined standards as recommended by the AllCare CCO DUR board. AllCare CCO provides ongoing educational outreach programs using DUR data to educate practitioners on common drug therapy problems, with the aim of improving prescribing and dispensing practices. AllCare CCO outreaches to providers with information on the targeted therapeutic interventions. As an educational tool, AllCare staff maintains a quarterly provider newsletter (AllCare Connection) to highlight clinical guideline updates, safety concerns and key formulary information. The newsletter is available to providers through the AllCare provider portal with the CCO formulary information. AllCare CCO's P&T committee functions as the DUR board and provides oversight and guidance of the CCO DUR program. AllCare CCO's DUR Board is tasked with helping AllCare CCO Pharmacy staff identify common drug therapy problems and develop educational topics where education of practitioners is	

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	needed to improve prescribing or dispensing practices. The DUR board makes recommendations on potential interventions for quality improvement programs and periodically re-evaluate and modify the interventions as necessary. The DUR board recommendations must be based upon an in-depth review of the results of the application of predetermined standards against claims data reports, must be appropriate based upon program experience, and must match the educational program with the drug therapy problems identified. Please see **Q8-DUR program policy-ACCCO.docx** for more detail on our DUR program. Please see **Q8-PT DUR Committee policy-ACCCO** for more detail on our DUR Board and their duties related to program oversight. Pages 1 and 2; Please see attachment **Q8-42519 P&T Committee DUR Board Meeting Minutes-ACCCO.docx** (page 3) and **Q8-62719 P&T Committee DUR Board Meeting Minutes-ACCCO.docx** (pages 2-3)for DUR board meeting minutes. Please see the zip file **Q8-MedImpact DUR program documents-ACCCO.zip** for more information on our ProDUR program through MedImpact. Please see the zip file **Q8-2018 DUR MCO AC Survey-ACCCO.zip** for our 2018 reporting with the OHA to CMS.	

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Requirement	**Evidence as Submitted by the CCO**	**Score**
9. The CCO notifies the requesting provider, and gives the member written notice of any decision by the CCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. *42 CFR §438.210(c)* *Contract: Exhibit B Part 2 (3)(h)*	AllCare CCO notifies the requesting Provider within the applicable timeframes on all service determinations. AllCare CCO created a Provider Portal in which our contracted (and some non-contracted) Providers can log in to and have access to eligibility, submit authorization requests, upload supporting documentation, view authorization determinations and the rationale for the determination, and send secure emails to the UM department. The Provider Portal is our main mechanism with communicating with our Providers. AllCare CCO pulls data monthly to monitor use of the Provider Portal. For the month of June 2019, we had a 98.6% adherence rate for our Providers using the Provider Portal to submit PA requests. Additionally, we utilize fax and telephonic mechanisms for Providers that do not have access to the Provider Portal or if the request was received by fax. For example, if a request was submitted via the Provider Portal, then we respond via the Provider Portal or if the request was received via fax, then we respond via fax. AllCare CCO provides written notice to members for each adverse service determination. This process is outlined in the next question, #10. AllCare CCO subcontracts Utilization Management to two Mental Health Organizations and five Dental subcontractors, and non-emergent medical transportation (NEMT) subcontractors. The MHO	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	and Dental subcontractors are audited to comply with AllCare CCO's policy. The NEMT subcontractor audit tool will be completed by 01/01/2020. The Expedited, Standard and NOABD policies below were recently revised. AllCare CCO will provide training to these policies that will be in effect by 1/1/2020. The monitoring processes and desk procedures will be refined to reflect the policy changes by 1/1/2020. In 2018, AllCare CCO identified the need for a structured monitoring process. AllCare CCO created an authorization 'universe' that will pull all authorization requests. In 2019, AllCare CCO has utilized this universe to gather the required reporting elements from the UM department to provide for the Exhibit I for Q1 and Q2. AllCare CCO is currently revising the universe to include all the areas that we would like to monitor. The Quarterly Monitoring policy is in DRAFT as we continue to solidify the policy and procedure. AllCare CCO's goal is to complete the universe, policy and procedure prior to 1/1/2020. AllCare CCO will provide a Quarterly Monitoring Report Analysis for Q12020. This initial analysis will capture the areas that are solidified for reporting. • **Q9-AllCare CCO Dental Audit Tool-ACCCO.docx** • **Q9-BH Review Tool Outline-ACCCO.pdf**	

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• **Q9-Member_Sample NOABD (fully adverse)-ACCCO.pdf** • **Q9-Member_Sample NOABD (Modified_Limited Approval)-ACCCO.pdf** • **Q9-PA Submission Dashboard (MonthlyAuthStatusSmryCharts)-ACCCO.PNG** • **Q9-Provider Fax Sample (fully adverse)-ACCCO.pdf** • **Q9-Provider Fax Sample (fully favorable)-ACCCO.pdf** • **Q9-Provider Fax Sample (Modified_Limited Approval)-ACCCO.pdf** • **Q9-Provider Portal Sample (fully adverse)-ACCCO.PNG** • **Q9-Provider Portal Sample (fully favorable)-ACCCO.PNG** • **Q9-Provider Portal Sample (Modified_Limited Approval)-ACCCO.PNG** • **Q9-RR Policy & Procedures_v2.2-ACCCO.pdf** (page 37) • **Q9-UM CCO 110 Expedited Service Determinations-ACCCO.docx** (Pages 1-6)	

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Requirement	**Evidence as Submitted by the CCO**	**Score**
	• **Q9-UM CCO 111 Standard Service Determinations-ACCCO.docx** (pages1-5) • **Q9-UM CCO 114 NOABD-ACCCO.docx** (pages 1-2) • **Q9-UM CCO RX 100 Expedited and Standard Outpatient Drug and PAD Service Determinations-ACCCO.docx** (pages 1-2 and 5-6)	
10. The written notice of adverse benefit determination must be consistent with the provisions under 42 CFR 438.10(c) and must include: a. The date of the notice; b. CCO name, address, phone number; c. Name of the member's Primary Care Practitioner, Primary Care Dentist, or behavioral health practitioner, as applicable; d. Member's name, address, and ID number e. Service requested or previously provided and adverse benefit determination the CCO made or intends to make; 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;	AllCare CCO mails a written member notice for each adverse (fully or partial) service determination. AllCare CCO utilizes the approved OHA NOABD (form 2405), including the approved OHA Appeal and Hearing request (form 3302). AllCare CCO also includes the approved OHA Nondiscrimination Policy (form 2996). All three of these notices/forms are included with each NOABD. AllCare CCO has dedicated UM Analysts that write NOABDs. Each NOABD is manually written and are not system or IT generated. The UM Analyst is trained to the NOABD policy, and service determination policies that reference timeframes. The UM Analyst is trained one-on-one by Supervisor or Manager. The training consists of observing the processing of a NOABD and creating denial rationale content. Subsequently followed with hands-on writing of NOABDs with direct one-on-one oversight of Supervisor or Manager. AllCare CCO conducts Health Equity training classes to employees. One of these classes is a Health	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
i. Whether the CCO considered other conditions if the service was below the funding line of the OHP Prioritized List of Health Services; j. The reasons for the adverse benefit determination, including reference to the specific statutes and administrative rules to the highest level of specificity for each reason and specific circumstances identified in the notice that include, but is not limited to: k. The right of the member 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. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. l. The member's right to request an appeal with the CCO within 60 days of the CCO's adverse benefit determination, including information on exhausting the CCO's one level of appeal described at §438.402(b) and the right to request a State fair hearing (contested case hearing) within 120 days after issuance of the CCO's Notice of Appeal Resolution or where the CCO failed to meet appeal timelines as outlin4ed in 410-141-3230; and the procedures for exercising these rights described in 410-141-3245. m. The circumstances under which an appeal process can be expedited and how to request it. n. The procedures for exercising the rights specified in this standard.	Literacy course. Effective 8/1/2019, the UM Department will require this course be mandatory for all UM Analysts that write NOABDs. Due to the frequency of classes offered this requirement should be able to be met within 18 months of hire. The UM Department maintains a tool called Hot Keys, which is a tool that allows for entry of standard language to be used time and time again. This creates controlled consistency with NOABD denial rationale content, including meeting the standards required, such as meeting literacy standards. Daily monitoring of timeliness is conducted by the UM Analyst. This daily review ensures that adverse determinations (fully or partial) are mailed timely and in compliance. AllCare CCO currently has a desk procedure. The NOABD policy below was recently revised. AllCare CCO will provide training to this policy that will be in effect by 1/1/2020. The monitoring processes and desk procedures will be refined to reflect the policy changes by 1/1/2020. Monthly monitoring will occur by Supervisor or Manager, which includes random selection and review of minimum 10 NOABDs per Analyst. This allows monthly feedback to the Analyst and is used as a training opportunity for any deficiencies identified, clarification on policy/procedure, layperson terms and all aspects of the NOABD process. The monthly NOABD reviews were identified as a needed process	

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Requirement	**Evidence as Submitted by the CCO**	**Score**
o. The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the member may be required to pay the costs of these services. *42 CFR §438.404(b)* *Contract: Exhibit I (3)(b)*	in March 2019. An IT generated random authorization data pull was created. A preliminary report, review of NOABDs and one-on-one meetings were held in April and May 2019. This process worked well and it was determined to proceed with a written policy and procedure. Effective 1/1/2020, this monitoring process will be in place. In addition ad-hoc review occurs simultaneously as the Exhibit I NOABD samples are pulled for OHA submission. AllCare CCO subcontracts Utilization Management to two Mental Health Organizations and five Dental and non-emergent medical transportation (NEMT) subcontractors. The MHO and Dental subcontractors are audited to comply with AllCare CCO's policy. The NEMT subcontractor audit tool will be completed by 01/01/2020. In 2018, AllCare CCO identified the need for a structured monitoring process. AllCare CCO created an authorization 'universe' that will pull all authorization requests. In 2019, AllCare CCO has utilized this universe to gather the required reporting elements from the UM department to provide for the Exhibit I for Q1 and Q2. AllCare CCO is currently revising the universe to include all the areas that we would like to monitor. The Quarterly Monitoring policy is in DRAFT as we continue to solidify the policy and procedure. AllCare CCO's goal is to complete the universe, policy and procedure prior to	

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	1/1/2020. AllCare CCO will provide a Quarterly Monitoring Report Analysis for Q12020. This initial analysis will capture the areas that are solidified for reporting. • **Q10-AllCare CCO Dental Audit Tool-ACCCO.docx** • **Q10-BH Review Audit Tool outline-ACCCO.pdf** • **Q10-New UM Analyst I Employee Orientation Checklist-ACCCO.docx** (pages 2-3) • **Q10-NOABD Appeal and Hearing Rights form (Spanish)-ACCCO.pdf** • **Q10-NOABD_Oral Interpretation-ACCCO.docx** (page 1) • **Q10-Sample NOABD English (fully adverse)-ACCCO.pdf** • **Q10-Sample NOABD English (Modified_Limited Approval)-ACCCO.pdf** • **Q10-Sample NOABD_AllCare CCO NOA-BD_English blank template-ACCCO.docx** • **Q10-Sample NOABD_AllCare CCO NOA-BD_Spanish blank template-ACCCO.docx** • **Q10-Sample NOABD_Spanish(2)(fully adverse)-ACCCO.pdf**	

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Requirement	**Evidence as Submitted by the CCO**	**Score**
	• **Q10-Sample NOABD_Spanish(fully adverse)-ACCCO.pdf** • **Q10-UM CCO 114 NOABD-ACCCO.docx** (pages 1-3) • **Q10-UM CCO 131 Alternative Language Format Notifications-ACCCO.docx (page 1)** • **Q10-UM CCO 138 Hot Key Creation and Monitoring-ACCCO.docx** (page 1) • **Q10-UM CCO 139 NOABD Monthly Monitoring-ACCCO.docx** (page 1) • **Q10-UM CCO Desk Procedure-Daily Denial Letters Due-ACCCO.docx** (pages 1 and 2)	
11. For standard authorization decisions, the CCO shall provide notice as expeditiously as the member's condition requires and within 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days: a. The member, or the provider, requests extension; or b. The CCO justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest. *42 CFR §438.210(d)(1)(i-ii)* *Contract: Exhibit B Part 2 (3)(h)*	AllCare CCO makes standard service determinations within 14 days and provides notice to the requesting Provider and written notice to the member if adverse (fully or partial). AllCare CCO created a Provider Portal in which our contracted (and some non-contracted) Providers can log in to and have access to eligibility, submit authorization requests, upload supporting documentation, view authorization determinations and the rationale for the determination, and send secure emails to the UM department. The Provider Portal is our main mechanism with communicating with our Providers. Additionally, we utilize fax and telephonic mechanisms for Providers that do not have access to	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	the Provider Portal or if the request was received by fax. For example, if a request was submitted via the Provider Portal, then we respond via the Provider Portal or if the request was received via fax, then we respond via fax. AllCare CCO will grant an extension if requested by the member, provider, or if we can justify the need for more information and the extension is in the best interest of the member. AllCare CCO sends a written extension notice to the Member within 14 days and sends a copy to the requesting Provider, and if applicable to the Provider we are awaiting information from. AllCare CCO utilizes a "Request for More Time to Review" notice, which has been approved by OHA. AllCare CCO utilizes daily monitoring reports that we use to ensure compliance. UM Analysts are assigned these reports daily and are responsible for ensuring authorization requests are in compliance. The Standard and NOABD policies below were recently revised. AllCare CCO will provide training to these policies that will be in effect by 1/1/2020. The monitoring processes and desk procedures will be refined to reflect the policy changes by 1/1/2020. AllCare CCO subcontracts Utilization Management to two Mental Health Organizations and five Dental and non-emergent medical transportation (NEMT) subcontractors. The MHO and Dental subcontractors are audited to comply with AllCare CCO's policy.	

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	The NEMT subcontractor audit tool will be completed by 01/01/2020. In 2018, AllCare CCO identified the need for a structured monitoring process. AllCare CCO created an authorization 'universe' that will pull all authorization requests. In 2019, AllCare CCO has utilized this universe to gather the required reporting elements from the UM department to provide for the Exhibit I for Q1 and Q2. AllCare CCO is currently revising the universe to include all the areas that we would like to monitor. The Quarterly Monitoring policy is in DRAFT as we continue to solidify the policy and procedure. AllCare CCO's goal is to complete the universe, policy and procedure prior to 1/1/2020. AllCare CCO will provide a Quarterly Monitoring Report Analysis for Q12020. This initial analysis will capture the areas that are solidified for reporting. • **Q11-AllCare CCO Dental Audit Tool-ACCCO.docx** • **Q11-BH Review Tool Outline-ACCCO.pdf** • **Q11-English Standard Extension Letter-ACCCO.docx** • **Q11-Spanish Standard Extension Letter-ACCCO.docx** • **Q11-Standard Authorization Daily Monitoring Report(II)-ACCCO.pdf**	

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• **Q11-Standard Authorization Daily Monitoring Report-ACCCO.pdf** • **Q11-UM CCO 111 Standard Service Determinations-ACCCO.docx** (pages 1-5) • **Q11-UM CCO 114 NOABD-ACCCO** (pages 2 and 4)	
12. For cases in which a provider indicates, or the CCO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the CCO 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. a. The CCO may extend the 72-hour time period by up to 14 calendar days if the member requests an extension, or if the CCO justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest. *42 CFR §438.210(d)(2)(i-ii)* *Contract: Exhibit B Part 2 (3)(i)*	AllCare CCO makes expedited service determinations within 72 hours and provides notice to the requesting Provider and written notice to the member if adverse (fully or partial). AllCare CCO created a Provider Portal in which our contracted (and some non-contracted) Providers can log in to and have access to eligibility, submit authorization requests, upload supporting documentation, view authorization determinations and the rationale for the determination, and send secure emails to the UM department. The Provider Portal is our main mechanism with communicating with our Providers. Additionally, we utilize fax and telephonic mechanisms for Providers that do not have access to the Provider Portal or if the request was received by fax. For example, if a request was submitted via the Provider Portal, then we respond via the Provider Portal or if the request was received via fax, then we respond via fax. AllCare CCO will grant an extension if requested by the member, provider or if we can justify the need for more information and the extension is in the best interest of the member. AllCare CCO sends a written	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	extension notice to the Member within 72 hours and sends a copy to the requesting Provider, and if applicable to the Provider we are awaiting information from. AllCare CCO utilizes a "Request for More Time to Review" notice, which has been approved by OHA. AllCare will make a service determination within 17 calendar days of receipt. AllCare CCO utilizes daily monitoring reports that we use to ensure compliance. UM Analysts are assigned these reports daily and are responsible for ensuring authorization requests are in compliance. The Expedited and NOABD policies below were recently revised. AllCare CCO will provide training to these policies that will be in effect by 1/1/2020. The monitoring processes and desk procedures will be refined to reflect the policy changes by 1/1/2020. AllCare CCO subcontracts Utilization Management to two Mental Health Organizations and five Dental and non-emergent medical transportation (NEMT) subcontractors. The MHO and Dental subcontractors are audited to comply with AllCare CCO's policy. The NEMT subcontractor audit tool will be completed by 01/01/2020. In 2018, AllCare CCO identified the need for a structured monitoring process. AllCare CCO created an authorization 'universe' that will pull all authorization requests. In 2019, AllCare CCO has utilized this universe to gather the required reporting elements from the UM department to provide for the	

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Exhibit I for Q1 and Q2. AllCare CCO is currently revising the universe to include all the areas that we would like to monitor. The Quarterly Monitoring policy is in DRAFT as we continue to solidify the policy and procedure. AllCare CCO's goal is to complete the universe, policy and procedure prior to 1/1/2020. AllCare CCO will provide a Quarterly Monitoring Report Analysis for Q12020. This initial analysis will capture the areas that are solidified for reporting. • **Q12-AllCare CCO Dental Audit Tool-ACCCO.docx** • **Q12-BH Review Tool Outline-ACCCO.pdf** • **Q12-English Expedited Extension Letter-ACCCO.docx** • **Q12-Expedited Authorization Daily Monitoring Report(II)-ACCCO.pdf** • **Q12-Expedited Authorization Daily Monitoring Report-ACCCO.pdf** • **Q12-Spanish Expedited Extension Letter-ACCCO.docx** • **Q12-UM CCO 110 Expedited Service Determinations-ACCCO.docx** (pages 1-6) • **Q12-UM CCO 114 NOABD-ACCCO.docx** (pages 2 and 4)	

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
13. For all covered outpatient drug authorization decisions, provide notice as described in section 1927(d)(5)(A) of the Act. a. Provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization. *42 CFR §438.210(d)(3)* *Sec. 1927. [42 U.S.C. 1396r-8] (d)(5)(A)* *Contract: Exhibit B Part 2 (3)(j)*	AllCare CCO notifies the requesting Provider within 24 hours of receipt of a PA request for outpatient drugs, including physician administered drugs and provides a timeframe for a final service determination. This statement is as follows, "Please note per OHP guidelines, we are required to process requests within 72 hours of receipt." AllCare CCO created a Provider Portal in which our contracted (and some non-contracted) Providers can log in to and have access to eligibility, submit authorization requests, upload supporting documentation, view authorization determinations and the rationale for the determination, and send secure emails to the UM department. The Provider Portal is our main mechanism with communicating with our Providers, which includes the acknowledgement of receipt of a request. Additionally, we utilize fax and telephonic mechanisms for Providers that do not have access to the Provider Portal or if the request was received by fax. For example, if a request was submitted via the Provider Portal, then we respond via the Provider Portal or if the request was received via fax, then we respond via fax. AllCare CCO utilizes a daily monitoring report that we use to ensure compliance. This report is ran multiple times per day. UM Analysts are assigned this report and are responsible for ensuring authorization requests are in compliance.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	The Expedited and Standard Outpatient Drug and Physician Administered Drug Service Determinations policy below were recently revised. AllCare CCO will provide training to this policy that will be in effect by 1/1/2020. The monitoring processes and desk procedures will be refined to reflect the policy changes by 1/1/2020. In 2018, AllCare CCO identified the need for a structured monitoring process. AllCare CCO created an authorization 'universe' that will pull all authorization requests. In 2019, AllCare CCO has utilized this universe to gather the required reporting elements from the UM department to provide for the Exhibit I for Q1 and Q2. AllCare CCO is currently revising the universe to include all the areas that we would like to monitor. The Quarterly Monitoring policy is in DRAFT as we continue to solidify the policy and procedure. AllCare CCO's goal is to complete the universe, policy and procedure prior to 1/1/2020. AllCare CCO will provide a Quarterly Monitoring Report Analysis for Q12020. This initial analysis will capture the areas that are solidified for reporting. • **Q13-OP Drug Daily Monitoring Report-ACCCO.pdf** • **Q13-PAD Daily Monitoring Report-ACCCO.pdf** • **Q13-Sample-Provider Portal Response-ACCCO.PNG**	

