Oregon Health Authority

2019 CCO Readiness Review

for

InterCommunity Health Network

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 clinical practice 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 InterCommunity Health Network (IHN), 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.

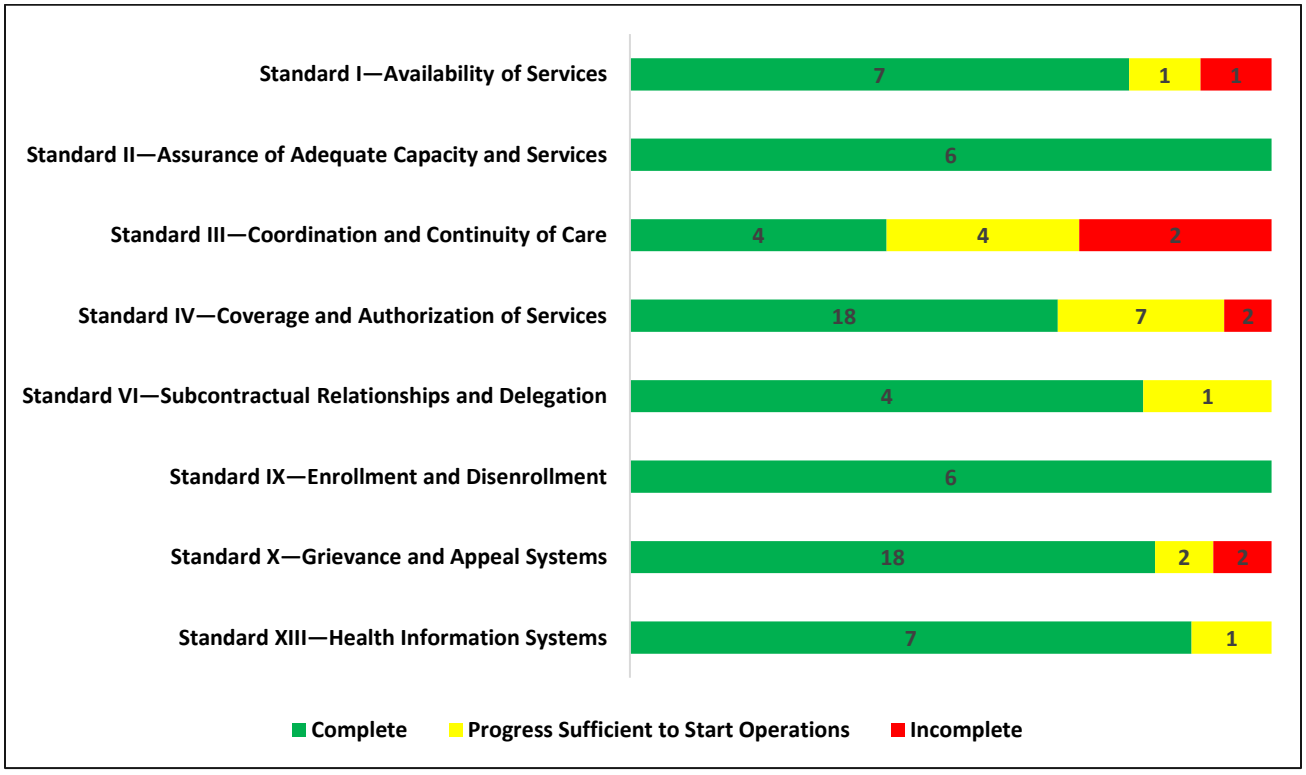
2. Phase 1 Results

Across all eight standards, IHN's overall percentage of complete elements is 75.3 percent. The CCO demonstrated:

- *Complete* ratings for 70 of the 93 total elements.
- *Progress Sufficient to Start Operations* ratings for 16 elements across six standards.
- *Incomplete* ratings for seven elements across four 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—IHN Phase 1—Critical Areas Readiness Review Results