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• **Q13-Sample-Provider Faxed Response-ACCCO.pdf** • **Q13-UM CCO RX 100 Expedited and Standard Outpatient Prescription Drug and Physician Administered Drug Coverage Determination –ACCCO.docx,** (pages 1 and 3)	
14. For reduction, suspension, or termination of a previously authorized Medicaid-covered service, the CCO gives notice at least ten (10) days before the date of action except: • The CCO gives notice on or before the date of action if: – The agency has factual information confirming the death of a member. – The agency receives a clear written statement signed by the member that he/she no longer wishes services or gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information. – The member has been admitted to an institution where he/she is ineligible under the plan for further services. – The member's whereabouts are unknown, and the post office returns agency mail directed to him/her indicating no forwarding address. – The agency establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.	AllCare CCO mails a written member notice for each adverse (fully or partial) service determination when there is a reduction, suspension, or termination of a previously authorized covered service. AllCare CCO utilizes the approved OHA NOABD (form 2405), including the approved OHA Appeal and Hearing request (form 3302). AllCare CCO also includes the approved OHA Nondiscrimination Policy (form 2996). All three of these notices/forms are included with each NOABD. AllCare CCO has dedicated UM Analysts that write NOABDs. Each NOABD is manually written and are not system or IT generated. The UM Analyst is trained to the NOABD policy, and service determination policies that reference timeframes. The UM Analyst is trained one-on-one by Supervisor or Manager. The training consists of observing the processing of a NOABD and creating denial rationale content. Subsequently followed with hands-on writing of NOABDs with direct one-on-one oversight of Supervisor or Manager.	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
– A change in the level of medical care is prescribed by the member's physician. – The notice involves an adverse determination made with regard to the preadmission screening requirements. • If probable member fraud has been verified, the CCO gives notice five (5) calendar days before the date of action. *42CFR438.404(c), 42CFR431.211, 42CFR431.213(a)-(g), 42CFR431.214(a)* *Contract: Exhibit I (3)(c)*	AllCare CCO conducts Health Equity training classes to employees. One of these classes is a Health Literacy course. Effective 8/1/2019, the UM Department will require this course be mandatory for all UM Analysts that write NOABDs. Due to the frequency of classes offered this requirement should be able to be met within 18 months of hire. The UM Department maintains a tool called Hot Keys, which is a tool that allows for entry of standard language to be used time and time again. This creates controlled consistency with NOABD denial rationale content, including meeting the standards required, such as meeting literacy levels. Daily monitoring of timeliness is conducted by the UM Analyst. This daily review ensures that adverse determinations (fully or partial) are mailed timely and in compliance. AllCare CCO currently has a desk procedure. The NOABD policy below was recently revised. AllCare CCO will provide training to this policy that will be in effect by 1/1/2020. The monitoring processes and desk procedures will be refined to reflect the policy changes by 1/1/2020. Monthly monitoring will occur by Supervisor or Manager, which includes random selection and review of minimum 10 NOABDs per Analyst. This allows monthly feedback to the Analyst and is used as a training opportunity for any deficiencies identified, clarification on policy/procedure, layperson terms and	

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	all aspects of the NOABD process. The monthly NOABD reviews were identified as a needed process in March 2019. An IT generated random authorization data pull was created. A preliminary report, review of NOABDs and one-on-one meetings were held in April and May 2019. This process worked well and it was determined to proceed with a written policy and procedure. Effective 1/1/2020, this monitoring process will be in place. In addition ad-hoc review occurs simultaneously as the Exhibit I NOABD samples are pulled for OHA submission. AllCare CCO subcontracts Utilization Management to two Mental Health Organizations and five Dental and non-emergent medical transportation (NEMT) subcontractors. The MHO and Dental subcontractors are audited to comply with AllCare CCO's policy. The NEMT subcontractor audit tool will be completed by 01/01/2020. In 2018, AllCare CCO identified the need for a structured monitoring process. AllCare CCO created an authorization 'universe' that will pull all authorization requests. In 2019, AllCare CCO has utilized this universe to gather the required reporting elements from the UM department to provide for the Exhibit I for Q1 and Q2. AllCare CCO is currently revising the universe to include all the areas that we would like to monitor. The Quarterly Monitoring policy is in DRAFT as we continue to solidify the	

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	policy and procedure. AllCare CCO's goal is to complete the universe, policy and procedure prior to 1/1/2020. AllCare CCO will provide a Quarterly Monitoring Report Analysis for Q12020. This initial analysis will capture the areas that are solidified for reporting. • **Q14-AllCare CCO Dental Audit Tool-ACCCO.docx** • **Q14-BH Review Audit Tool Outline-ACCCO.pdf** • **Q14-UM CCO 114 NOABD-ACCCO.docx** (pages 1-5) • **Q14-UM CCO 139 NOABD Monthly Monitoring-ACCCO.docx** (page 1) • **Q14-UM CCO Desk Procedure 100-Termination, Suspension or Reduction of Services-ACCCO.docx** (pages 1-2)	
HSAG Findings: The CCO's Notice of Action-Adverse Benefit Determination Notice to Member policy included the required information for this element with one exception. The policy did not indicate that, for a reduction, suspension, or termination of a previously authorized Medicaid-covered service, the CCO gave notice on or before the date of action if the notice involved an adverse determination made with regard to the preadmission screening requirements.		
Required Actions: HSAG recommends that the CCO revise its Notice of Action-Adverse Benefit Determination Notice to Member policy to state that the CCO gives notice on or before the date of action if the notice involves an adverse determination made with regard to preadmission screening requirements.		

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
15. The CCO defines Emergency Services as covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish the services and needed to evaluate or stabilize an emergency medical condition. *42 CFR §438.114(a)* *Contract: Exhibit A (C)*	AllCare CCO defines and covers emergency services as outlined in policy: • **Q15-UM CCO 135 Emergency and Post Stabilization Services-ACCCO.docx** (pages 1-2)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
16. The CCO defines Poststabilization Care Services as covered services, related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition, or to improve or resolve the member's condition. *42 CFR §438.114(a)* *Contract: Exhibit A (H)(109)*	AllCare CCO defines and covers poststabilization care services as outlined in the below policies. • **Q16-UM CCO 135 Emergency and Post Stabilization Services-ACCCO.docx (page 2)** • **Q16-AllCare CCO BH Crisis Management System Policy_post stabilization highlighted-ACCCO. Pdf** (page 8) • **Q16-CCO Oral Health Post-Stabilization Services-ACCCO.docx**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
17. The CCO: a. Covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the CCO; and b. Does not deny payment for treatment obtained under either of the following circumstances: i. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes	AllCare CCO covers and pays for emergency services, as outlined in the attached policies. AllCare CCO provides training to Claims Analysts and the Configuration Team which is outlined in both the Urgent and Emergent Services Policy and the Claims Training Manual example to enforce that Urgent or Emergent services which, under industry standards, is identified by place of service. These claims and encounters do not require authorization and any clean claim that presents for payment will	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
specified in paragraphs (a), (b), and (c) of the definition of emergency medical condition in paragraph (a) of this section. ii. A representative of the CCO instructs the member to seek emergency services. *42 CFR §438.114(c)(1)* *Contract: Exhibit B Part 2 (4)(a)(3,5&11)*	process without denying. The Oregon Health Authority does require, based on Federal Guidelines (42 CFR 455.100-106, 42CFR 455.436, and 42 CFR 1002.3 – Program Integrity: Medicaid) that providers enroll with the Oregon Health Authority in order to be paid for services. • **Q 17-UM CCO 135 Emergency and Poststabilization Services-ACCCO.docx** (pages 2-3) • **Q17 Claims Training Manual Example-ACCCO.docx** • **Q17 ER Monitoring Denial Report Example-ACCCO.xlsx** • **Q17 Claims Urgent and Emergent Services Policy-ACCCO.DOCX** (page 3)	
18. The CCO does not: a. Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms; and b. Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, MCO, PIHP, PAHP or applicable State entity of the Member's screening and treatment within 10 calendar days of presentation for emergency services. *42 CFR §438.114(d)(1)* *Contract: Exhibit B Part 2 (4)(a)(1&10)*	AllCare CCO is sure to not limit what constitutes an emergency by diagnosis and is responsible for covering the emergency service regardless of notification to the members PCP or AllCare Health as outlined in policy: **Q 18-UM CCO 135 Emergency and Poststabilization Services-ACCCO.docx** (pages 2-3)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
19. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42 CFR §422.114(d)(2)* *Contract: Exhibit B Part 2 (4)(a)(9)*	AllCare CCO covers emergency services at no cost to the member. An AllCare CCO member will not be held liable for payment for the treatment of an emergent condition. Please see the attached policies: • **Q 19-UM CCO 135 Emergency and Poststabilization Services-ACCCO.docx** (page 4) • **Q19-Claims Urgent and Emergent Services Policy-ACCCO.docx** • **Q19-DIRECT PROVIDER AGREEMENT TEMPLATE-ACCCO.docx** (pages 5 and 11)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
20. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in paragraph (b) of this section as responsible for coverage and payment. *42 CFR §422.114(d)(3)* *Contract: Exhibit B Part 2 (4)(a)(9)*	AllCare CCO covers and pays for emergency and poststabilization services until the member has been sufficiently stabilized. This determination is made by the treating provider and AllCare CCO is responsible for coverage and payment until the treating providers specified date of stabilization. • **Q20-UM CCO 135 Emergency and Post Stabilization Services-ACCCO.docx** (page2)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
21. Poststabilization care services are covered and paid for in accordance with provisions set forth at 42 C.F.R. §422.113(c). a. The CCO is financially responsible (consistent with §422.214) for post-stabilization care services obtained within or outside the CCO's network that are pre-approved by a plan provider or other organization representative;	AllCare CCO covers and pays for poststabilization care services in and out of network for pre-authorized services. Services provided for poststabilization that are not pre-authorized and are in or out of network are covered and paid for as outlined in the attached poststabilization policy. AllCare CCO members are not financially responsible for any covered service.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
b. The CCO is financially responsible for post-stabilization care services obtained within or outside the CCO's network that are not pre-approved by a plan provider or other organization representative, but administered to maintain the member's stabilized condition within 1 hour of a request to the CCO for pre-approval of further post-stabilization care services; c. The CCO is financially responsible for post-stabilization care services obtained within or outside the CCO's network that are not pre-approved by a plan provider or other organization representative, but administered to maintain, improve, or resolve the member's stabilized condition if: i. The CCO does not respond to a request for pre-approval within 1 hour; ii. The CCO cannot be contacted; or iii. The CCO's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the CCO must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in §422.113(c)(3) is met. d. Must limit charges to members for post-stabilization care services to an amount no greater than what the organization would charge the member if he or she had obtained the services through the CCO's network. For purposes of cost sharing, post-stabilization care services begin upon inpatient admission.	Please see the following attached policies for additional detail. • **Q21-UM CCO 135 Emergency and Post Stabilization Services-ACCO.docx** (pages 2-4) • **Q21-Claims Urgent and Emergent Services Policy-ACCO.docx** • **Q 21-CCO Oral Health Poststabilization-ACCO.docx** • **Q21-AllCare CCO BH Crisis Management System Policy_post stabilization highlighted-ACCCO.pdf** (pages 8 and 10)	

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
42 CFR §438.114(e) *42 CFR §422.113(c)(2)(i-iv)* *Contract: Exhibit B Part 2 (4)(a)(6&8)*		
22. The CCO's financial responsibility for post-stabilization care services it has not pre-approved ends when: a. A plan physician with privileges at the treating hospital assumes responsibility for the member's care; b. A plan physician assumes responsibility for the member's care through transfer; c. A CCO representative and the treating physician reach an agreement concerning the member's care; or d. The member is discharged. *42 CFR §438.114(e)* *42 CFR §422.113(c)(3)(i-iv)* *Contract: Exhibit B Part 2 (4)(a)(7)*	AllCare CCO has a policy to show when the CCO's financially responsibility for poststabilization services has ended. Please see the following attachment. • **Q22-UM CCO 135 Emergency and Post Stabilization Services-ACCO.docx** (page 4)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
23. The CCO has written policies and procedures that describe the process for receiving member requests, approving non-emergent medical transportation (NEMT) services, and scheduling, assigning, and dispatching providers. *Contract: Exhibit B Part 2 (4)(b)*	AllCare CCO provides non-emergent medical transportation through our subcontracted partner ReadyRide. AllCare CCO requires ReadyRide to adhere to all applicable OARs and AllCare CCO policies and procedures. AllCare CCO employs a staff member (the NEMT Liaison) to work closely with and help oversee ReadyRide operations. ReadyRide's Call Center Policy and Procedure (attachment Q23-RR Policy & Procedures_v2.2-ACCCO) details how calls are received and scheduled; assigned; and dispatched. For medical trips that are out-of-the area and/or to a specialist, ReadyRide contacts the NEMT Liaison for	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	confirmation that the medical service has been authorized by the CCO. For health-related services, also known as flexible services, the ride must be approved by the NEMT Liaison. If there is medical or clinical complexity associated with the request, the NEMT Liaison must consult with an AllCare clinical staff member such as a Medical Director or Registered Nurse. • Please see attachments **Q23-CCO NEMT desk procedure-ACCCO.docx** (pages 2-4) and **Q23-NEMT Liaison job description-ACCCO.pdf** for more details. Please see attachment **Q23-RR Policy & Procedures_v2.2-ACCCO.pdf**: Section 2 **pages 7-12** for how NEMT calls are received and scheduled; section 3 **pages 14-16** for how rides are assigned; and section 8 **pages 29-34** for how rides are dispatched.	
24. The CCO maintains a NEMT Call Center with minimum operating hours Monday through Friday from 9:00am to 5:00pm. For after hours arrangements, the CCO provides an afterhours message in English and Spanish instructing the caller how to access the alternative arrangement. *Contract: Exhibit B Part 2 (4)(b)(13)*	AllCare CCO provides non-emergent medical transportation through our subcontracted partner ReadyRide. ReadyRide maintains a call center that operates with live personnel Monday through Friday 8:00 am through 6:00 pm. ReadyRide employs at least one bilingual operator who is certified as a Spanish interpreter. AllCare CCO provides information on how to contact and schedule a ride with ReadyRide on the AllCare CCO website. This information is also available in both the English and Spanish versions of the AllCare	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	CCO member handbook and the ReadyRide rider handbook. For after-hours calls, ReadyRide has a message with instructions in English and Spanish on how to schedule an after hour ride. ReadyRide does provide rides 24 hours a day seven days a week. • Please see attachment **Q24- Ready Ride after Hours Script-ACCCO.pdf** for ReadyRide's after-hours script for the English and Spanish instructions. • Please see attachment **Q24-RR Policy & Procedures_v2.2-ACCCO.pdf** for the ReadyRide Call Center Policy & Procedures. Call center instructions calls during and after business hours are located on **pages 5 and 39**. • **Attachment Q24-AllCareCCOwebsite screenshot-ACCCO.pdf** is a screenshot of our AllCare CCO webpage with information on how members can contact ReadyRide. • Please see attachments **Q24-2018accco-member-handbook-ACCCO.pdf** and **Q24-2018accco-member-handbook-spanish-ACCCO.pdf** for our member handbooks. Information on ReadyRide is available on **page 29 of the English version and page 30 of the Spanish version**. • Please see attachments **Q24-2018-RR-riders-guide-english-web-ACCCO.pdf**	

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	and **Q24-2018-RR-riders-guide-spanish-web-ACCCO.pdf** for our rider s' guide. Information on scheduling a ride is available on pages 4-5 of the English version and **pages 3-4 of the Spanish version** • Please see attachment **Q24-Readyride Service Contract-ACCCO.pdf** for a copy of our contract with ReadyRide	
25. The CCO has written policies and procedures for Emergency Dental Services and Urgent Care Services for Emergency Dental Conditions that describe when treatment of an emergency or urgent dental condition should be provided in an ambulatory dental office setting and when emergency dental services should be provided in a hospital setting. *Contract: Exhibit B Part 2 (4)(k)(2)*	AllCare CCO has a policy and procedure for urgent and emergency dental care, as outlined in the policy: • **Q25-Oral Health Urgent and Emergent Services-ACCCO.docx** (page 2) • **Q25-Oral Health Timely Access to Care-ACCCO-docx** • **Q25-Oral Health Audit Tool-ACCCO.docx**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
26. The CCO has written policies and procedures and monitoring systems for an emergency response system that provides immediate, initial or limited duration response for emergency behavioral health situations. *Contract: Exhibit M (2)(g)*	Providing documentation and no narrative: • **Q26-Crisis Management System Policy-ACCCO.pdf,** pages 2-8 and 11-12 • **Q26-Clinical Crisis & Mobile Crisis Review Tool-ACCCO.pdf** • **Q26-Jackson County Crisis log June 2019 – ACCCO.xlxs** • **Q26-CCH Review Report 12.30.18 – ACCCO.pdf,** pages 11, 12 and 14	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
27. The CCO ensures that all members have access to Mobile Crisis Services to promote stabilization in a community setting rather than arrest, presentation to an emergency department, or admission to an acute psychiatric care facility. *Contract: Exhibit M (2)(g)(2)*	Providing documentation and narrative: • **Q27-Crisis System Management Policy-ACCCO.pdf,** pages 6-8 and 11-12 • AllCare CCO monitors Mobile Crisis services by receiving and reviewing the Mobile Crisis Quarterly Report completed by each of our contracted Community Mental Health Programs (CMHP). See attachment **Q27-Mobile Crisis Unit Response Quarterly Report template-ACCCO.xlxs** for an example of the report that will be submitted to AllCare CCO. AllCare CCO has requested that these reports be submitted quarterly by the CMHPs starting September 1, 2019.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services	
	Total #
Complete	**25**
Progress Sufficient	**2**
Incomplete	**0**
Not Applicable (NA)	**0**

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. Notwithstanding any relationship(s) that the CCO may have with any subcontractor, the CCO maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. *42 CFR §438.230(b)(1)* *Contract: Exhibit B Part 4(13)*	AllCare CCO's subcontracts, policies and procedures reflect the understanding that AllCare CCO has 'ultimate responsibility' for its subcontractors **Q1-Subcontractors and Delegated Entities-ACCCO.pdf** page 1 overview. Please see also: **Q1-Options for Southern Oregon, Inc 4.1.2017-ACCO.pdf** page 23 paragraph 2 and **Q1-AllCare CCO - 2015 Advantage Dental, LLC-Contract language-ACCCO.pdf** pages 4, 24-25 paragraph 2. AllCare CCO will require each subcontractor to perform the services and meet the obligations and terms of conditions as if the subcontractor is AllCare CCO. AllCare CCO will demonstrate oversight, monitoring and reporting of its subcontractors annually by: 1) routine activities such as appeals, grievances, and internal concerns monitored and reported up to the Quality Committee and BOG; 2) formal audit and review practices as documented in the compliance policies with results monitored and reported up to the Compliance Committee, Quality Committee and the BOG. Please see the example of oral health subcontractor oversight and the policies/procedure/oversight/monitoring processes below: • **Q1-Subcontractors Scope of Work-ACCCO.doc;** page 1	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• **Q1-Quality Policy Description-ACCCO.doc;** page 18 • **Q1-Fraud Waste and Abuse Plan-ACCCO.docx;** pages 1, 4, 8 and 15 • **Q1-Oral Health Subcontractor Oversight-ACCCO.docx** For delegated credentialing **Q1-Delegated Credentialing Policy-ACCCO.docx**, AllCare continually monitors contractors' performance to determine whether the specified delegated activities are being carried out in accordance with this policy and AllCare standards. As one means of accomplishing this objective, AllCare conducts an annual review of contractors, including, at a minimum, audits of the contractor's credentialing and recredentialing files. These annual reviews, together with other reports of oversight and monitoring, will be reviewed by AllCare's Credentialing Committee at least quarterly and forwarded to the Peer Review Committees and the Board of Directors as needed. After completion of all aspects of the audit, the AllCare team will prepare and deliver to AllCare's Medical Director a report specifying deficiencies and preparing a Corrective Action Plan. AllCare will then send a letter to the contractor, notifying them of the results of the audit and requiring proof of completion of the Corrective Action Plan within the time set by AllCare, not to exceed 90 days. The Medical Director shall report to the Credentialing Committee	