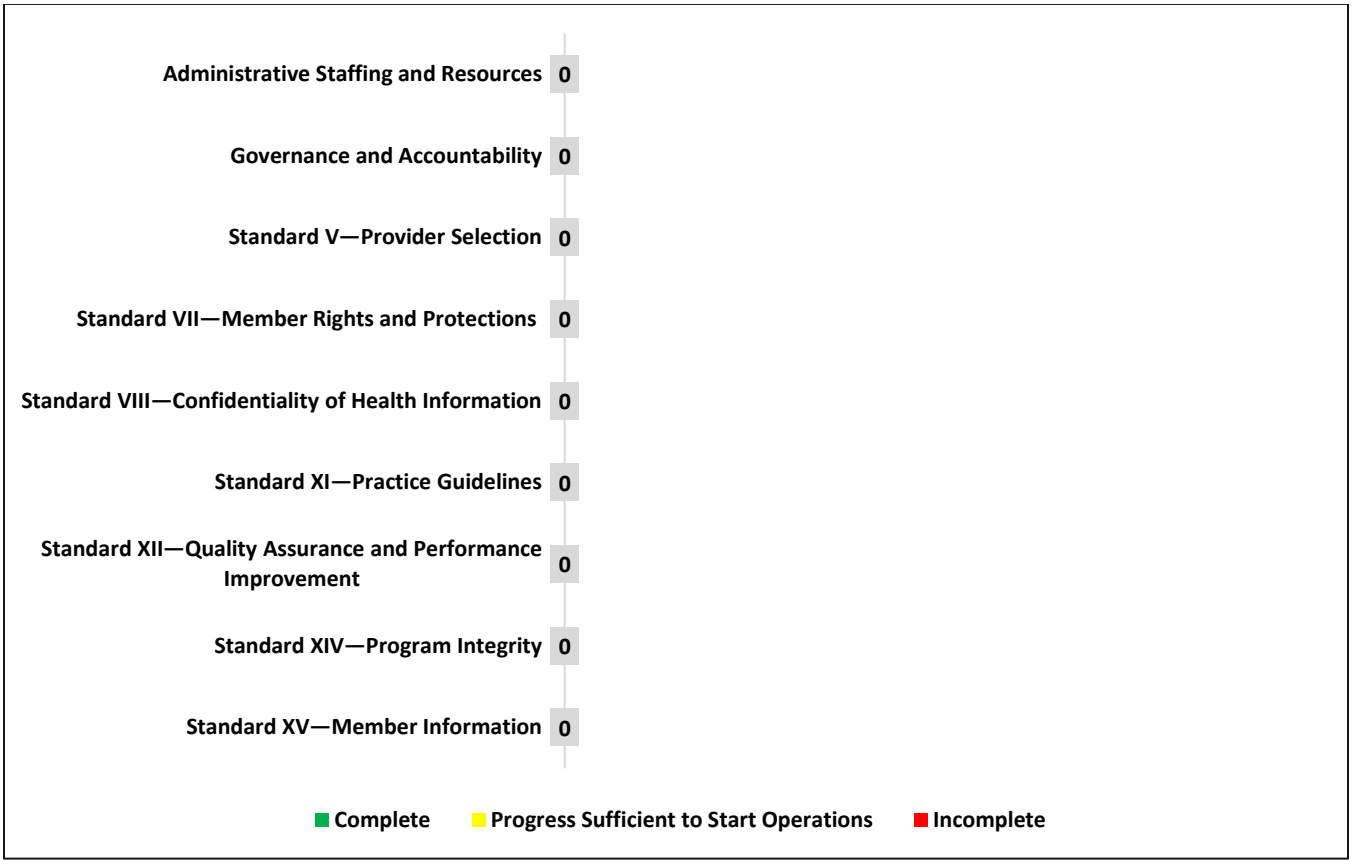
3. Phase 2 Results

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

Across all eight standards, IHN'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—IHN 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 IHN'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)*	• PRC-17 Delivery System Network Adequacy Monitoring and Reporting, "Policy" Section and "Procedure" 2a&b. • DSN Adequacy Excel Snapshot • 2019 DSN Provider Capacity and Narrative Report Template (entire document)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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)*	• PRC-17 Delivery System Network Adequacy Monitoring and Reporting, "Policy" Section and "Procedure" 2a&b. • Participating Provider Agreement + IHN (entire document) • DSN Adequacy Excel Snapshot • 2019 DSN Provider Capacity and Narrative Report Template (entire document) • NEMT Contract (First Page – proof of NEMT services) • 2019 IHN CCO Member Handbook – (first 3 unnumbered pages of the handbook) pages 9 ,17,18,26 • Provider Manual page 44-45	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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	• 2019 IHN CCO Member Handbook – "Covered Medical Benefits", Page 24 (Specialist non-referral requirement for women's care) ((For CY2020, IHN CCO will be adding language to its	☒ Complete ☐ Progress Sufficient to Start Operations