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	the audit findings and progress in satisfying the Corrective Action Plan requirements. **Q1-Pages from AllCare CCO - 2015 Advantage Dental, LLC-Contract language-ACCCO.pdf** page 5 section 9.3; **Q1-Options for Southern Oregon, Inc 4.1.2017-ACCO.pdf** page 10 section 5.1, page 7 paragraph 4.	
2. All contracts or written arrangements between the CCO and any subcontractor must be submitted to OHA annually and within 30 days of addition of a subcontractor and must include: • The delegated activities or obligations, and related reporting responsibilities. Contractor shall not fully subcontract the provision of Behavioral Health services and Care Coordination to another entity. • The subcontractor agreement to perform the delegated activities and reporting responsibilities specified in compliance with the CCO's obligations. • The contract or written arrangement must either provide for revocation of the delegation of activities or obligations or specify other remedies in instances where the State or CCO determine that the subcontractor has not performed satisfactorily. • The requirements for written agreements as outlined in the CCO's contract with OHA, including fully integrated service delivery and funding (as defined in ORS 414.025). *42 CFR §438.230(c)(1-3)* *Contract: Exhibit B Part 4 (12), (13)(a)(1) and (13)(b)(1)(a-j), Exhibit M(1)*	Per the **Q2-Subcontractors and Delegated Entities Policy-ACCCO.pdf** All contracts or written arrangements between AllCare and any subcontractor will be submitted to OHA annually with the Subcontractors and Delegated Entities Report and within 30 days of addition of a subcontractor. These contracts are currently under legal review and will include updated exhibits with specific language to ensure compliance with updated ORS and OAR delegation regulations and responsibilities of AllCare and Subcontractors. AllCare legal counsel will be able to complete this contract update upon receipt of OHA guidance regarding authorized and prohibited functions (including prohibition of Grievance & Appeals functions to Behavioral Health Organizations, among other anticipated updates). Please refer to **Q2-Letter to create delegated agreement-ACCCO.docx** for details on language requested from counsel. Further new or revised AllCare policies and procedures will be written and can be submitted to OHA or HSAG after OHA guidance is released.	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Contracts and associated Policies & Procedures either currently include or will be updated within 60 days of receipt of updated OHA delegation guidelines to include the following: a) The delegated activities or obligations, and related reporting responsibilities. AllCare shall not fully subcontract the provision of Behavioral Health services and Care Coordination to another entity b) The subcontractor agreement to perform the delegated activities and reporting responsibilities specified in compliance with AllCare's obligations c) The contract or written arrangement must either provide for revocation of the delegation of activities or obligations or specify other remedies in instances where the State or AllCare determine that the Subcontractor has not performed satisfactorily. d) The requirements for written agreements as outlined in the AllCare's contract with OHA, including fully Integrated service delivery and funding (as defined in ORS 414.025). Please see each bullet below where each bullet is addressed in the Delegated Credentialing Policy • **CRD-003-Delegated Credentialing Policy-ACCCO.docx, 1.2, 2, 5, 5.1, 5.2** • **CRD-003-Delegated Credentialing Policy-ACCCO.docx, 3, 5, 5.1, 5.2**	

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• **CRD-003-Delegated Credentialing Policy-ACCCO.docx, 9, 9.1, 9.2** • **CRD-003-Delegated Credentialing Policy-ACCCO.docx, 2** AllCare currently submitted this list to OHA **Q2-subcontracted and delegated entities template-ACCCO.xlxs** and will continue to do so within 30 days of any change in subcontractor or addition. Please see the AllCare Subcontractor and Delegated Entities policy: **Q2-Subcontractors and Delegated Entities Policy-ACCCO.pdf**(Whole document)	
HSAG Findings: AllCare provided policies and procedures that stated its written subcontractor agreements will include federal and State requirements and that AllCare will submit information about subcontractor agreements annually and within 30 days of any subcontractor change to OHA. However, AllCare did not provide a base or template subcontractor agreement as the CCO was in the process of updating them at the time of the desk review. During the remote interview session, AllCare staff members stated that they are on track to have all subcontractor agreements updated and executed prior to January 1, 2020.		
Required Actions: While the submitted policies and procedures provided evidence that AllCare understands the requirements of the subcontractor written agreements, HSAG was unable to confirm that all required elements are contained in the agreements as they were in the process of being updated. HSAG recommends that AllCare provide evidence to OHA that subcontractor agreements have been updated to include all State and federal requirements.		
3. The CCO evaluates the prospective subcontractor's readiness and ability to perform the scope of work outlined in the written agreement prior to the effective date of the contract. • Copies of the evaluation must be provided to OHA any time the CCO enters into a new subcontractor agreement. *Contract: Exhibit B Part 4(13)(a)(1)*	AllCare CCO's Contracts Manager, Chief Compliance Officer, CCO and any subject matter expert in the area that is being considered for subcontracting services, will conduct an on-site review to assess for systems readiness, FWA requirements (background checks and checking the exclusion lists for employees, Board and providers), FWA training.	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• **Q3-CRD-003-Delegated Credentialing Policy-ACCCO.docx, 1, 1.1, 1.1.1, 1.1.2** • **Q3-Subcontractors and Delegated Entities Policy-ACCCO.pdf,** Page 2, Paragraph 3 • **Q3-Subcontractors Scope of Work-ACCCO.doc** Evidence: • **Q3-Behavioral Health Compliance Review Outline & Document Request 2018-ACCCO.docx** • **Q3-BH Personnel Review 2018-ACCCO.docx** • **Q3-AllCare Chart Review-ACCCO.docx** • **Q3-AllCare Dental Audit Tool-ACCCO.docx**	
HSAG Findings: AllCare's Subcontractors and Delegated Entities policy stated that AllCare will perform a pre-delegation assessment on potential subcontractors prior to the effective date of the contract. No other information as to how the assessment would be completed or the tools used was included. The Delegated Credentialing policy stated that a pre-delegation assessment will be conducted if the subcontractor is not an accredited or certified entity. This policy contained specific information about the pre-delegation processes used by AllCare. If a subcontractor is certified or accredited, AllCare requests a current copy of the credentialing and recredentialing policies and procedures and a copy of the current certification or accreditation from the National Committee for Quality Assurance (NCQA).		
Required Actions: HSAG recommends that the CCO revise the Subcontractors and Delegated Entities policy to include more specificity as to the processes and tools used for conducting the pre-delegation readiness assessment.		
4. The CCO has a process to monitor the subcontractor's performance on an ongoing basis. • Formal reviews shall be conducted by the CCO at least annually.	AllCare CCO will continue to strengthen and align oversight and formal reviews with the requirements outlined in the OARS. AllCare CCO will review audit tools for all subcontractors and make the	☒ Complete ☐ Progress Sufficient to Start Operations

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Contract: Exhibit B Part 4(13)(a)(12-14)	necessary changes by 10/01/2019. AllCare currently conducts on-site audits of the dental organizations, PBM, mental health providers, credentialing entities, A & D providers and methadone clinics. Though quarterly meetings occur with the NEMT provider, an audit tool will be developed and an audit will be scheduled for September 2019. • **Q4-Quality Policy Description-ACCCO.doc** Pages 18-19; • **Q4-Delegated Credentialing Policy-ACCCO.docx**, 7, 8; • **Q4-Subcontractors and Delegated Entities Policy-ACCCO.pdf,** page3, paragraph 4; • **Q4-Subcontractors Scope of Work-ACCCO.doc** Evidence; • **Q4-Subcontractor Audits_2018-2019-ACCCO.docx** • **Q4-Example Behavioral Health Review Personnel Tool-ACCCO.docx** • **Q4-Example Behavioral Health Audit Tool-ACCCO.docx** • **Q4-Example Oral Health Chart Review Tool-ACCCO.docx** • **Q4-Example Subcontractor Oral Health Audit Tool-ACCCO.docx**	☐ Incomplete ☐ NA

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
5. Whenever deficiencies or areas of improvement are identified, the CCO and subcontractor shall take corrective action. *Contract: Exhibit B Part 4(13)(a)(15-17)*		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		
6. The Contractor must provide to OHA, annually and within 30 days of any change in subcontractor, the Subcontractors and Delegated Entities Report. The report should identify any activities the Contractor has agreed to perform under the contract that have been subcontracted or delegated, and include information related to the subcontracted work including: • The legal name of the Subcontractor; • The scope of work being subcontracted; • Copies of ownership disclosure form, if applicable; • Copies of all written agreements with Subcontractors to ensure all contracts meet the requirements outlined in 42 CFR 438.230; • Any ownership stake between the Contractor and Subcontractor. *Contract: Exhibit B Part 4(13)(a)(5-6)*	Per the **Q6-Subcontractors and Delegated Entities Policy-ACCCO.xlxs** All contracts or written arrangements between AllCare and any subcontractor will be submitted to OHA annually with the Subcontractors and Delegated Entities Report and within 30 days of addition of a subcontractor and will include: a) The delegated activities or obligations, and related reporting responsibilities. AllCare shall not fully subcontract the provision of Behavioral Health services and Care Coordination to another entity b) The subcontractor agreement to perform the delegated activities and reporting responsibilities specified in compliance with AllCare's obligations c) The contract or written arrangement must either provide for revocation of the delegation of activities or obligations or specify other remedies in instances where the State or AllCare determine that the subcontractor has not performed satisfactorily.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	d) The requirements for written agreements as outlined in the AllCare's contract with OHA, including fully integrated service delivery and funding (as defined in ORS 414.025). Q6 Current subcontractors: • **Q6-subcontracted and delegated entities template-ACCCO.xlsx** • **Q6-AllCare - Curry County Mental Health-ACCCO.pdf** • **Q6-AllCare & Options Mental Health Services Agreement-ACCCO.pdf** • **Q6-AllCare CCO - 2015 Advantage Dental Services, LLC-ACCCO.pdf** • **Q6-AllCare CCO - Willamette Dental 06.2015-ACCCO.pdf** • **Q6-Capitol Agreement-ACCCO.pdf** • **Q6-La Clinical del Valle Family Healthcare Center Inc. Dental Agreement-ACCCO.pdf** • **Q6-ODS Community Health, Inc.-ACCCO.pdf** • **Q6-Options for Southern Oregon, Inc 4.1.2017-ACCCO.pdf** • **Q6-Subcontractors and Delegated Entities Policy-ACCCO.xlxs**	

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
7. The Contractor must notify OHA in writing within 30 days of terminating any Subcontractor and provide an updated Subcontractors and Delegated Entities report. The Contractor must notify OHA in writing within 30 days of terminating any Participating Provider contract when such termination is a for-cause termination, including but not limited to: • Failure to meet requirements under the contract; • For reasons related to fraud, integrity, or quality; • Deficiencies identified through compliance monitoring of the entity; or • Any other for-cause termination. *Contract: Exhibit B Part 4(13)(b)(4)*		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		

Standard VI—Subcontractual Relationships and Delegation	
	Total #
Complete	**3**
Progress Sufficient	**2**
Incomplete	**0**
Not Applicable (NA)	**2**

Standard IX—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. In compliance with 42 C.F.R. §438.3(d), the CCO: a. Shall accept individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), up to the limits set under the Contract. b. Shall not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll. c. Shall not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability. *42 CFR §438.3(d)(1-4)* *Contract: Exhibit B Part 3 (6)(a)(2-3)*	AllCare does not deny any enrollment for OHP members on the basis of race, color, national origin, sex, sexual orientation, gender identity or disability. We accept all enrollment records submitted by OHA via our 834 Eligibility file. Enrollments are uploaded in to our system as received in the file. Please see: • **Q1-Maintaining Accurate member Eligibility-ACCCO.docx,** page 1	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
2. The CCO shall not request disenrollment because of an adverse change in the member's health status, or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the CCO seriously impairs the entity's ability to furnish services to either this particular member or other members). *42 CFR §438.56(b)(2)* *Contract: Exhibit B Part 3 (6)(a)(4)*	As outlined in the federal and OHA requirements, AllCare CCO will not request a member's disenrollment due to changes in their health status, utilization of medical services, diminished mental capacity or uncooperative or disruptive behavior except when his or her continued enrollment with AllCare would seriously impair the entity's ability to furnish services to the individual or other individuals. Please see: • **Q2-Member Disenrollment Request-ACCCO.docx**, page 2	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IX—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the CCO**	**Score**
3. The CCO shall assure the State that it does not request disenrollment for reasons other than those permitted under the Contract. The CCO may request disenrollment if a member: a. Is uncooperative or disruptive, except where this is a result of the member's special needs or disability; b. Commits fraudulent or illegal acts such as permitting the use of his or her OHP Client identification card by another person, altering a prescription, theft or other criminal acts committed in any provider's or CCO's premises; c. Makes a credible threat to cause grievous physical injury, including but not limited to, death to others in the near future, and that significant risk cannot be eliminated by a modification of policies, practices or procedures; or d. Commits an act of physical violence, to the point that the member's continued enrollment in the CCO seriously impairs the CCO's ability to furnish services to either the member or other members. *42 CFR §438.56(b)(3)* *Contract: Exhibit B Part 3 (6)(b)(4-5)*	AllCare does not request any disenrollment request unless it is a condition outlined in our contract. If disenrollment is requested for an uncooperative or disruptive member, a member who may have committed fraudulent or illegal acts, makes creditable threats to staff, providers, or provider staff, or commits acts of physical violence we would follow the contractual language and submit the required documentation to the AllCare CCO Account Representative such as but not limited to the follow: • Obtaining police reports when applicable • Documentation such as emails, recorded calls, Case Management notes • OHA form; CCO Requests for Unruly member Assistance from the State Please see: • **Q3-Member Disenrollment Request-ACCCO.docx,** page 4 • **Q3-Unruly OHP Member Document-ACCCO.docx**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
4. The CCO allows a member to request disenrollment as follows: a. For cause, at any time. b. Without cause, at the following times: i. During the 90 days following the date of the member's initial enrollment into the CCO, or during the 90 days following the date the State sends the member notice of that enrollment, whichever is later.	A member disenrollment request is submitted by member to OHA. If it is a retro disenrollment we are notified by the CES Department and action is taken by AllCare CCO. If it is a normal request it will be included in the 834 Eligibility file as a Termination record. AllCare CCO does not review these requests. OHA reviews and will notify AllCare CCO of their action.	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IX—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the CCO**	**Score**
ii. At least once every 12 months thereafter. iii. Upon automatic reenrollment under paragraph (g) of this section, if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity. iv. When the State imposes the intermediate sanction specified in 42 CFR §438.702(a)(4) and this Contract. *42 CFR §438.56(c)(1),(2)(i-iv)* *Contract: Exhibit B Part 3 (6)(b)(3)*	Please see: • **Q4-Member Disenrollment Request-ACCCO.docx,** Pages 2, 3 • **Q4-2020-Member Handbook-ACCCO.docx,** Pages 32-33	
HSAG Findings: The MBRSERV 020—Request of Member Disenrollment policy included the requirements for Element 4.a. and 4.b.ii.–4.b.iv. However, the timeframe for Element 4.b.i. was not consistent with federal regulations or the CCO contract. The policy identified that a newly enrolled member could request disenrollment within 12 months of his or her initial plan enrollment or the date OHA sends the notice of the enrollment, whichever is later, and not the required 90-day time frame. The CCO's Member Handbook—ACCCO, however, included the required 90-day time frame. During the remote interview session, CCO staff members stated they are currently reviewing and updating all policies, as appropriate, to reflect current federal and contract requirements.		
Required Actions: HSAG recommends that the CCO ensure all time frames related to member disenrollment requests identified in its policy are updated to be consistent with federal requirements and the CCO contract.		
5. The member (or his or her representative) must submit an oral or written disenrollment request, as required by the State— i. To the State (or its agent); or ii. If the request is received by the CCO, the CCO forwards that request to OHA or DHS Eligibility. *42 CFR §438.56(d)(1)* *Contract: Exhibit B Part 3 (6)(b)(3)(a)*	Requests to be disenrolled from AllCare CCO which come from Member or the Member Representative are sent to the state for review. Member must request this orally or in writing. Please see: • **Q5-Member Disenrollment Request-ACCCO.docx** • **Q5- 2020-Member Handbook-EN-DRAFT-ACCCO.pdf,** Page 33	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IX—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• **Q5-Member Change Requests-ACCCO.docx,** Page 2	
HSAG Findings: The MBRSERV 020—Request of Member Disenrollment and the MBRSERV 023—Member Change Requests policies included the requirements for this element. Further, the Member Handbook EN—Draft informed members that they may ask OHA to remove them from the CCO but did not specify that members must submit a request for disenrollment orally or in writing.		
Required Actions: HSAG recommends that the CCO ensure member information materials inform the member (or member's representative) that disenrollment requests must be submitted orally or in writing.		
6. The following are cause for disenrollment: a. The member moves out of the CCO's service area. b. The CCO does not, because of moral or religious objections, cover the service the member seeks. c. The member needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the provider network; and the member's primary care provider or another provider dete1mines that receiving the services separately would subject the member to unnecessary risk. d. For Members that use MLTSS, the Member would have to change their residential, institutional, or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider with the CCO and, as a result, would experience a disruption in their residence or employment. e. Other reasons, including but not limited to poor quality of care, lack of access to services covered under the Contract, or lack of access to providers experienced in dealing with the member's care needs.	AllCare CCO Member Service staff will report any member demographic changes to; OregonHealthPlan.Changes@dhsoha.state.or.us Via the OHP Secure Website A Member may be disenrolled from AllCare CCO for reasons, but not limited to are listed below; • They move out of the service area • The CCO does not cover due to moral or religious reasons • The member needs services that the providers in the service are a do not cover • Poor quality of care Please see: • **Q6-Member Disenrollment Request-ACCCO.docx,** page 3; • **Q6- 2020 Member Handbook-EN-DRAFT-ACCCO.pdf,** page 31-32; • **Q6-Demographic changes-ACCCO.docx,** pages 1, 2;	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IX—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the CCO**	**Score**
42 CFR §438.56(d)(2) *Contract: Exhibit B Part 3 (6)(b)(3)(a)(ii)*		
HSAG Findings: The MBRSERV 020—Request of Member Disenrollment policy included the requirements for Element 6.a., 6.b., 6.c., and 6.e.; however, the policy did not specify that, for members who use managed long-term services and supports (MLTSS), a cause for disenrollment is allowable when the member would have to change his or her residential, institutional, or employment supports provider due to a provider's change in status from an in-network to an out-of-network provider and would subsequently experience a disruption in his or her residence or employment.		
Required Actions: HSAG recommends that the CCO revise its member disenrollment policy to ensure all required "for cause" disenrollment reasons are documented.		