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)*	handbook which specifically calls out "women's health" for increased clarity to the member) • PRC-17 Delivery System Network Adequacy Monitoring and Reporting (women health providers are a "Provider Service Type" that is measured and ensured through the policy's adequacy monitoring) Page 1 b (i)(3) • DSN Adequacy Excel Snapshot	☐ Incomplete ☐ NA
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)*	• 2019 IHN CCO Member Handbook – "Second Opinion" Page 14 • MM-00 Secondary Opinion Policy (Entire Document)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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)*	• IHN -Non-Par Reimbursement Letter Final • MM Plan (page 14)	☒ 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)*	• Member Handbook – "Member Rights and Responsibilities", Page 17	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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.	• N/A	☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*		
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, 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	• Member handbook – "Getting Mental Health Care", Page 30-33 • Member handbook – "Mental Health Benefits", Page 34-36 • HSAG Narrative Standard I #8 (entire document)	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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. 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*		
HSAG Findings: The CCO's member handbook accurately captured the specialty behavioral health services available to CCO members and the associated accessibility requirements. The CCO's Narrative Standard I document also outlined network requirements for specialty behavioral health services and prioritized populations. However, none of the submitted documentation described the processes used by the CCO monitor and ensure timely access to these services, nor did the CCO's responses articulate the mechanisms available to demonstrate the CCO maintains a sufficient network to ensure access.		

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Required Actions: The CCO should update its policies and procedures to describe the mechanisms used to collect, monitor, and report on its provider network to ensure timely access to specialty behavioral health providers for priority populations in accordance with the time frames specified in the State contract.		
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. 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)*	• Provider Manual pgs. 15-16	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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	• Req 8 Cultural Responsiveness Training Strategic Plan, A1, A2, A3 • Req 8 IHN CCO Health Equity Strategic Plan Page 3 goal B • CC-05 Linguistic Interpreter Services-Page 1 Policy last paragraph, Page 2 III, V	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	• 2019 IHN CCO Member Handbook – (first 3 unnumbered pages of the handbook) pages 9,17,18, • Provider Manual pgs 44-45	☐ NA
HSAG Findings: The CCO's documentation provided evidence that it promotes culturally competent services through its member handbook (i.e., nondiscrimination and culturally sensitive health education sections), its Health Equity Strategic Plan, and a piloted Health Equity Summit. However, neither the submitted documentation nor staff member responses indicated how network providers are encouraged to adopt culturally competent practices.		
Required Actions: HSAG recommends that the CCO incorporate education and documentation on the CCO's expectations regarding the delivery culturally competent care and nondiscrimination requirements to its network providers through mechanisms such as the provider manual or provider agreements.		
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)*	• N/A	☐ 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	**7**
Progress Sufficient	**1**
Incomplete	**1**
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*	• PRC-17 Delivery System Network Adequacy Monitoring and Reporting, "Procedure" Section 1(b)i and (d) • 2019 DSN Provider Capacity and Narrative Report Template (entire document)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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*	• PRC-17 Delivery System Network Adequacy Monitoring and Reporting, "Procedure" Section 1. • DSN Provider Report Protocol (entire document) • 2019 DSN Provider Capacity and Narrative Report Template (entire document)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

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)*	• PRC-17 Delivery System Network Adequacy Monitoring and Reporting, "Procedure" Section 1(a)i • DSN Provider Report Protocol (entire document) • 2019 DSN Provider Capacity and Narrative Report Template (entire document)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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)*	• PRC-17 Delivery System Network Adequacy Monitoring and Reporting, "Procedure" Section 1(a)i • DSN Provider Report Protocol • 2019 DSN Provider Capacity and Narrative Report Template (entire document)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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)*	• PRC-17 Delivery System Network Adequacy Monitoring and Reporting, "Procedure" Section 1(a)i • DSN Provider Report Protocol (entire document) • 2019 DSN Provider Capacity and Narrative Report Template (entire document)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	• PRC-17 Delivery System Network Adequacy Monitoring and Reporting, "Procedure" Section 1(a)i • 2019 DSN Provider Capacity and Narrative Report Template (entire document) • Rx-43 Pharmacy Network, "Procedure" Section 4(a)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