Standard IX—Enrollment and Disenrollment	
	Total #
Complete	**3**
Progress Sufficient	**3**
Incomplete	**0**
Not Applicable (NA)	**0**

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. The CCO develops and implements a grievance system for members that includes an appeals process, a grievance process, and a process to access the State's fair hearing system as specified in rule (subpart F). If the CCO is responsible for sending notice of action, they must notify members in a timely manner. *42 CFR §438.228(a)* *Contract: Exhibit I*	AllCare CCO does not subcontract out the appeal process. All appeals are processed internally at AllCare CCO. If an appeal is received by a subcontractor, the appeal is sent immediately on to AllCare CCO for processing. This includes, NEMT, Oral Health, and Mental Health. Subcontractors currently process grievances that are submitted directly to them. On a quarterly basis AllCare CCO does receive an Exhibit I from each subcontract that includes the grievance that were submitted and processed by them. AllCare CCO monitors for timeliness, trends in providers or clinics and the resolution of the complaint. If AllCare is not in agreement with the resolution of the complaint, AllCare CCO will reach out to the subcontractor for additional information and clarity. In some instances, AllCare CCO will reach out to the member and offer additional resolutions that were not provided by the subcontractor. AllCare CCO recognizes the system currently in place for processing grievances is not clearly defined in the contract and will begin the process to update the contract to provide a more clear process for AllCare CCO to have a more of a "real time" oversight of each complaint submitted to a subcontractor. AllCare CCO has policies and processes in place to reflect the OARs, CFRs and the Contract. Please see the following documents: • **Q1-Grievance Policy–ACCCO.docx**, full policy;	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• **Q1-Appeals and Hearing Policy-ACCCO.docx,** full policy**;** • **Q1-Appeal Effectuation Policy – ACCCO.docx,** full policy**;** • **Q1-Oversight of Exhibit I-ACCCO.docx,** Full Policy; • **Q1-AllCare Member Handbook-ACCCO.pdf,** Pages 55-57; • **Q1-AllCare CCO Provider Manual-ACCCO.pdf,** Page 35 and pages 39-40; • **Q1-Claims Notice of Denial of Payment Processes-ACCCO.pdf,** Full document; • **Q1-NOA-ABD-ACCCO.docx,** Full Policy.	
2. The CCO has internal grievance procedures under which Medicaid members may challenge the denial of coverage of, or payment for medical assistance (adverse benefit determination). • The CCO may have only one level of appeal for members. • A member may request a State fair hearing (contested care hearing) after receiving an appeal resolution notice from the CCO that the adverse benefit determination has been upheld. • If the CCO fails to adhere to required timeframes for processing appeals, the member is deemed to have exhausted the CCO's appeal process and the member may initiate a State fair hearing (contested case hearing). *42 CFR §438.402(a-c)* *42 CFR §438.400(a)(3), (b)* *Contract: Exhibit I (1)(a-b)*	Please see: • **Q2-Appeals and Hearing Policy-ACCCO.docx,** page 1, Purpose; • **Q2-Appeals and Hearing Policy-ACCCO.docx**, Page 2, B. Timeframes for submitting an Appeal, #2 and page 11; • **Q2-Member Handbook-ACCCO.pdf**, Page 55; • **Q2-Desk Top Procedure for Appeals Policy-ACCCO.docx**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
3. The CCO defines an Adverse Benefit Determination as: 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, as defined by the State. e. The failure of the CCO to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. f. For a resident of a rural area with only one CCO, the denial of a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network. 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. *42 CFR §438.400(b)* *42 CFR §438.52(b)(2)(ii)* *RFA: Appendix A (C)*	Please see: • **Q3-NOA-ABD-Policy-ACCCO.docx**, Page 1, Definition	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
4. The CCO defines Appeal as a review by the CCO of an Adverse Benefit Determination. *42 CFR §438.400(b)* *RFA: Appendix A (H)(11)*	AllCare's definition of an appeal (means a request for review of an adverse determination or denial) is consistent with the CFRs, OARs and the CCO contract. AllCare CCO has policies and processes in place to reflect the OARs, CFRs and the Contract. Please see: • **Q4-Appeals and Hearing Policy – ACCCO.docx,** page 1, Purpose; • **Q4-Appeals and Hearing Policy – ACCCO.docx,** page 1, Policy.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
5. The CCO defines Grievance as an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. • 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. Grievances include the member's right to dispute an extension proposed by the CCO to make an authorization decision. *42 CFR §438.400(b)* *RFA: Appendix A (H)(57)*	AllCare takes all member and provider complaints seriously. Each one is investigated and processed to ensure that our members are receiving the best quality of care they can from our providers. Please see: • **Q5-AllCare Member Handbook-ACCCO.pdf**, page 55 and 60; • **Q5-Grievance Policy–ACCCO.docx,** Page 1, Policy.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
6. A member may file a grievance with the CCO at any time, either orally or in writing. Grievances can be submitted to the State or the CCO.	AllCare CCO encourages members to submit their complaints to AllCare either in writing or orally. AllCare want to improve our systems and network in order to provide the best quality of care to our members.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
42 CFR §438.402(c)(2)(i), (c)(3)(i) *Contract: Exhibit I (2)(a)*	Please see: • **Q6-Member Handbook-ACCCO.pdf,** Page 55**;** • **Q6-Screenshot Website of Complaint Forms-ACCCO.docx;** • **Q6-Grievance Policy–ACCCO.docx,** Page 2**,** Submitting a Complaint; • **Q6-Complaint Packet Spanish-ACCCO.pdf** • **Q6-Complaint Packet English-ACCCO.pdf**	☐ NA
7. A member may file an appeal within 60 calendar days from date on the notice of adverse benefit determination. • The member may request an appeal either orally or in writing. Unless the member requests an expedited resolution, an oral appeal must be followed by a written, signed appeal. *42 CFR §438.402(c)(2)(ii), (c)(3)(ii)* *Contract: Exhibit I (1)(b)(2), (1)(c)(2-3)*	Please see: • **Q7-Appeals and Hearing Policy-ACCCO.docx** page 2, B. Timeframes for submitting an Appeal, #1; • **Q7-Appeals and Hearing Policy-ACCCO.docx** page 3, C. Submitting an Appeal, # 2 and #3; • **Q7-Member Handbook-ACCCO.pdf**, Page 55-56; • **Q7-NOA-ABD Template Letter-ACCCO.docx**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
8. The CCO must acknowledge receipt of each grievance and appeal. *42 CFR §438.406(b)(1)* *Contract: Exhibit I (4)(a)(1)*	AllCare CCO Acknowledges the receipt of all member appeals and complaint. Please see: • **Q8-Receipt Member Appeal Template-ACCCO.docx**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• **Q8-Receipt of Written Complaint Template -ACCCO.docx** • **Q8-Grievance Policy-ACCCO.docx,** Page 5, C. Verbal receipt of complaint #5, f; • **Q8-Grievance Policy-ACCCO.docx,** Page 5, D. Written Grievance is received #1; • **Q8-Desk Top Procedure for Grievance – ACCCO.docx**, Page 3; • **Q8-Appeals and hearing Policy-ACCCO.docx,** Page 4, D. Receipt of verbal appeal, #1; • **Q8-Appeals and hearing Policy-ACCCO.docx,** page 4, E. Written Appeal, #2; • **Q8-Desk Top Procedure for Appeal Processing-ACCCO.docx,** Page 4.	
9. A member may file an appeal within 60 calendar days from date on the notice of adverse benefit determination. • The member may request an appeal either orally or in writing. Unless the member requests an expedited resolution, an oral appeal must be followed by a written, signed appeal. *42 CFR §438.402(c)(2)(ii), (c)(3)(ii)* *Contract: Exhibit I (1)(b)(2), (1)(c)(2-3)*	Please see: • **Q9-Appeals and Hearing Policy–ACCCO.docx**, page 1, Policy. • **Q9-Appeals and Hearing Policy-ACCCO.docx** page 2, C. Submitting an Appeal, #1 & 3; • **Q9-A-G Phone Scripts-ACCCO.docx**, Page 1, Phone Script Standard Appeal and page 2, Phone Script for Expedited Appeal; • **Q9-Member Handbook-ACCCO.pdf** • **Q9-NOA-ABD Template Letter-ACCCO.docx**	☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: This element was a duplicate of element #7.		
Required Actions: None.		
10. The CCO resolves each grievance in writing and provides notice as expeditiously as the member's health condition requires. Within five (5) business days from the date of the CCO's receipt of the grievance, the CCO: a. Notifies the member that a decision on the grievance has been made and what the decision is; or b. Acknowledges receipt of the grievance and notifies the member that there will be a delay in the CCO's decision of up to 30 days. c. Notice to the member must be in a format and language that may be easily understood by the member. *42 CFR §438.408(a)-(b)(1), (d)(1)* *Contract: Exhibit I (2)(h)*	AllCare CCO allows members to submit their complaint to AllCare CCO, the subcontractor, OHA and the ombudsman. AllCare CCO will work with each entity to assist in the resolution of each complaint. The subcontractor submits a quarterly exhibit I to AllCare 30 days after the end of the quarter. AllCare monitors and reviews the Exhibit I for timeliness and trends in providers or clinics. The combined Exhibit is then reviewed by the Quality Committee quarterly. Please see: • **Q10(a-c)-Grievance Policy–ACCCO.docx** Page 1; • **Q10(a-c)-Grievance Policy–ACCCO.docx** Page 4, C; Verbal receipt of a complaint #5, f; and #6, a, I; • **Q10(b)-Grievance Policy–ACCCO.docx Page 6, D. Written Grievances is Received, #2;** • **Q10(a-c)-Grievance Policy–ACCCO.docx Page 6, F.** Notice of Resolution of Grievance, #2; and #3, c. • **Q10(a-c)-Complaint Closure Letter Template-ACCO.docx** • **Q10(a-c)-Member Sample letter I-ACCCO.pdf**	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• **Q10(a-c)-Member Sample Letter II-ACCO.pdf** • **Q10(a-c)-Oversight of Exhibit I-ACCCO.docx** • **Q10(a-c)-Desk Top Procedure for Grievance Policy-ACCCO.docx,** Pages 3 and 8-9 Examples of Subcontractor's policies: • **Q10-Example Subcontractor Advantage Dental Enrollee Grievance and Appeals-ACCCO.pdf** • **Q10-Example Subcontractor Curry Community Health Grievances and Appeals-ACCCO.pdf** • **Q10-Example Subcontractor Options Consumer Grievances and Appeals.pdf** • **Q10-Example Subcontractor Willamette Dental Grievance-ACCCO.pdf**	
HSAG Findings: Although the CCO's grievance policies stated that only written grievances are responded to in writing, CCO staff members noted during the remote interview session that the majority of its grievances are currently responded to in writing, including those received orally. CCO staff members stated that the organization is prepared to be in compliance with requirement to respond to all grievances in writing by January 1, 2020.		
Required Actions: HSAG recommends that the CCO revise the applicable policies and procedures to indicate that all grievances must be responded to in writing, effective January 1, 2020.		
11. In handling grievances and appeals, the CCO must 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, auxiliary aids and services	AllCare CCO has added system to assist limited English speaking member to communicate with AllCare CCO. AllCare CCO has added an additional toll-free phone number for limited English speaking	☒ Complete ☐ Progress Sufficient to Start Operations

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. *42 CFR §438.406(a)* *Contract: Exhibit I (1)(c)(4)*	members to call directly to have an interpreter on the call prior to the phone ringing at AllCare. In addition, AllCare has develop an interpreter training program that has been accredited for certifying interpreters. AllCare has increased the number of interpreters in our service area from 2 in 2015 to over 100 in 2019 and they include 13 different languages, including sign language. Please see: • **Q11-Grievance Policy-ACCCO.docx**, Page 1, Policy; • **Q11-Grievance Policy–ACCCO.docx**, Page 3, C. Verbal Receipt of a Complaint 1, f; • **Q11-Appeals and Hearing Policy-ACCCO.docx**, Page 3, C. Submitting an Appeal, 6; • **Q11-A-G Phone Scripts-ACCCO.docx** • **Q11-Medical Interpreters Directory List-ACCCO.pdf** • **Q11-Member Handbook-ACCCO.pdf**, page 55; **Q11-Complaint Packet-Spanish-ACCCO.pdf** **Q11-Complaint Packet-English-ACCCO.pdf** Member Rights Brochure posted on the website: • **Q11-Member Rights and Responsibilities Spanish-web-ACCCO.pdf**	☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• **Q11-Member Rights and Responsibilities English-web-ACCCO.pdf** • **Q11-NOA-ABD Template-ACCCO.docx** • **Q11-NOA-ABD Policy-ACCCO.docx** • **Q11-Web Screen Shots Guidance-ACCCO.docx**	
12. The CCO ensures that the individuals who make decisions on grievances and appeals are individuals who: • Were not involved in any previous level of review or decision-making nor a subordinate of any such individual. • Have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding any of the following: • An appeal of a denial that is based on lack of medical necessity. • A grievance regarding the denial of expedited resolution of an appeal. • A grievance or appeal that involves clinical issues. • Take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. *42 CFR §438.406(b)(2)* *Contract: Exhibit I (1)(c)(6-7)*	AllCare CCO has Medical Directors on staff who are licensed in various specialties such as: Pediatrics, OB/GYN, Family Practice, LCSW, Dentist and clinical pharmacist. Please see: • **Q12-Grievance Policy-ACCCO.docx,** Page 1, Purpose; • **Q12-Grievance Policy-ACCCO.docx,** Page 1, Policy; • **Q12-Grievance Policy-ACCCO.docx,** Page 6, E. Review of the Complaints; • **Q12-Grievance Policy-ACCCO.docx,** Page 7, F. Notice of Resolution of Grievances, #3, d.; • **Q12-Appeals and Hearing Policy-ACCCO.docx,** page 5, E. Written appeal, #10 and all subcomponents; • **Q12-Desk Top Procedures for Grievance Policy.ACCCO.docx** • **Q12-Desk Top Procedure for Appeals Policy-ACCCO.docx**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
13. The CCO's appeal process must provide: a. That oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the member or the provider requests expedited resolution. b. The member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The CCO must inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in §438.408(b) and (c) in the case of expedited resolution. c. The member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the CCO (or at the direction of the CCO) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals. d. That included, as parties to the appeal, are: i. The member and his or her representative, or ii. The legal representative of a deceased member's estate. *42 CFR §438.406(b)(3-6)* *Contract: Exhibit I (4)(b)*	AllCare CCO has and will continue to have a thorough appeals process. AllCare works directly with the member and the provider to process all appeals in a timely manner. Please see: • **Q13-Appeals and Hearing Policy-ACCCO.**docx a. **Q13-Appeals and Hearing Policy-ACCCO.docx**: page 2-3 C. Submitting an Appeal, #2 and 3; and Page 4, D. Receipt of a verbal appeal, #2 b. **Q13-Appeals and Hearing Policy-ACCCO.docx** Page 3 C. Submitting an Appeal, #5: c. **Q13-Appeals and Hearing Policy-ACCCO.docx** Page 3, C. Submitting an Appeal, #9; **Q13(c)-Desk Top Procedure for Appeals Policy-ACCCO.docx** d. **Q13-Appeals and Hearing Policy-ACCCO.docx** page 2 A. Who can submit an appeal or Contested Case Hearing: • **Q13-A-G Phone Scripts - ACCCO.docx**, Pages 1-2; • **Q13 NOA-ABD template.pdf** • **Q13-Member Handbook-ACCCO.pdf**, Page 55; • **Q13-Member Rights and Responsibilities English-web-ACCCO.pdf**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• **Q13-Member Rights and Responsibilities Spanish-web-ACCCO.pdf**	
14. The CCO must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, no later than 16 days from the day the CCO receives the appeal. • For expedited resolution of an appeal and notice to affected parties, within 72 hours after the CCO receives the appeal. • For notice of an expedited resolution, the CCO must also make reasonable efforts to provide oral notice of resolution. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR §438.408(b)(2)-(3)* *Contract: Exhibit I (4)(c)(2)*	Please see: • **Q14-Appeals and Hearing Policy-ACCCO.docx** page 7, H. Resolution of an Appeal 1, a; • **Q14-Appeals and Hearing Policy-ACCCO.docx** page 8, H. Resolution of an Appeal 1, b, i, ii &iv; • **Q14-Appeals and Hearing Policy-ACCCO.docx** page 7, H. Resolution of an Appeal 1, b, v; • **Q14-Desk Top Procedure for Appeals Policy-ACCCO.docx** • **Q14-Appeals and Hearing Policy-ACCCO.docx** page 9 - 10, I, Notice of Appeal Resolution-ACCCO, #1; Examples: **Q14-Example Member Letter I-ACCCO.pdf**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
15. The CCO may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: • The member requests the extension; or • The CCO shows (to the satisfaction of the State, upon request) that there is need for additional information and how the delay is in the member's interest.	Please see: • **Q15-Appeals and Hearing Policy-ACCCO.docx.** Pages 7-8, H. Resolution of an Appeal, 1, a, i-iv; • **Q15 Appeals and Hearing Policy-ACCCO.docx** Pages 8, H. Resolution of an Appeal, 1, b, vi, I – IV;	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• If the CCO extends the timeframes, it must—for any extension not requested by the member: – Make reasonable efforts to give the member prompt oral notice of the delay. – Within 2 calendar days, give the enrollee written notice of the reason for the delay and inform the enrollee of the right to file a grievance with the CCO if he or she disagrees with that decision. – Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. • If the CCO fails to adhere to the notice and timing requirements for extension of the appeal resolution timeframe, the member may initiate a State fair hearing (contested case hearing). *42 CFR §438.408(c)* *Contract: Exhibit I (4)(c)(1)(c), (4)(c)(2)*	• **Q15-Appeal Time Extension Letter Template-ACCCO.pdf** • **Q15-Complaint Time Extension Letter Template-ACCCO.docx** • **Q15-Example Member Complaint Extension Letter I.pdf** • **Q15-Example Member Complaint Extension Letter II.pdf**	
16. The written notice of appeal resolution must include: The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing (contested case hearing), and how to do so. – The right to request that benefits/services continue while the hearing is pending, and how to make the request.	AllCare CCO has policies and processes in place to reflect the OARs, CFRs and the Contract. • **Q16-Appeals and Hearing Policy-ACCO.docx**, Page 9 - 10, I Notice of Appeal Resolution #1, a and b; • **Q16-NOAR-Letter Template-ACCO.docx**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
– That the member may be held liable for the cost of these benefits if the hearing decision upholds the CCO's adverse benefit determination. *42 CFR §438.408(e)* *Contract: Exhibit I (4)(c)(4)*		
17. The member may request a State fair hearing (contested case hearing) after receiving notice that the CCO is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of resolution. • The parties to the State fair hearing (contested case hearing) include the CCO, as well as the member and his or her representative or the representative of a deceased member's estate. *42 CFR §438.408(f)* *Contract: Exhibit I (5)*	Please see: • **Q17-Appeals and Hearing Policy-ACCCO.docx**, Pages 10, I Notice of Appeal Resolution, #1, a and b; • **Q17-Appeals and Hearing Policy-ACCCO.docx**; Pages 11, J Contested State Hearing, #3 and 6 Notice of Appeal Resolution page 3, 5 and 9.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
18. The CCO maintains an expedited review process for appeals, when the CCO determines, or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. The CCO's expedited review process includes: • The CCO ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. • If the CCO denies a request for expedited resolution of an appeal, it must: – Transfer the appeal to the time frame for standard resolution.	When a clinical provider request an expedited review of a denial of a pre-service determination, the expedited review is granted. The rational is that the clinical provider is aware of the member's current healthcare state and that the member does meets the criteria for an expedited review. Please see: • **Q18-Appeals and Hearing Policy-ACCCO.docx**, Page 1, Policy; • **Q18-Appeals and Hearing Policy-ACCCO.docx**, Page 8, H. Resolution of an Appeal b. i;	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
– Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and follow-up within two calendar days with a written notice. *42 CFR §438.410* *Contract: Exhibit I (4)(c)(3)(e)*	• **Q18-Appeals and Hearing Policy-ACCCO.docx**, Page 9, H. Resolution of an Appeal #1, b. v., vii. I & III); • **Q18-Desk Top Procedure for Appeals Policy-ACCCO.docx**, Pages 6-7.	
19. The CCO provides for continuation of benefits/services while the CCO-level appeal and the State fair hearing (contested case hearing) are pending if: • The member files timely* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the CCO mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal in accordance with required timeframes. **Note: This definition of timely filing only applies when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced. The provider may not request continuation of benefits on behalf of the member.* *42 CFR §438.420(a)-(b)* *Contract: Exhibit I (6)(a)-(b)*	When a member request continuation of benefit during the appeal process, AllCare CCO Appeals and Grievance Coordinators (AGC) calls the member to ensure they understand the benefit is for services they were already receiving. In most situations, the member was confused and thought that they were requesting continuation of their health care coverage. In addition, when the member does qualify for continuation of benefit, the AGC educates the member on the possibility of repayment of the service if the denial is upheld. Please see: • **Q19-Appeals and Hearing Policy-ACCCO.docx**, Page 11-12, K. Continuation of Benefits #1, a-d; • **Q19-Desk Top Procedure for Appeals Policy-ACCCO.docx**, Page 7-8; • **Q19-Claims Notice of Denial of Payment Process.pdf**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
20. If, at the member's request, the CCO continues or reinstates the member's benefits while the appeal or State fair hearing (contested case hearing) is pending, the benefits must be continued until one of following occurs: • The member withdraws the appeal or request for State fair hearing. • The member fails to request a State fair hearing and continuation of benefits within 10 calendar days after the CCO sends the notice of an adverse resolution to the member's appeal. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR §438.420(c)* *Contract: Exhibit I (6)(c)*	Please see: • **Q20-Appeals and Hearing Policy-ACCCO.docx**, Page 12, L Continuation of Benefit Pending Contested Case Hearing, 3 1 & 2 a-d; • **Q20-Desk Top Procedure for Appeals Policy-ACCCO.docx**, Pages 7-8;	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
21. If the final resolution of the appeal is adverse to the member, that is, upholds the CCO's adverse benefit determination, the CCO may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. *42 CFR §438.420(d)* *Contract: Exhibit I (6)(d)*	AllCare CCO will make arrangements with the member if the final decision is adverse regarding the repayment to AllCare CCO for the amount AllCare CCO paid for the service. Please see: • **Q21-Appeals and Hearing Policy-ACCCO.docx** Page 12, M Member Responsibilities for services furnished while the Appeal or Contested Case Hearing is Pending, #1; • **Q21-Desk Top Procedure for Appeals Policy-ACCCO.docx**, Page 8; • **Q21-Claims Notice of Denial of Payment Processes.pdf**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
22. Effectuation of Reversed appeal resolutions: • If the CCO or the State fair hearing (contested case hearing) officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the CCO must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than seventy-two (72) hours from the date it receives notice reversing the determination. • If the CCO or the State fair hearing (contested case hearing) officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the CCO or the State must pay for those services, in accordance with State policy and regulations. *42 CFR §438.424* *Contract: Exhibit I (7)*	Please see: • **Q22-Appeals and Hearing Policy-ACCCO.docx** Page 7, G. Case Review Completed by AllCare CCO and Effectuation of First Level of Appeal, #2- 3; • **Q22-Appeals and Hearing Policy-ACCCO.docx** Page 12, N, #1 & 2; • **Q22-Appeal Effectuation Policy-ACCCO.docx** Page 1, Policy; • **Q22-Desk Top Procedure for Appeals Policy-ACCCO.docx** pages 8, 18, & 19; • **Q22-Claims Notice of Denial of Payment Process-ACCCO.pdf**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
23. The CCO maintain records of all member grievances and appeals. The record must be accurately maintained in a manner accessible to the State and available upon request to CMS. The record of each member grievance or appeal must contain, at a minimum, all of the following information: • A general description of the reason for the appeal or grievance; • The date received; • The date of each review or, if applicable, review meeting;		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• Resolution at each level of the appeal or grievance, if applicable; • Date of resolution at each level, if applicable; • Name of the covered person for whom the appeal or grievance was filed, member ID number, and date the member filed the grievance or appeal; • Notations of oral and written communications with the member; and • Notations about appeals and grievances the member decides to resolve in another way if the CCO is aware of this. *42 CFR §438.416* *Contract: Exhibit I (9)*		
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		
24. The CCO provides the information about the grievance appeal, and fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing (contested case hearing) after the CCO has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes.	Please see: • **Q24-Contracts Letter Policy-ACCCO.pdf, Page** 1; • **Q24-Provider Delivery of Services Training policy-ACCCO.pdf**, Page 2; • **Q24-Provider Manual-ACCCO.pdf**, Page 39.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• The member's right to have a provider or authorized representative file a grievance and/or an appeal on his or her behalf, provided he or she has provided written consent • The toll-free numbers to file a grievance or an appeal • The fact that, when requested by the member: – Services that the CCO seeks to reduce or terminate will continue if the appeal or request for State fair hearing (contested case hearing) is filed within the time frames specified for filing. – The member may be required to pay the cost of services furnished while the appeal or State fair hearing (contested case hearing) is pending, if the final decision is adverse to the member. *42 CFR §438.414* *42 CFR §438.10(g)(xi)* *Contract: Exhibit B Part 3 (5)(b)*		

Standard X- Grievance and Appeal Systems	
	Total #
Complete	**21**
Progress Sufficient	**1**
Incomplete	**0**
Not Applicable (NA)	**2**

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. The Contractor shall maintain a health information system that collects, analyzes, integrates, and reports data sufficient to support program requirements, including but not limited to: Utilization of services a. Claims and encounters b. Grievances, appeals and hearing records c. Disenrollment for other than loss of Medicaid eligibility d. Member characteristics i. Race ii. Ethnicity iii. Preferred Language iv. Names and phone numbers of the member's PCP or clinic v. Attestation of member rights and responsibilities e. Client Process Monitoring Systems Forms data using the Measures and Outcome Tracking System (MOTS) f. LTPC Determination Forms *42 CFR §438.242(a)* *Contract: Exhibit J (1)*	1. AllCare CCO utilizes a claim processing system produced by Citra named EZ-CAP (version 6.5.5.2). Combined with additional software packages that support the importing and exporting of ANSI X12 5010 files along with a prior authorization and referral application programming interface (API), data is stored in a Microsoft SQL Server 2012 Service Pack 4 database with a web page frontend. Citra EZ-CAP has a variety of modules that support the support AllCare CCO's operations. AllCare CCO has regular auditing procedures in place to ensure data integrity. (See Highlighted Procedures on page 2 in Q1a-EncounterAuditingPolicy-ACCCO.docx) AllCare CCO will maintain these processes in CCO 2.0. a. Non-clean claims are returned to the provider for review and resubmission. (This is highlighted in Q1a-ClaimBillingForServicesPolicy-ACCCO.docx – Pages 1 and 2) Clean professional and institutional claims are processed in the core claims system (Citra EZ-CAP) and are adjudicated in conjunction with the plan benefit rules. Claims that cannot be auto-adjudicated are reviewed utilizing system edits, audits and manual review. (This is highlighted in Q1a-ClaimBillingForServicesPolicy-ACCCO.docx – Page 9)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	For professional and institutional encounters, see Procedure section on page 1 of Q1a-EncounterReportingProcedure-ACCCO.docx, which describes the data AllCare CCO collects, how it is sourced and provided from the Citra EZ-CAP system. Pharmacy claim processes are monitored and coordinated between AllCare CCO and MedImpact which is a Pharmacy Benefit Manager (PBM). Pharmacy encounter data is provided to AllCare CCO to store and report on as requested. Dental claim processes are monitored and coordinated between AllCare CCO and Performance Health Technology (PHTech), a third party claim administrator. Dental encounters are reported from PHTech as requested. (This is highlighted on page 1 of Q1a-DentalEncounterValidationPolicy-ACCCO.docx). All encounters are submitted to OHA in accordance with Policy referenced in Q1a-DataSubmissionValidationPolicy-ACCCO.docx and Q1a-DentalEncounterValidationPolicy-ACCCO.docx. Claims and encounters process support documents i. Q1a-ClaimBillingForServicesPolicy-ACCCO.docx	

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	ii. Q1a-DataSubmissionValidationPolicy-ACCCO.docx iii. Q1a-DentalEncounterValidationPolicy-ACCCO.docx iv. Q1a-EncounterAuditingPolicy-ACCCO.docx v. Q1a-EncounterValidationPolicy-ACCCO.docx vi. Q1a-EncounterReportingProcedure-ACCCO.docx vii. Q1a-DentalDataMonitoringPolicy-ACCCO.docx To further demonstrate system capabilities stated above, the relevant section of the Citra EZ-CAP User Manual is attached as the following document: i. Q1a-EZCAPUserManual-Section2-Claims-ACCCO.pdf (pages 1-110) b. AllCare CCO provides OHA with quarterly Appeals/Grievance/Denials, based on incidents logged in the Citra EZ-CAP system and as collected from AllCare CCO's subcontractors. The Appeals, Grievance and Denial information is compiled, reviewed, and reported to OHA as contractually required. Grievance, appeal, and hearing data are entered into Citra EZ-CAP Customer Services Module to capture who is identifying the event as well as when	

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	communication events occur. (See highlighted section in Q1b-AppealsandHearingPolicy-ACCCO.docx sections (I)(E)(6) and (I)(E)(8) on Page 5) Reports of this data are supplied to business owners on a scheduled basis to facilitate their business processes. (See Highlighted section in in Q1b-AppealsandHearingPolicy-ACCCO.docx, section (I)(S)) Grievances and Appeals process support documents i. Q1b-AppealEffectuationPolicy-ACCCO Q1b-.docx ii. Q1b-AppealsandHearingPolicy-ACCCO.docx iii. Q1b-DeskTopProcedureforAppealsPolicy-ACCCO.docx iv. Q1b-DeskTopProcedureforGrievancePolicy-ACCCO.docx v. Q1b-GrievancePolicy-ACCCO.docx vi. Q1b-OversightoftheExhibitIPolicy-ACCCO.docx To further demonstrate system capabilities stated above, the relevant section of the Citra EZ-CAP User Manual is attached as the following document:	

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	i. Q1b-EZCAPUserManual-Section11-CustomerService-ACCCO.pdf (pages 1-9) c. The Oregon Health Authority (OHA) manages all enrollment and disenrollment of Oregon Health Plan (OHP) members. AllCare CCO receives daily and monthly eligibility files and processes them through the core claims system (Citra EZ-CAP; see Q1d-OHA834Import-ACCCO.docx, page 2-3). Users with specific permissions may manually update the core claims system with a disenrollment as identified in MMIS. However, upon next eligibility file receipt, data will reflect what was provided by OHA. Member process support documents i. Q1d-OHA834Import-ACCCO.docx To further demonstrate system capabilities stated above, the relevant section of the Citra EZ-CAP User Manual is attached as the following document: i. Q1c-EZCAPUserManual-Section5-Eligibility-ACCCO.pdf (pages 1, 6, 7, 16, 18, 22, 31, 34) d. AllCare CCO is able to collect member characteristics both from OHA's eligibility file as well as direct from the member should the data be different. Two main systems house the data; Citra EZ-CAP and HMS Essette Case	

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Management, allowing AllCare CCO to report on member characteristics relevant to the information being requested. Member process support documents i. Q1d-OHA834Import-ACCCO.docx, page 2-3 ii. Q1d-MemberRights-ACCCO.pdf iii. Q1d-EnrolleeRightsAndProtections-ACCCO.docx, page 2-3 To further demonstrate system capabilities stated above, the relevant sections of the Citra EZ-CAP User Manual are attached as the following document: i. Q1c-EZCAPUserManual-Section5-Eligibility-ACCCO.pdf (pages 1, 5, 11, 15) ii. Q1d-EZCAPUserManual-Section5-Providers-ACCCO.pdf (pages 1, 12, 21-24) e. When Measures and Outcome Tracking System data becomes available, AllCare CCO will import the data for integration and reporting. AllCare CCO's existing systems are currently capable of accepting this data and reporting as requested. f. LTPC is a manual process that is tracked in the core claim system (Citra EZ-CAP) as a prior authorization. Information relevant to the LTPC is notated within the authorization for reporting purposes. Subsequent claims and encounters will	

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	be associated to the authorization for identification in order to support all reporting requests. LTPC process support documents i. Q1f-LTPCDeskProcedure-ACCCO.docx AllCare CCO will maintain these processes in CCO 2.0.	
2. Contractor's claims processing and retrieval systems shall collect data elements necessary to enable the mechanized claims processing and information retrieval systems operated by the State. 42 CFR §438.242(b)(1)	2. Citra EZ-NET is the EDI user interface and a component of the Citra EZ-CAP core claims system. Citra EZ-NET has data segments and segment contents that are validated during the importing of electronic claim files in 837P and 837I format. Citra EZ-NET ensures that ANSI X12 5010 data compliance is adhered to and will reject an entire file if those standards are not met. Additionally, Citra EZ-NET provides validation of HCPCS, CPT, diagnosis codes, modifiers, NDC numbers, future dates of service, hospitalization date (on professional claims/encounters), member IDs, names, dates of birth, and provider information as presented in Citra EZ-CAP. These edits are prior to posting the data into Citra EZ-CAP. To further demonstrate system capabilities stated above, the relevant sections of the Citra EZ-CAP User Manual are attached as the following document: a. Citra EZ-EDI v6.5.5.2 into Citra EZ-CAP v6.5.5.2	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

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	i. Q2-EZEDIUserGuide-ClaimImports-ACCCO.pdf (pages 1-89) b. Citra EZ-EDI v6.5.5.2 utilizes Citra EZ-MAP v6.5.5.2 for inbound and outbound mapping i. Q2-EZMAPEditorGuide-MapUtility-ACCCO.pdf (pages 1-60) c. Citra EZ-CAP v6.5.5.2 claim processing i. Q2-EZCAPUserManual-Section2-Claims-ACCCO.pdf (pages 1-110) Creation of outbound 837P and 837I files is scheduled weekly although Check Run, which is typically every 2 weeks. Supporting SQL tables are populated each week via AllCare CCO DBMS systems and Liaison is the tool used to generate 837 files for submission. Potentially up to 16 files for submission will be created – 4 plans x 2 Claim Sources (Professional or Institutional) x 2 Claim Types (COB and Non-COB). (Q2-LiaisonDeltaHelp-SolutionManger-ACCCO.pdf pages 1-92, Q2-LiaisonDeltaHelp-ECSUserGuide-ACCCO.pdf, pages 1-501) NextGen (Mirth) Connect v3.7.1 is being tested as a replacement tool for Liaison and currently mirrors production of the 837 files. (Q2-ConnectUserGuide-ConfigurationAndUsage-ACCCO.pdf, pages 1-381) All 837 submissions to OHA will be completed before Friday each week. Per review of an	

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	Encounter Submission Summary Report and approval from the Claims department. Results for the 837 submissions come in the form of Response files (.999) are provided from OHA and downloaded by AllCare CCO. Results are reviewed for errors and summary for weekly VAF reporting to OHA. (Q2-EncounterExtractProcedure-ACCCO.docx, page 2) AllCare CCO submits encounters to support the All Payer All Claims (APAC) requirement per a published calendar from OHA. There are 8 files generated for submission which are provided by both the pharmacy benefit provider vendor MedImpact and in-house processes. Annually, there are 2 additional files required for submission: Appendix 1 and Appendix 2. A password protected file is created containing all required submission files and submitted to OHA's chosen auditor, Milliman. (Q2-APACSubmissionPolicy-ACCCO.docx, page 1, Q2-APACSubmissionProcedure-ACCCO.docx, pages 1-4) APAC submission validation comes in the form of emails from Milliman to ensure all files were accepted and passed. There are 3 levels of validation edits: 1. Level 1 - Edits. AllCare CCO IT Staff will verify that a confirmation email for each file	

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	type submitted is received. AllCare IT Staff will correct any errors and resubmit (if needed). 2. Level 2 - Validation is provided Quarterly by Milliman and speaks to data consistency. Revisions to the data submission may be necessary if the results call for correction or problems are identified. 3. Level 3 - Validation is provided Annually by Milliman and speaks to the overall state of data submitted by the plan. (Q2-APACSubmissionProcedure-ACCCO.docx, page 4) AllCare CCO utilizes Performance Health Technology (PHTech) for dental claims collection and processing. AllCare CCO monitors both the DCO submission processes to PHTech and the encounter submissions to OHA via PHTech utilizing a series of monitoring reports, a copy down of the CIM data base daily and through chart and onsite audits performed annually. (Q2-DentalEncounterValidationPolicy-ACCCO.docx, pages 1-2) For Pharmacy claims, AllCare CCO utilizes MedImpact and ensures that all pharmacy claims data meet the data content standards as required by the National Council for Prescription Drug Programs (NCPDP) as available on their web site	

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	http://www.ncpdp.org/ or by contacting the National Council for Prescription Drug Programs organization. (Q2-DataSubmissionValidationPolicy-ACCCO.docx, page 3) To further demonstrate system capabilities stated above, the relevant sections of the Citra EZ-CAP User Manual are attached as the following document: a. Q2-EZEDIUserGuide-ClaimExports-ACCCO.pdf (pages 1-57) AllCare CCO will maintain these processes in CCO 2.0	
3. Contractor shall collect data at a minimum on: a. Member and provider characteristics as specified by OHA and in Exhibit G b. Member enrollment c. All services furnished to members through an encounter data system, pharmacy, or other methods as specified by OHA 42 CFR §438.242(b)(2) Contract: Exhibit J(2)	3. AllCare CCO collects member characteristics from OHA's eligibility file (See Q3a-OHA834Import-ACCCO.docx, page 2) and stores them in the core claims system (Citra EZ-CAP). This information is combined with data received from claims and encounters to create a complete view of the member's characteristics. Provider characteristics are collected as a result of the credentialing application process. The data is stored in AllCare CCO's provider credentialing application (IntelliSoft). Information is reviewed on a quarterly basis by contacting the provider with data currently on file to confirm or update the provider characteristics as presented. a. AllCare CCO is able to leverage the member and provider characteristics stored in AllCare	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

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Requirement	**Evidence as Submitted by the CCO**	**Score**
	CCO's systems to report to OHA. Data for Network Adequacy is reported to the business owner as requested and submitted to OHA for reporting requirements. Supporting documentation i. Q3a-OHA834Import-ACCCO.docx b. AllCare CCO receives member enrollment information through OHA's eligibility file. Once ingested into the core claims system (Citra EZ-CAP) member enrollment may be reported with any of the currently stored member characteristics on record. Supporting documentation i. Q3a-OHA834Import-ACCCO.docx, page 2-3 c. AllCare CCO collects all clean claim data on members directly for professional and institutional claims. Dental claim data is provided by PHTech, a third party administrator, as processed by their systems and collected by AllCare CCO. All claims data is stored in AllCare CCO systems. Supporting documentation i. Q3c-MedicaidDataProcessFlow-ACCCO.pdf AllCare CCO will maintain these processes in CCO 2.0.	

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4. Contractor shall ensure that data received from providers, either directly or through a third party, is accurate, truthful, and complete in accordance with OAR 410-120-1280 and OAR 410-141-3420 by: a. Verifying the accuracy and timeliness of data reported b. Screening the data for completeness, logic, and consistency c. Submitting the certification to verify current member eligibility for fully dual eligible members using the AVR system or MMIS Web Portal. d. Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts in accordance with OHA Electronic Data Transmission (EDT) procedures in OAR Chapter 943 Division 120. 42 CFR §438.242(b)(3)(i-iii) Contract: Exhibit J(3)	4. a. AllCare CCO follows all Federal law requiring that state Medicaid agencies take all reasonable measures to ensure, that in most instances, it will be the payer of last resort. AllCare CCO accepts electronic claims submissions and current, commercially available versions of paper claim forms, HCFA CMS 1500 or UB 04. (See Q4a-ClaimBillingForServicesPolicy-ACCCO.docx, pages 1, 3) For non-pharmacy encounter claims, professional, dental, and institutional claims submitted to OHA (Oregon Health Authority) by AllCare CCO will meet the data content and submission standards as required by HIPAA 45 CFR Part 162, the Authority's electronic data transaction rules (OAR 943-120-0100 through 943-120-0200), the Division's 837 technical specifications for encounter data, and the Division's encounter data submission guidelines that are subject to periodic revisions and available on the Authority's web site. (See Q4a-DataSubmissionValidationPolicy-ACCCO.docx, page 1) AllCare CCO performs auditing of random select office/providers or if identified, an office or provider that is exhibiting questionable billing practices audits will be conducted at minimum, on an annual basis and as needed unless	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

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	otherwise deemed necessary to perform earlier. (See Q4a-EncounterAuditingPolicy-ACCCO.docx, page 2) AllCare CCO submits professional and institutional encounter claims at least once per month for no less than 50 percent of all claim types received and adjudicated that month. AllCare CCO will submit all remaining unreported encounter claims for services received and adjudicated within 180 days of the date of service excepting AllCare CCO may only delay submission of encounter claims within 180 days from the date of service with prior notification to the Authority for specific reasons. (See Q4a-DataSubmissionValidationPolicy-ACCCO.docx, page 2) AllCare CCO encounter data tracking and reporting for professional and institutional claims are internal and occurs bi-monthly. The number of encounters are counted, noted and sent to the Claims Department Director and Supervisor for review and approval for submission to the Oregon Health Authority. (See Q4a-EncounterValidationPolicy-ACCCO.docx, pages 2-3) Acknowledgement files are monitored by the AllCare CCO IT staff and all 999 files are reviewed for encounters that did not pass through the OHA transponder. Acknowledgement	

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	findings and any errors are presented on a report to the Claims Director and Claims Supervisor. Based on OHA response and acknowledgement of encounter data files, a report is auto generated that contains any pended encounters. The Claims Department Supervisor reviews all response data monitors appropriate corrections to be performed either through files submission or manual correction within the state portal, MMIS. (See Q4a-EncounterValidationPolicy-ACCCO.docx, pages 2-3) Data validation is performed after each encounter data submission along with a Monthly Claim Count which tracks incoming and outgoing claims, their origin (paper or electronic) by clearinghouse and date received. For Pharmacy claims, AllCare CCO utilizes MedImpact and ensures that all pharmacy claims data meet the data content standards as required by the National Council for Prescription Drug Programs (NCPDP) as available on their web site http://www.ncpdp.org/ or by contacting the National Council for Prescription Drug Programs organization. (See Q4a-DataSubmissionValidationPolicy-ACCCO.docx, page 3, point A) All pharmacy encounter claims data will be submitted by the AllCare CCO whether by the AllCare CCO's pharmacy benefit manager or the	

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Requirement	**Evidence as Submitted by the CCO**	**Score**
	AllCare CCO's subcontractor at least once a month for all services received and adjudicated that month and must submit all remaining unreported AllCare CCO pharmacy encounter claims within 60 days from the date of service. (See Q4a-DataSubmissionValidationPolicy-ACCCO.docx, page 3, point B) AllCare CCO utilizes Performance Health Technology (PHTech) for dental claims collection and processing. AllCare CCO monitors both the DCO submission processes to PHTech and the encounter submissions to OHA via PHTech utilizing a series of monitoring reports, a copy down of the CIM data base daily and through chart and onsite audits performed annually. (See Q4a-DentalEncounterValidationPolicy-ACCCO.docx, pages 2-3) Upon receipt of the dental encounter data file, OHA issues an ICN number (individual claim number), which presents in the return file to PHTech and a copy of the return file is also sent to AllCare CCO. PHTech then produces and sends to AllCare CCO a Status File which contains the following: File name, file number, date file created, and number of encounters submitted. Number of encounters that hit first pass edits, the edit error, the OHA issued ICN number, pend	

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	error number, (if any) encounter aging data and number of encounter DMC (denied must correct) pend errors AllCare CCO has designated data analysts to review dental encounter pend errors in the MMIS Portal and submit the appropriate CVF and VAF forms to the assigned Encounter Date Liaison. The assigned Encounter Data liaison sends validation forms, CCV (Claim Count Validation) to enable the plan to cross reference and verify encounters submitted from the previous submission. (See Q4a-DentalEncounterValidationPolicy-ACCCO.docx, pages 2-3) PHTech produces multiple reports that outline the Dental Organization, number of claims, file submission names, imported claims and rejected/pended claims. Internal review is done monthly to identify any anomalies. Regular meetings with AllCare CCO and PHTech are in place to discuss processes and refine policies as needed with AllCare CCO's Dental Coordinator and Director of Oral Health. Immediate conversation between AllCare CCO and PHTech is initiated if a discrepancy occurs and a written explanation along with resolve is also required by the Claims Operations Director. (See Q4a-DentalEncounterValidationPolicy-ACCCO.docx, page 3)	

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	AllCare CCO maintains a policy and procedure for the AllCare CCO Oral Health Program to monitor rendered and billed procedures on a random sampling of charts for each subcontractor. (See Q4a-DentalDataMonitoringPolicy-ACCCO.docx, page 1) Reporting on claim and encounter data requires accessing key data elements within the claims processing system, Citra EZ-CAP, as well as supplemental data received from subcontractors or delegated entities. General guidelines for ensuring complete and accurate claim and encounter reports is documented in the attached procedure. (See Q4a-EncounterReportingProcedure-ACCCO.docx, pages 1-2) b. A professional or institutional encounter claim submitted to AllCare CCO is considered valid only if all required data is entered or attached to the claim form and where it follows the HIPAA Codes rules, 45 CFR 162, which applies to all Medicaid Code Set requirements, including the use of diagnostic or procedure codes for prior authorization, claims submissions and payments. (See Q4a-ClaimBillingForServicesPolicy-ACCCO.docx, pages 1-2) • A primary diagnosis code is required on all claims, using the HIPAA nationally required	

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	diagnosis Code Set, unless specifically excluded in individual Division Program rules; • When billing using ICD-10-CM codes, all diagnosis codes are required to the highest degree of specificity; • Hospitals are always required to bill using the 5th digit, in accordance with methodology used in the Medicare Diagnosis Related Groups. For claims requiring a procedure code the provider must bill as instructed in the appropriate Division Program rules or AllCare CCO Policy and must use the appropriate HIPAA procedure Code Set such as CPT, HCPCS, ICD-10-CM, ADA CDT, NDC, established according to 45 CFR 162.1000 to 162.1011,which best describes the specific service or item provided. For claims that require the listing of a diagnosis or procedure code as a condition of payment, the code listed on the claim form must be the code that most accurately describes the client's condition and the service(s) provided. Providers must use the ICD-10-CM diagnosis coding system when a diagnosis is required unless otherwise specified in the appropriate individual Division Program rules. Hospitals must follow national coding guidelines:	

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	• When there is no appropriate descriptive procedure code to bill AllCare CCO, the provider must use the code for "unlisted services." A complete and accurate description of the specific care, item, or service must be documented on the claim; • Where there is one CPT, CDT or HCPCS code that according to CPT, CDT and HCPCS coding guidelines or standards, describes an array of services the provider must bill the Division using that code rather than itemizing the services under multiple codes. • Providers must not "unbundled" services in order to increase the payment for AllCare CCO. AllCare CCO contracts with Dental Care Organizations (DCOs) that with submit their encounter data files to PHTech who in turn, loads the encounters in their core system, CIM. Upon in load of encounter files, PHTech runs a series of claims edits which identify unclean claims/encounters. Unclean claims and encounter errors are sent to the submitter for correction, valid (non-errored) claims are then further processed and adjudicated by the CIM system. (See Q4a-DentalEncounterValidationPolicy-ACCCO.docx, pages 1-2)	

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	Nightly, AllCare CCO receives a copy of the PHTech CIM data base and produces internal reporting to monitor level of encounter submission, denials and adjudication status are monitored monthly. AllCare CCO monitors the CIM processed claims through a series of monitoring reports and through chart and onsite audits performed annually. (See Q4a-DentalEncounterValidationPolicy-ACCCO.docx, pages 1-2) Validation of Encounter Data is performed by a designated AllCare CCO reviewer using several types of reviews: 1. Encounter data is validated by performing a record count of all unique claim ids and comparing that count to a record count performed directly from the data table. 2. Enrollment and PCP assignment is validated by testing reasonableness against known enrollment counts. 3. Pharmacy data is validated for record count and paid amount against summary exhibits generated from the MedImpact reporting portal. 4. Members are attributed to providers based on meeting enrollment requirements. 5. Further validation is performed by an independent reviewer's examination of thee	

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	reasonableness of results in comparison to prior iterations of the report. 6. The reviewer will review the content and methodology used within the project being reviewed in accordance with the standards outlined within this policy document. A completed review form will be signed off once the reviewer is satisfied with the accuracy of the data being reviewed. (See Q4a-EncounterReportingProcedure-ACCCO.docx, page 2) c. AllCare CCO receives daily and monthly files from Oregon Health Authority (OHA) via OHA's hosted secure file transfer protocol (SFTP) server. AllCare CCO's internal systems restructure the 834 eligibility file to allow for required data segments to be captured in the Citra EZ-CAP eligibility system. The files are then electronically placed in a folder ready for the Director of Member Services to upload in to the Citra EZ-CAP system. Eligibility reporting is generated and reviewed by the Director of Member Services and verification of any member discrepancies is confirmed using MMIS and corrected in Citra EZ-CAP. (See Q4c-OHA834Import-ACCCO.docx, pages 2-3) AllCare CCO receives a daily database backup file from Performance Health Technology	

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	(PHTech), AllCare CCO's dental encounter vendor. PHTech places the backup file on an AllCare CCO hosted SFTP server and AllCare CCO retrieves the file via automated scheduled processes. The retrieved file is stored into AllCare CCO's local network location. Next, an automated scheduled database restoration job takes in the database file and makes it available for querying and reporting by AllCare CCO. d. AllCare CCO receives a daily database backup file from AllCare CCO's dental encounter vendor, Performance Health Technology (PHTech). PHTech places the backup file on an AllCare CCO hosted secure file transfer protocol (SFTP) server and AllCare CCO retrieves the file via automated scheduled processes. The retrieved file is stored into AllCare CCO's local network location. Next, an automated scheduled database restoration job takes in the database file and makes it available for querying and reporting by AllCare CCO. In addition, daily and monthly pharmacy claim files are received from MedImpact, AllCare CCO's pharmacy benefits manager (PBM), and are loaded into AllCare CCO's reporting database systems. MedImpact places the backup file on a hosted secure server that is accessed by AllCare CCO. AllCare CCO retrieves the files via automated scheduled processes.	

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	File interactions with subcontractors, vendors, and other delegated entities utilize a variety of formats including, but not limited to, ANSI X12 5010 834, 837I, and 837P files. Additionally, Health Level Seven International (HL7) formatted files, flat text files, along with proprietary formats are all employed in ensuring AllCare CCO can leverage the most available data in service of AllCare CCO's members. One method used to ensure AllCare CCO's partner organizations are supplying accurate data and securing their environments is by monitoring those entities using an internally designed audit tool for third party system review. Below is a link to the tool used and an example response. i. Q4d-DelegatedEntityAuditTool-ACCCO.docx, pages 1-7 ii. Example: Q4d-DelegatedEntityAuditToolMedImpactExample-ACCCO.docx, pages 1-12 AllCare CCO will maintain these processes in CCO 2.0	
5. Contractor shall make all collected and reported data available to the State and upon request to OHA and CMS. 42 CFR §438.242(b)(4) Contract: Exhibit J(3)(g)	5. AllCare CCO is currently submitting and will continue to submit all required reporting to OHA and CMS. Additionally, AllCare CCO submits data related to measures and metrics, financial monitoring, and required exhibits, among other ongoing and ad-hoc requests.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

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Requirement	**Evidence as Submitted by the CCO**	**Score**
	AllCare CCO submits encounters to support the All Payer All Claims (APAC) requirement per a published calendar from OHA. Annually, there are 2 additional files required for submission: Appendix 1 and Appendix 2. AllCare CCO submits professional and institutional encounter claims at least once per month for no less than 50 percent of all claim types received and adjudicated that month. AllCare CCO submits all remaining unreported encounter claims for services received and adjudicated within 180 days of the date of service excepting. Pursuant to ORS 433.094 AllCare CCO currently generates and submits the ALERT data process extracts for immunization information pulled from the Citra EZ-CAP core claims system and is performed after each check run (approx. every week). The process involves uploading the extracted files to the state ALERT website. AllCare CCO provides OHA with Hospital Network Adequacy, Report G based on encounter information pulled from the Citra EZ-CAP system. The Summary and detail are created through querying the encounter database and providing results to the Claims Manager. Review is performed and the report is submitted to the OHA via Secure File Transfer Protocol to the appropriate OHA mailbox.	

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Requirement	**Evidence as Submitted by the CCO**	**Score**
	AllCare CCO provides OHA with quarterly Appeals/Grievance/Denials, Exhibit I based on incidents logged in the Citra EZ-CAP system and as collected from AllCare CCO's subcontractors. The Appeals, Grievance and Denial information is compiled, reviewed, and reported to OHA as contractually required. The Coordinated Care Organization (AllCare CCO) annually demonstrates compliance with federal and state Provider Network Standards by submitting a DSN Provider Capacity Report on July 1st of every year. Participating Providers, whether employed by, or under subcontract, with a CCO, or paid fee-for-service, must have agreed to provide the described services, or items, to Medicaid and Fully Dual Eligible CCO members to be included in the DSN Provider Capacity Report. An inventory of the provider and facility types that must be included in the DSN Provider Capacity Report is found in Exhibit G of the CCO contract. Financial reporting, Exhibit L, is compiled and reviewed by AllCare CCO's CFO. The data is compiled from AllCare CCO's financial sources and other internal data stores. Annually, AllCare CCO currently provides clinical quality metrics (i.e. EHR reported measures) collected from its EHR system or are reported in from other non-EHR clinics. The data	

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	is reviewed for accuracy prior to sending by: 1. Comparing reported denominator totals against expected prevalence rates for a clinic's population, e.g. 1,000 adult members at a clinic, A1c testing for diabetics should represent 10-20% (100 to 200 expected denominator count) of an adult population based on disease rates, 2. Looking into clinics with outlier performance rates; 3. Comparing results from year to year. AllCare CCO also performs chart review measures each year (Colorectal Cancer Screening and Postpartum Care) where a sample of 411 members for each measure from OHA is completed and submitted with documentation to OHA regarding the presence, or absence, of qualifying services for the measures. a. CCO encounter (837) extraction policy/procedure i. Q5-EncounterExtractProcedure-ACCCO.docx, page 2 ii. Q5-EncounterExtractPolicy-ACCCO.docx, page 1 b. All Payer All Claims (APAC) extraction policy/procedure i. Q5-APACSubmissionPolicy-ACCCO.docx, page 1 ii. Q5-APACSubmissionProcedure-ACCCO.docx, pages 1-4	

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	c. ALERT data process extract i. Q5-AlertImmunizationExtractProcedure-ACCCO.docx, pages 1-2 d. Provider Network Standards i. Q5-DeliveryServiceNetworkPolicy CCO-ACCCO.pdf, pages 1-2 e. Clinical Quality Metrics i. Q5-OHAAuditPolicy-ACCCO.docx, pages 1-2 ii. Q5-EHRBasedPerformanceMeasureReporting-ACCCO.docx, pages 1-2 AllCare CCO will maintain these processes in CCO 2.0.	
6. Contractor shall confirm the member's responsibility for its portion of payment as stated in 42 CFR 438.10 (i.e., any cost sharing that will be imposed by the CCO, consistent with those set forth in the State plan.) 42 CFR 438.10(e)(2)(vii) and (g)(2)(C)(viii) Contract: Exhibit J(1)(c)(5)		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		

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Requirement	**Evidence as Submitted by the CCO**	**Score**
7. The CCO shall provide to OHA, upon request, verification that members were contacted to confirm that billed services were provided in accordance with 42 CFR §455.20 and 433.116 (e) and (f) by: a. Providing a notice, within 45 days of the payment of a claim, to all or a sample group of the Members who received services; b. The notice must, based on information from the Contractor's claims payment system, specify: i. The services furnished ii. The name of the provider furnishing the services iii. The date on which the services were furnished iv. The amount of the payment made by the member, if any, for the services c. The sample shall not include specially protected information such as genetic, mental health, alcohol and drug or HIV/AIDS. 42 CFR §455.20; 433.116 (e) and (f) Contract: Exhibit J(1)(c)(6)		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		
8. The CCO shall: a. Collect and maintain sufficient member encounter data to identify the provider who delivers any item(s) or service(s) to members.		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete

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b. Submit member encounter data to OHA at a frequency and level of detail to be specified by CMS and OHA, based on program administration, oversight, and program integrity needs. c. Submit all member encounter data that the State is required to report to CMS under §438.818. d. Specifications for submitting encounter data to the Agency in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate. 42 CFR §438.242(c)(1-4)		☒ NA
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		
9. Contractor shall develop IS contingency planning in accordance with 45 C.F.R. §164.308. Contingency plans shall include: a. Data Backup plans b. Disaster Recovery plans c. Emergency Mode of Operation plans d. Application and data criticality analysis and testing; and revisions procedures shall also be addressed within the required contingency plans. 45 CFR §164.308	9. AllCare CCO currently does, and will continue to, adhere to requirements of 45 CFR § 164.308 for the 2020 CCO contract. a. Data is backed up and stored offsite daily. Reference the AllCare CCO backup policies (See Q9a-DataBackupandRetentionPolicy-ACCCO.pdf) and supplemental desktop procedures (See Q9a-BackupSystemUsageProcedure-ACCCO.pdf). b. Systems functionality and data access is ensured through a full Disaster Recovery policy and plan. The plan is contained and highlighted within the policy (See Q9b-	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

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Requirement	**Evidence as Submitted by the CCO**	**Score**
	ITSystemsDisasterRecoveryPolicy-ACCCO.pdf, page 5). c. Emergency Mode Operation may be declared as referenced within the Disaster Recovery plan. Refer to AllCare CCO's method for declaring Emergency Mode Operation (See Q9c-ITSystemsDisasterRecoveryPolicy-ACCCO.pdf, page 5) and AllCare CCO's policy surrounding Emergency Mode Operation (See Q9c-EmergencyModeOperationPolicy-ACCCO.pdf). Upon declaration of an Emergency Mode Operations situation, AllCare Executive staff will determine the need to trigger the Company's Business Continuity Plan (SeeQ9c-BusinessContinuityPlan-ACCCO.zip). The Plan is reviewed quarterly and annually, changes are made as needed and staff are training annually. AllCare is currently developing a new training program that will begin during the 4th quarter 2019. d. Requirements for application and data analysis, testing, as well as policy review and revision are embedded in contingency planning policies. Reference the highlighted sections of the following documents: i. Q9d-DataBackupandRetentionPolicy-ACCCO.pdf (pages 4-5) ii. Q9d-ITSystemsDisasterRecoveryPolicy-ACCCO.pdf (pages 5-6)	

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	AllCare CCO will maintain these processes in CCO 2.0.	
10. The CCO shall develop and maintain an OHA-approved HIT Roadmap inclusive of CCO's activities, milestones and timelines. The HIT Roadmap must describe where the CCO has implemented its own HIT and where it leverages collaborative HIT solutions, as well as describe how the CCO: a. Uses HIT to achieve its desired outcomes b. Supports EHR adoption for its contracted providers c. Supports access to health information exchanges to enable sharing patient information for care coordination for its contracted providers d. Ensures access to hospital event notifications for its contracted providers e. Uses hospital event notifications in the CCO to support its care coordination and population health efforts f. Uses HIT to administer VBP arrangements, provide support to providers with VBP arrangements, and uses HIT for population health efforts Contract: Exhibit J(2)(a, f-j)		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element will be reviewed by the OHA HIT for the readiness review.		
Required Actions: None.		
11. The CCO shall provide an annual HIT Roadmap update to OHA for review and approval. The HIT Roadmap update must: a. Identify any changes to the prior-approved HIT Roadmap.		☐ Complete ☐ Progress Sufficient to Start Operations

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
b. An attestation to progress made on its HIT Roadmap, including supporting documentation c. An attestation that the COO has an active, signed HIT Commons MOU, and i. Adheres to the terms of the HIT Commons MOU ii. Pays the annual HIT Commons assessments subject to the payment terms of the HIT Commons MOU iii. Serves, if elected, on the HIT Commons Governance Board, or one of its committees iv. Participates in OHA's HITAG, at least annually d. Report the EHR(s) vendor/product used by its contracted providers and its progress on EHR adoption targets via the Performance Expectations report e. Report the HIE tool(s) used by its contracted providers and its progress on HIE access targets via the Performance Expectations report f. Report on its use of HIT to administer VBP arrangements and support its contracted providers with VBP arrangements. g. Report on its use of HIT to support population health management Contract: Exhibit J(2)(b, k)		☐ Incomplete ☒ NA
HSAG Findings: This element will be reviewed by the OHA HIT for the readiness review.		
Required Actions: None.		
12. The CCO shall: a. Participate as a member in good standing of the HIT Commons		☐ Complete ☐ Progress Sufficient to Start Operations

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
b. Maintain an active, signed HIT Commons MOU c. Adhere to the terms of the HIT Commons MOU d. Pay the annual HIT Commons assessments subject to the payment terms of the HIT Commons MOU e. Serve, if elected, on the HIT Commons governance board or one of its committees. Contract: Exhibit J(2)(d)		☐ Incomplete ☐ NA
HSAG Findings: This element will be reviewed by the OHA HIT for the readiness review.		
Required Actions: None.		
13. The CCO shall participate in OHA's HIT Advisory Group (HITAG) at least once annually. Contract: Exhibit J(2)(e)		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element will be reviewed by the OHA HIT for the readiness review.		
Required Actions: None.		
14. The CCO shall document and report to OHA, annually, on how HIT is used to support contracted providers by providing: a. Information (at least quarterly) on measures used in the VBP arrangements b. Accurate and consistent information on patient attribution c. Information on patients requiring intervention and the frequency of that information	14. a. See Q14-QualityReportProductionPolicy-ACCCO.docx – highlighted Policy section on pages 2-3. Additionally, refer to Q14-PCPQualityReportExample-ACCCO.docx for an example of the quality reports distributed to program participants showing all current year measures included in that APM.	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

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Requirement	**Evidence as Submitted by the CCO**	**Score**
d. Other actionable data (e.g., risk stratification, member characteristics) to support providers' participation in VBP arrangements and implementation of interventions. e. Use of HIT to support contracted providers to participate in VBP arrangements Contract: Exhibit J (2)(k)(7)	b. See Q14-QualityReportProductionPolicy-ACCCO.docx – highlighted area on page 2 (item 1.a.) and page 3 (Definitions #1). c. See Q14-QualityReportProductionPolicy-ACCCO.docx – highlighted area on page 3 (item 3.f.) and page 4 (Definitions #4). d. AllCare CCO currently does not utilize risk stratification in AllCare CCO's VPB arrangements but will be developing a prototype for a meaningful report that AllCare CCO plans to roll out in 2020. AllCare CCO currently contracts for Milliman's MedInsight reporting platform and have their Milliman Advanced Risk Adjusters (MARA) as a tool. The Prospective MARA factors represent a predictive risk score for a patient over the next year, reflecting the expected medical cost for the patient relative to an average patient cost (e.g. the average MARA factor is 1.0 and a patient with a MARA factor of 2.0 has an expected medical cost of twice the average patient cost). AllCare CCO plans to risk stratify membership using the MARA risk factors and chronic conditions. With the development of a risk stratification report AllCare CCO will explore the feasibility of building a VBP measure supported by this data. Steps to be included in the report and measure development process:	

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• Research of risk stratification type reports in the healthcare arena. • Develop prototype of risk stratification report. Include patient risk scores (MARA), demographics, number and type of chronic conditions (e.g. COPD, diabetes, etc), and assignment of risk category by patient based on risk scores and chronic conditions (e.g. high risk, rising risk, moderate risk, low risk). • Analyze report to gain understanding of the data. Assess areas of opportunity, review trends in the data. • Determine actionable data that can be targeted for intervention by the assigned provider and how that could align to measurement. • Design VBP measure focused on use of risk stratification data. • Present the risk stratification measure concept to AllCare CCO's Physician Committee for feedback and approval for inclusion in AllCare CCO's 2020 or 2021 VBP measure set. • Develop education and training program for rollout of risk stratification model and measure to provider network.	

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Requirement	**Evidence as Submitted by the CCO**	**Score**
	e. AllCare CCO will be using health information technology (HIT) in three ways to support contracted providers participating in VBP arrangements: 1. Measure data for AllCare CCO's VBP models are extracted in data sets from core systems using SAS and SQL programming. Data sets that contain data for the VBP measures are imported into an Excel model that has the functionality programmed to produce provider quality reports. The quality reports are produced quarterly and provide status on performance relative to benchmark (target). 2. In conjunction with the release of quarterly progress reports AllCare CCO also sends out detailed gap list information that identifies the provider's eligible members that have not yet had a qualifying service during the measurement period. AllCare CCO's Provider Portal will be used to provide the gap list information in a timely and readily accessible format for providers. 3. AllCare CCO hosts the EHR platform for many of AllCare CCO's participating providers and provides technical support to the clinics, including eCQM support for the EHR based measures. AllCare CCO staff run the clinical quality reports for the	

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	participating clinics. Additionally, feedback and training are provided to clinical staff that address gaps observed by AllCare CCO staff during the process of generating reports. AllCare CCO will maintain these processes in CCO 2.0.	
HSAG Findings: AllCare submitted the Provider Quality Report Production policy, which outlined the processes and reporting standards for providing quarterly and year-end reports to the providers. The primary sources of Value Based Payment data were claims the CCO receives, data feeds from EZ-CAP, dental and pharmacy delegates, and eCQM data derived from EHRs, as well as data received directly (survey, attestations, information gathered during office visits, etc.) from participating providers and vendors. Using a combination of analytic tools (SAS and SQL), AllCare calculates a set of measures to support the development, calculation, and reporting of VBP-related performance metrics to OHA and providers. These metrics are incorporated into Microsoft (MS) Excel spreadsheets to facilitate review and use by providers. The CCO shares information on member attribution, member-level gaps in care (gap lists), and provider performance on quality measures. AllCare provided a sample of its quarterly Primary Care Provider Quality Report, which is distributed electronically via secure email to provider offices. AllCare mentioned during the Web review that the reports do not currently include details by member demographics such as age, gender, race, and language, but there are plans to include those in the future. AllCare does not currently utilize risk stratification in VBP arrangements but mentioned during the remote interview session review that the CCO is currently developing a risk stratification report to roll out in 2020 using the Milliman Advanced Risk Adjusters™ (MARA) tool. The CCO plans to incorporate reports into the provider portal for secure access.		
Required Actions: HSAG recommends that AllCare continue development and implement its risk stratification report to support providers' participation in VBP arrangements and assist in the implementation of interventions.		
15. The CCO shall document and report to OHA, annually, on how HIT is used to support population health management, including: a. The ability to identify and report on member characteristics (e.g., past diagnoses and services) b. The capability of risk stratifying members c. The ability to provide risk stratification and member characteristics to contracted providers with VBP	15. AllCare CCO utilizes a variety of data elements to identify and report members for population health. As defined by business users, reports of members that meet identified criteria are provided in order to direct care as overseen by Population Health. a. AllCare CCO uses member characteristics; such as diagnoses, received services,	☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

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Requirement	**Evidence as Submitted by the CCO**	**Score**
arrangements for the population(s) addressed in the arrangement(s). Contract: Exhibit J (2)(k)(8)	enrollment group code and or any other data stored data elements, to determine members that meet population health criteria. Data is stored in AllCare CCO core systems and reported as requested by business owners. See the policy Q15a-MemberCharacteristicsIDandReportingPolicy-ACCCO.docx. See highlighted areas on page 2 in Q15a-ReportingProcedure-ACCCO.docx i. Q15a-MemberCharacteristicsIDandReportingPolicy-ACCCO.docx ii. Q15a-ReportingProcedure-ACCCO.docx b. AllCare CCO collects and aggregates data via a number of different sources for member risk stratification. Data is reported to business owners as requested in support of population health activities. See highlighted section on page 2 in Q15b-MemberRiskStratificationPolicy-ACCCO.docx i. Q15b-MemberRiskStratificationPolicy-ACCCO.docx ii. Q15b-ReportingProcedure-ACCCO.docx	

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Requirement	**Evidence as Submitted by the CCO**	**Score**
	c. AllCare CCO reviews member data to identify gaps in care that must be addressed by the member's PCP. Every month, PCP Providers are supplied this information in order to support their VBP associated with identified gaps by the AllCare CCO Provider Relations department. See highlighted section on page 2 in Q15c-ProvidingRisktoProviderswithVBPPolicy-ACCCO.docx. i. Q15c-ProvidingRisktoProviderswithVBPPolicy-ACCCO.docx ii. Q15c-ReportingProcedure-ACCCO.docx AllCare CCO will maintain these processes in CCO 2.0.	
HSAG Findings: AllCare currently uses member characteristics such as past services, diagnoses, group codes, and stored data elements to populate its data warehouse. The CCO demonstrated the ability to produce reports from the data warehouse to support management of its population health activities. Moreover, AllCare provided policies related to reporting procedures and member risk stratification but did not upload sample reports for review. AllCare staff members noted that spreadsheets are the primary method for sharing information with providers. During the remote interview session, AllCare confirmed that it does not currently utilize risk stratification but has contracted with Milliman's MedInsight to implement the MARA tool. The CCO stated it is currently developing a risk stratification report to roll out in 2020. Additionally, AllCare also discussed plans to support its population health activities by implementing a population health module, available through the case management system, Essette, by the end of 2019. Staff members indicated they have future plans to integrate care coordination, social determinants of health (SDOH), and health information technology (HIT) with the use of this module.		

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Required Actions: HSAG recommends that AllCare continue its development of the risk stratification report to incorporate the capability of risk stratifying members. HSAG recommends that the CCO complete its workplan to implement the population health module as a method to provide risk stratification and member characteristics to contracted providers with VBP arrangements for the population(s) addressed in the arrangement(s).		

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	Total #
Complete	**6**
Progress Sufficient	**2**
Incomplete	**0**
Not Applicable (NA)	**7**

Appendix B. Delivery System Network (DSN)

The DSN Provider Capacity Report is an inventory of each individual provider (i.e., physician, mid-level practitioner, or other practitioner), facility, or business, whether employed by or under subcontract with a CCO, or paid fee-for-service, that agrees to provide the described services, or items, to Medicaid and fully dual-eligible CCO members. Containing an inventory of the provider categories and service categories outlined in Exhibit G of the CCO contract, HSAG evaluated the data to assess general capacity of each CCO's existing and proposed DSN. Specifically, HSAG evaluated the DSNs on four key domains:

- Quality of DSN Provider Capacity Reporting
- Provider Network Capacity
- Provider Accessibility
- Geographic Distribution

Quality of DSN Provider Capacity Reporting

The Quality of DSN Provider Capacity Reporting domain assessed the CCO's ability to provide complete provider network data in the required format. Key measures included:

- Percent Present—the percent of key data fields that are populated
- Percent Valid Format—the percent of key fields where data are submitted in the required format (e.g., dates as dates)
- Percent Valid Values—the percent of key data fields containing valid data

Table B-1 and Table B-2 contain the quality metric results for the individual practitioner and facility and service provider capacity reports, respectively. Overall, the quality of AllCare's Provider Capacity Reports were good with minor errors associated with the individual practitioner file.

Table B-1—AllCare Phase 1—Individual Practitioner DSN Provider Capacity File Quality Metrics

DSN Data Field	DSN Quality Metrics		
	% Present	% Valid Format	% Valid Values
Accepting New Medicaid Enrollees	83.8	100.0	
Address #1	100.0		
Provider's Capacity	9.9	100.0	
City	100.0		
Status of Medicaid Contract	100.0	94.9	
County	100.0		
Credentialing Date	100.0	51.5	9.1
DMAP (Medicaid ID)	100.0	100.0	
Provider First Name	100.0		

DSN Data Field	DSN Quality Metrics		
	% Present	% Valid Format	% Valid Values
Group/Clinic Name	99.4		
Non-English Language 1	8.1		
Non-English Language 2			
Non-English Language 3			
Provider Last Name	100.0		
Provider Network Status	100.0	100.0	
Provider NPI	100.0	100.0	100.0
Number of Members Assigned to PCPs	18.8	100.0	
PCP Indicator	90.5	100.0	
PCPCH Tier	17.9	100.0	
Phone Number	100.0		
Provider Category	100.0	100.0	100.0
Provider Service Category	100.0	100.0	100.0
Provider TIN	100.0	99.0	
Provider Taxonomy	99.2	99.8	99.5
Zip Code	100.0		

In general, key DSN data fields in the individual practitioner capacity report were populated although one data field (i.e., PCP Indicator) was populated for only 84 percent of the records. More importantly, while credentialing date was populated for 100 percent of the records, only 51.5 percent were presented in a value format; only 9.1 percent of the records contained valid dates. The overall average completeness was 83.8 percent across both required and conditional[B-1] fields and jumped to 98.5 percent when excluding conditional fields. Of note, only 8.1 percent of providers were associated with a non-English language.

Table B-2—AllCare Phase 1—Facility and Service DSN Provider Capacity File Quality Metrics

DSN Data Field	DSN Quality Metrics		
	% Present	%Valid Format	% Valid Values
Address #1	100.0		
Facility or Business Name	100.0		
City	100.0		

[B-1] Conditional fields represent data elements which are not required for every record (i.e., provider name), but are conditional on other provider fields or demographics (e.g., the number of members assigned to a PCP is limited to provider defined as PCPs).

DSN Data Field	DSN Quality Metrics		
	% Present	%Valid Format	% Valid Values
Status of Medicaid Contract	100.0	100.0	
County	100.0		
DMAP (Medicaid ID)	100.0	100.0	
Facility NPI	100.0	100.0	100.0
Phone Number	100.0		
Provider Category	100.0	100.0	100.0
Provider Service Category	100.0	100.0	98.9
Facility TIN	100.0	92.7	
Facility or Business Taxonomy	100.0	99.5	99.4
Zip Code	100.0		

Overall, key DSN data fields in the facility and service provider capacity report were present and populated with valid values with an overall average completeness of 100.0 percent across all data fields.

Provider Network Capacity

The provider network capacity domain addressed the underlying infrastructure of the CCO's provider network and assessed whether or not required health services were available to beneficiaries through a sufficient supply and variety of providers. Table B-3 provides the number and percent of providers by provider specialty category and contract status. All providers presented in the DSN were contracted or had a contract pending at the time of submission.

Table B-3—AllCare Phase 1—Individual and Facility/Service Provider Capacity[1] by Specialty Category[2] and Contract Status

Provider Specialty Category	Total		Contract Status = Yes		Contract Status = PEND	
	Number	Percent	Number	Percent	Number	Percent
Individual Practitioners						
Primary Care Provider	313	18.8	313	100.0	0	0.0
Specialty Provider	803	48.2	803	100.0	0	0.0
Dental Service Provider	149	8.9	149	100.0	0	0.0
Mental Health Provider	369	22.1	369	100.0	0	0.0
SUD Provider	28	1.7	28	100.0	0	0.0
Certified or Qualified Health Care Interpreters	0	0.0	0	0.0	0	0.0

Provider Specialty Category	Total		Contract Status = Yes		Contract Status = PEND	
	Number	Percent	Number	Percent	Number	Percent
Traditional Health Workers	0	0.0	0	0.0	0	0.0
Alcohol/Drug	0	0.0	0	0.0	0	0.0
Health Education, Health Promotion, Health Literacy	5	0.3	5	100.0	0	0.0
Palliative Care	0	0.0	0	0.0	0	0.0
Facility/Service Practitioners						
Hospital, Acute Psychiatric Care	4	3.1	4	100.0	0	0.0
Ambulance and Emergency Medical Transportation	0	0.0	0	0.0	0	0.0
Federally Qualified Health Centers	11	8.7	11	100.0	0	0.0
Home Health	4	3.1	4	100.0	0	0.0
Hospice	0	0.0	0	0.0	0	0.0
Hospital	9	7.1	9	100.0	0	0.0
Imaging	0	0.0	0	0.0	0	0.0
Indian Health Service and Tribal Health Services	2	1.6	2	100.0	0	0.0
Mental Health Crisis Services	3	2.4	3	100.0	0	0.0
Community Prevention Services	7	5.5	7	100.0	0	0.0
Non-Emergent Medical Transportation	1	0.8	1	100.0	0	0.0
Pharmacies	49	38.6	49	100.0	0	0.0
Durable Medical Providers	13	10.2	13	100.0	0	0.0
Post-Hospital Skilled Nursing Facility	8	6.3	8	100.0	0	0.0
Rural Health Centers	7	5.5	7	100.0	0	0.0
School-Based Health Centers	7	5.5	7	100.0	0	0.0
Urgent Care Center	2	1.6	2	100.0	0	0.0

Note: Provider counts where Contract Status = "No" are not displayed in the table but are included in the total. When the *Total* number is higher than the sum of contracted and pending contract counts, the specialty category is highlighted.

[1] Provider capacity counts are based on unique providers deduplicated by NPI and Service Category.
[2] Specialty Category designations specifying *adult* and *pediatric* providers were combined and deduplicated by NPI to preventing counting providers within a specialty category more than once.

In general, AllCare's individual provider capacity demonstrated network coverage of required physical health (primary and specialty), oral health, and mental health and substance use providers. Provider data, however, did not include documentation of certified or qualified health care interpreters, traditional health workers, alcohol/drug providers, or palliative care providers. Additionally, of the 17 required facilities and services, three provider service categories had a count of zero—i.e., ambulance and emergency medical transportation, hospice, and imaging services.

Provider Accessibility

The provider accessibility domain evaluated the degree to which contracted services are accessible to the beneficiary population based on the number of providers who are accepting new patients and that provide services in an non-English language. Table B-4 displays the number and percent of providers by provider specialty category who were accepting new patients and who speak a non-English language.

Table B-4—AllCare Phase 1—Provider Accessibility by Service Category[2]

Provider Specialty Category	Total Providers[1]	Accepting New Patients		Speak Non-English Language	
		Number	Percent	Number	Percent
Primary Care Provider	313	158	50.5	16	5.1
Specialty Provider	803	788	98.1	51	6.4
Dental Service Provider	149	99	66.4	45	30.2
Mental Health Provider	369	134	36.3	20	5.4
SUD Provider	28	0	0.0	2	7.1
Certified or Qualified Health Care Interpreters	0	0	0.0	0	0.0
Traditional Health Workers	0	0	0.0	0	0.0
Alcohol/Drug	0	0	0.0	0	0.0
Health Education, Health Promotion, Health Literacy	5	5	100.0	0	0.0
Palliative Care	0	0	0.0	0	0.0
TOTAL	**1667**	**1184**	**71.0**	**134**	**8.0**

Note: Provider counts are based on all providers regardless of contract status.

[1] Provider counts are based on unique providers deduplicated by NPI and Service Category.

[2] Specialty Category designations specifying *adult* and *pediatric* providers were combined and deduplicated by NPI to preventing counting providers within a specialty category more than once.

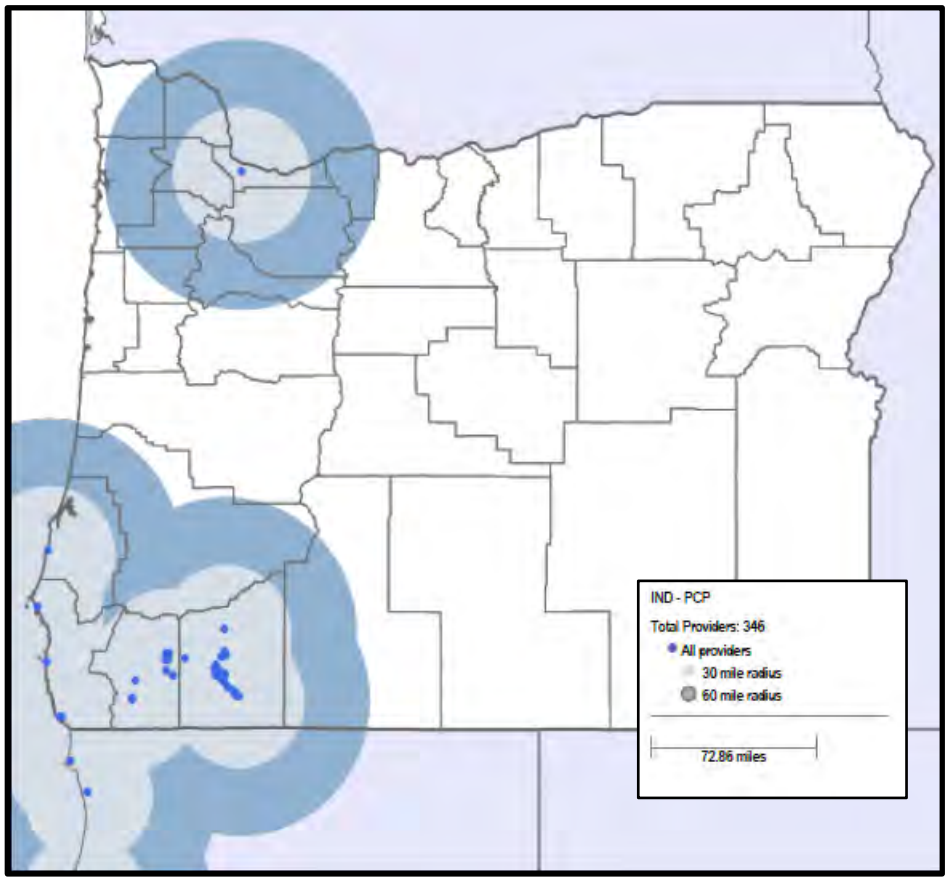
Overall, only 71.0 percent of AllCare's provider network was accepting new patients with less than three quarters of AllCare's core providers (i.e., physical, oral, and mental health) indicating they were accepting new patients. Of particular interest, two core specialty categories indicated that 50 percent or fewer providers were accepting new patients (i.e., PCPs and mental health providers). Additionally, just over two-thirds of dental providers were accepting new patients. Of its individual practitioners, only 8.0

percent noted speaking a language other than English with primary care providers, specialty providers, and mental health service providers reporting 5.1 percent, 6.4 percent, and 5.4 percent, respectively, speaking a non-English language.

Geographic Distribution

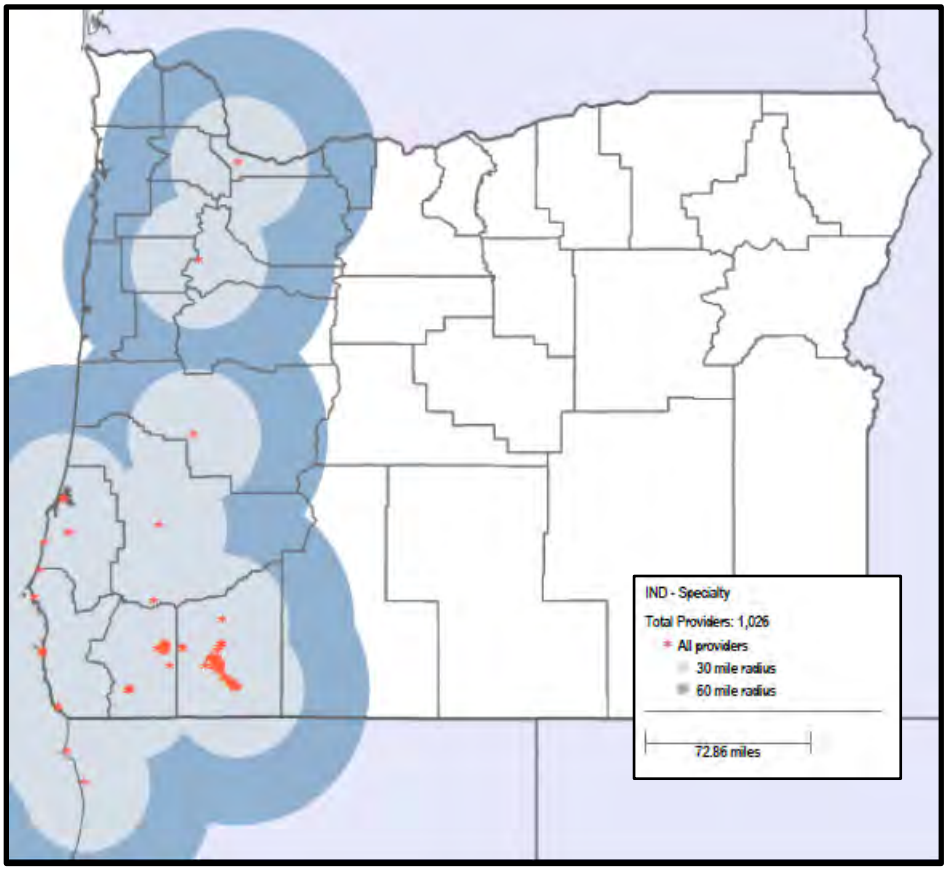
The geographic distribution of providers relative to member populations assessed whether or not the practitioner and facility locations were spread proportionately across the beneficiary population. Since beneficiary data was not available at the time of this analysis, the geospatial maps display the coverage areas around each provider location based on pre-defined distance thresholds (i.e., 30 miles and 60 miles) in alignment with OHA's current access standards. Graphic representations are provided for key individual and facility providers. Most of the zip codes within AllCare's service area (i.e., Curry County, Josephine County, Jackson County, and part of Douglas County), are classified as rural with the exception of the areas surrounding Medford and Phoenix/Talent.

Figure B-1—AllCare Phase 1—Geographic Distribution of Primary Care Providers (PCPs)



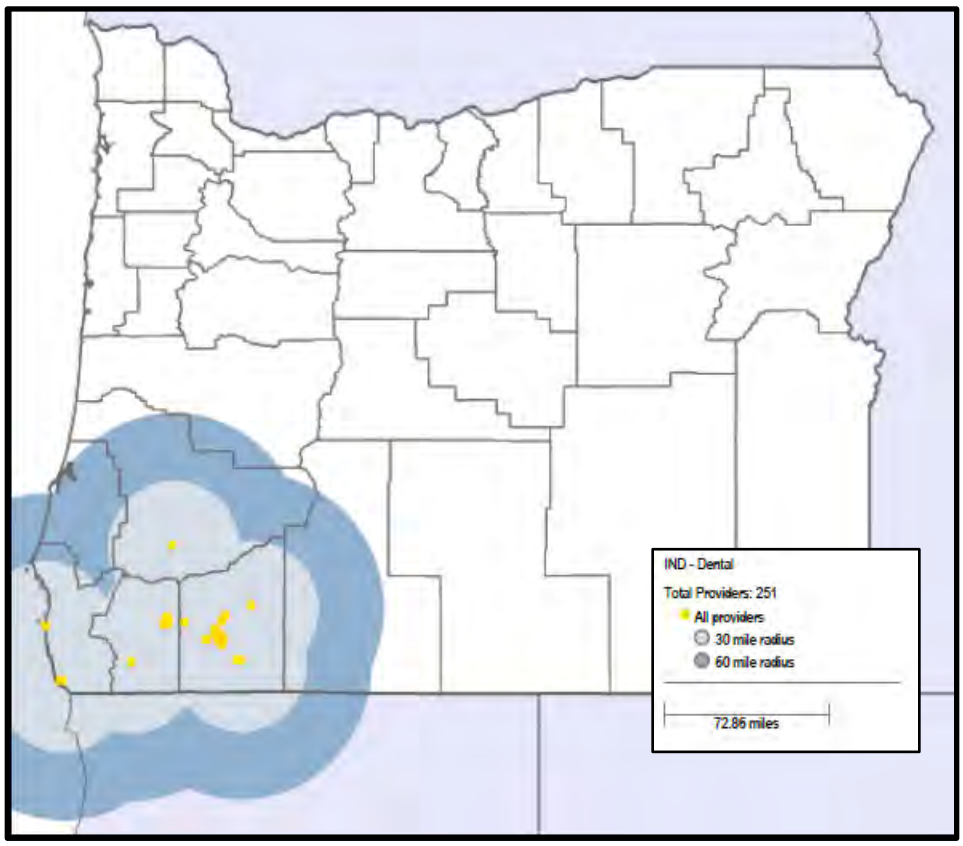
As shown in Figure B-1, the distribution of AllCare's network of PCPs is sufficient to cover the CCO's service area. All regions of the service area are within 60 miles of a primary care provider in rural areas and within 30 miles in urban areas.

Figure B-2—AllCare Phase 1—Geographic Distribution of Specialty Providers



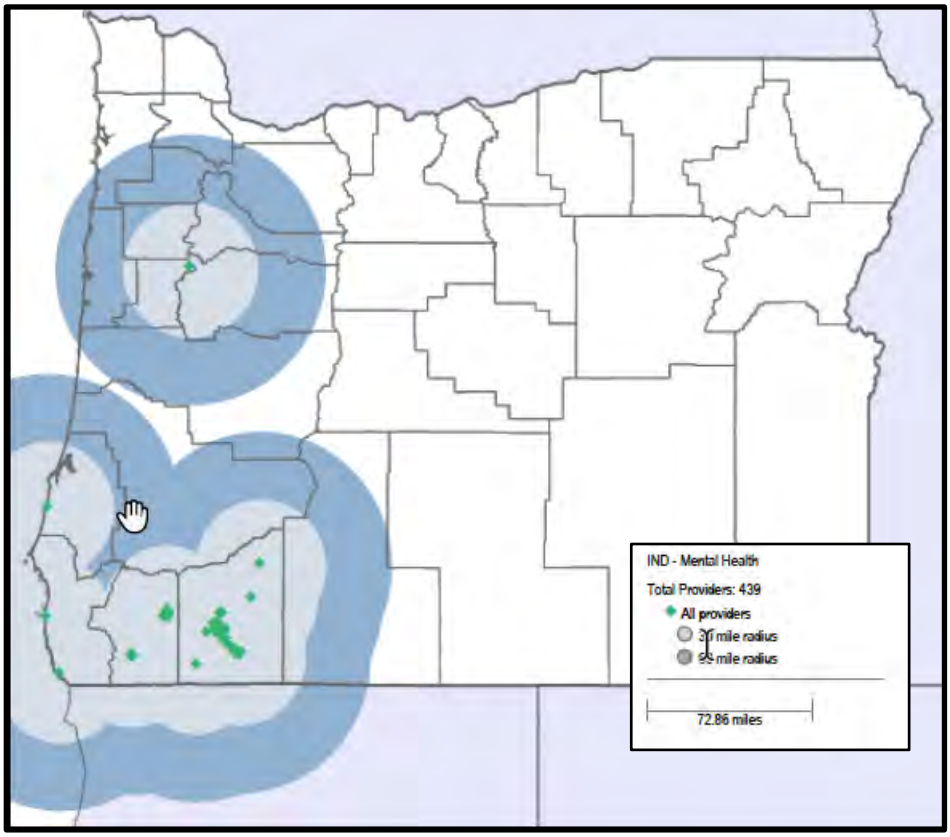
As shown in Figure B-2, the distribution of AllCare's specialty providers is sufficient to cover the CCO's service area. All regions of the service area are within 60 miles of a specialty provider in rural areas and within 30 miles in urban areas.

Figure B-3—AllCare Phase 1—Geographic Distribution of Dental Service Providers



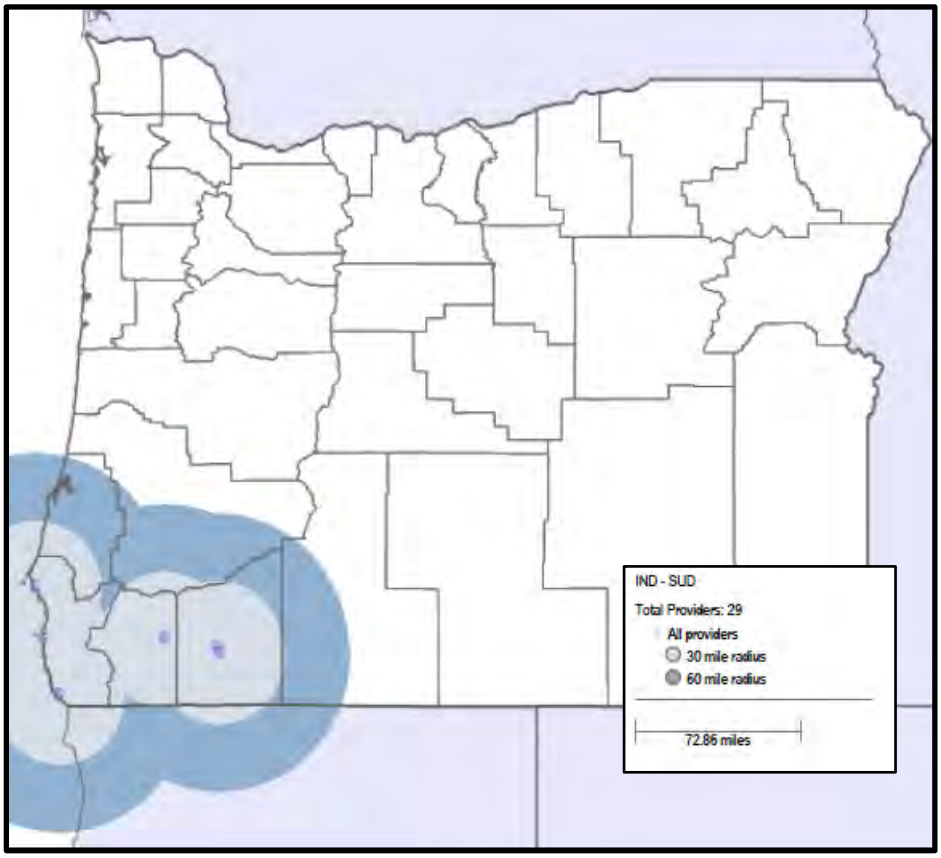
As shown in Figure B-3, the distribution of AllCare's dental service providers is sufficient to cover the CCO's service area. In general, most regions within the service area are within 30 miles of a dental provider, and all regions are within 60 miles.

Figure B-4—AllCare Phase 1—Geographic Distribution of Mental Health Providers



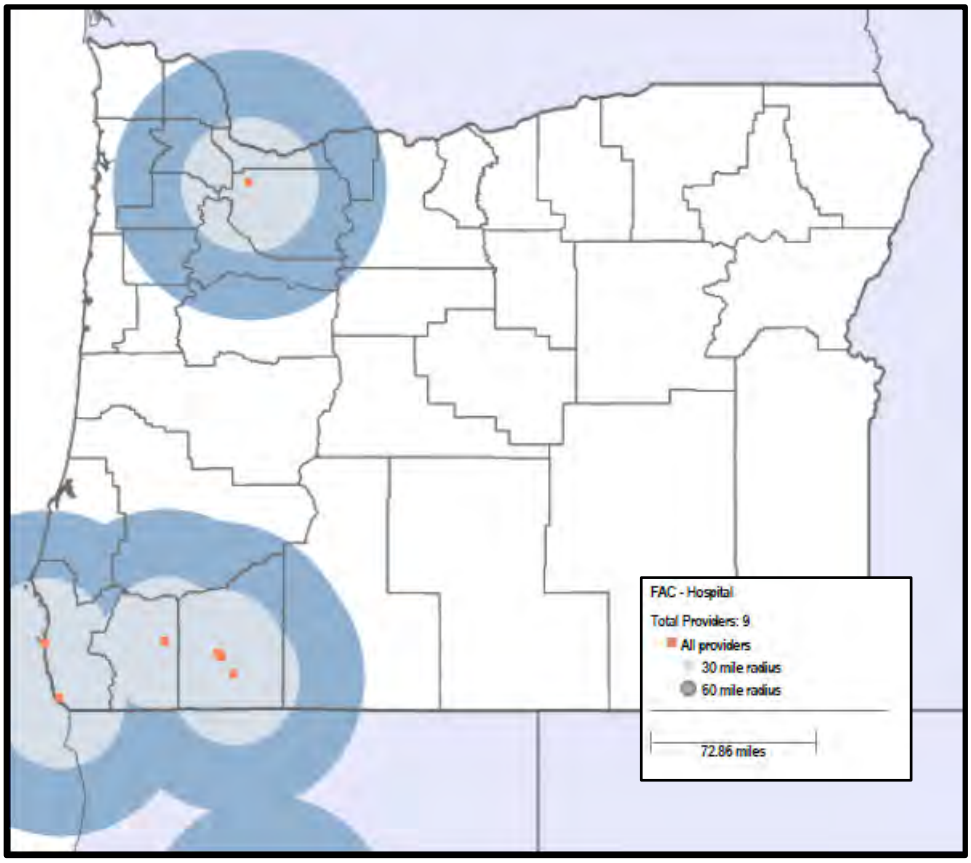
As shown in Figure B-4, the distribution of AllCare's mental health providers is sufficient to cover the CCO's service area. In general, most regions within the service area are within 30 miles of a mental health provider, and all regions are within 60 miles.

Figure B-5—AllCare Phase 1—Geographic Distribution of Substance Use Disorder (SUD) Providers



As shown in Figure B-5, the distribution of AllCare's SUD providers is sufficient to cover the CCO's service area. All regions of the service area are within 60 miles of a SUD provider in rural areas and within 30 miles in urban areas.

Figure B-6—AllCare Phase 1—Geographic Distribution of Hospitals



As shown in Figure B-6, the distribution of AllCare's hospital facilities is sufficient to cover the CCO's service area. All regions of the service area are within 60 miles of a hospital in rural areas and within 30 miles in urban areas.

Figure B-7—AllCare Phase 1—Geographic Distribution of Clinic-based Facilities

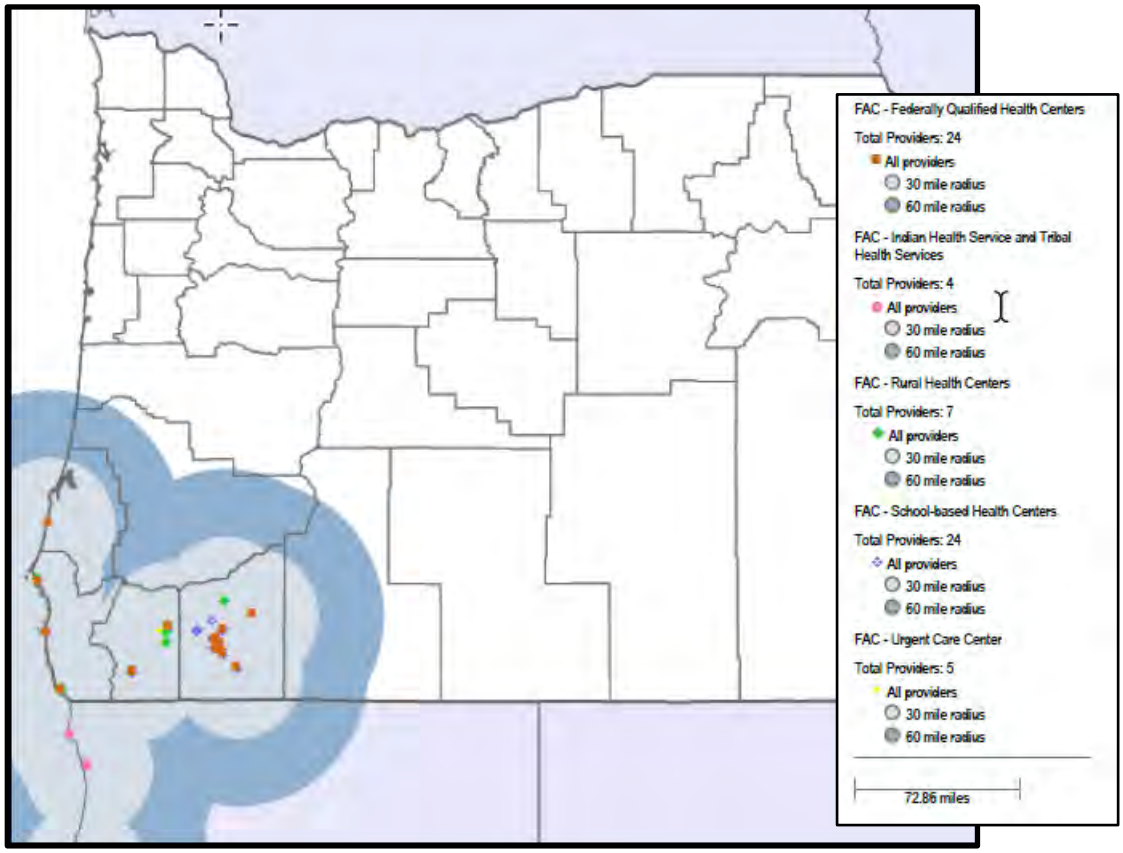


Figure B-7 displays the distribution of several clinic-based facilities within AllCare's service areas, including FQHCs, Indian Health Services and Tribal Health Services, Rural Health Centers, School-Based Health Centers, and Urgent Care Centers. The map shows that the distribution of clinic-based facilities is sufficient to cover the CCO's service area. Nearly all regions of the service area are within 30 miles of a clinic-based facility and all areas are with 60 miles of the nearest facility.

Appendix C. Phase 2 Evaluation Tool

[Pending completion of the Phase 2 RR]