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)*	**ED-26** Pg. 1; Policy; Pg. 1; Procedure 1 and 3 **IHN.17.002.AM IHN Member Rights and Responsibilities**; pg. 1-3 Procedure 1b, c, d, f, h, n, p, q, r, z, aa, cc, dd; Procedure 2 a, l, p **IHN-CCO 2020 Draft Handbook**; • What is a Coordinated Care Organization, pg. 6 • How We Coordinate Your Care pg. 8 • Care Helpers pg. 9 • Getting Healthcare pg. 12, 14 • Member Rights and Responsibilities pg. 17, 18 • Helpful Member Information pg. 20 • Getting Medical Care pg. 23, 27, 29 • Getting Prescription Medications pg. 29 • Getting Mental Health Care pg. 30, 31 • Mental Health Benefits pg. 34. 35 • Getting Dental Care pg. 36 **MM-52** in its entirety, pg. 1-3 **MM-53** in its entirety, pg. 1-3 **Member Written Workflow** Pg. 2-3; New and Reinstated IHN-CCO Member Onboarding Process	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Pg. 5-9; Transition of Care IHN-CCO Members Onboarding Process Pg. 10; Transitioning IHN-CCO Members Between Settings Pg. 11-12; Transitioning IHN-CCO Members Offboarding Process **Member Onboarding Workflow** **RX-3** in its entirety **Transitions Between Settings Workflow** **Transitions of Care Onboarding Workflow** **Transitions of Care Offboarding Workflow**	
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)*	**MM-13** Pg. 1; Definitions 1-7 Pg. 1-2; Policy Statement Pg. 2-3; Procedure 1a, b; 2d, e; 3b; 4c **MM-44** in its entirety Pg. 1-2; Definitions 1-10 Pg. 2; Procedure 1, 3f and g **MM-47** in its entirety pg. 1-4 **MM-52** in its entirety pg. 1-3 **Long Term Services and Supports MOU**; pg. 1-3 **IHN-CCO Plan of Care template** **Member Written Workflow** Pg. 5-9; Transition of Care IHN-CCO Members Onboarding Process	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Pg. 10; Transitioning IHN-CCO Members Between Settings Pg. 11-12; Transitioning IHN-CCO Members Offboarding Process **Transitions Between Settings Workflow** **Transitions of Care Onboarding Workflow** **Transitions of Care Offboarding Workflow**	
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)*	**MM-13** Pg. 1; Definitions 1 and 7 Pg. 1-2; Policy Statement Pg. 2-3; Procedure 3; 4c **MM-33** in its entirety; pg. 1-4 **MM-44** in its entirety; pg. 1-3 **IHN-CCO Screening and Assessment Form** **Member Written Workflow** Pg. 3-4; New and Reinstated IHN-CCO Member Onboarding Process Pg. 13-14; Internal Identification of Member Health Needs & Health Risks **Member Onboarding Workflow** **Screening and Stratification Workflow** **Care Coordination Form**; Timeline for implementation:	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**

	• Care Coordination Form approved by Customer Experience and Brand Strategy- 081519
	• Form provided to SHPO Compliance for review- 081619
	• SHPO Compliance provides feedback on Care Coordination form- 083019
	• PCBA submits form to OHA for review and approval- 091019
	• OHA reviews and provides feedback to IHN-CCO- 101119
	  o If OHA requires revisions IHN-CCO will make required revisions- 102019
	  o Resubmit to OHA- 102019
	  o OHA reviews and approves- 112019
	• New Care Coordination Form submitted to publication vendor to be included in next batch of new member packets- 113019
	• New Care Coordination Form sent to new members beginning 121519
	AxisPoint Health Narrative for Standard III pg 1	

HSAG Findings: The Intensive Case Management and Intensive Care Coordination policy provided by the CCO stated that all members will receive a Care Coordination Form in the new member welcome packet. Members can complete the form and return it to IHN. Members will be screened within 30 days of enrollment or as quickly as their health needs require. IHN attempts to contact the member three times to complete the screening. During the remote interview session, CCO staff members stated that they are still developing the process for initial screening of all newly enrolled members and will be delegating this function to AxisPoint Health. The CCO was unable to provide a demonstration of the forms, systems, and tracking mechanisms to be used as they were still in development.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Required Actions: The CCO should continue to develop processes and documentation regarding the screening of all newly enrolled members. The CCO should ensure that all policies, procedures, timelines, and workflows are reflective of the final process implemented by the CCO and are consistent with State and federal requirements.		
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)*	IHN-CCO has contracts with all five hospitals in the region. The hospitals as a downstream entity have service agreements that meet the required action with specialty and patient-centered primary care home providers. Including a Hospital to PCPCH Service Agreement Index to catalogue the 51 agreements. A sample is provided. **Hospital to PCPCH Service Agreement index** in its entirety **Sample service agreement** in its entirety pg. 1-3 **IHN-CCO Participating Provider Agreement**; Pg. 2; Definitions 1.6 Covered Services; 1.12 Medically Necessary/Medical Necessity Pg. 4; Definitions 1.25 provider Manual; 1.26 Quality Improvement Plan Pg. 4-5; Provision of Services 2.2 Standard of Care Pg. 6; Duties of Provider 3.2 Quality Assurance and Utilization Management; 3.6 Referrals of Members and Services	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: The CCO provided a sample service agreement with a hospital (2014) that included all required provisions of this element. The IHN-CCO participating provider agreement submitted did not include any of the required provisions. During the remote interview session, CCO staff members stated that they will have the participating provider agreements updated prior to January 2020.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Required Actions: HSAG recommends that the CCO update its service agreements with specialty providers to include all provisions as required in the contract with OHA.		
5. The CCO has processes in place to ensure that: a. Hospitals and specialty service providers are accountable for achieving successful transitions of care. 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)*	All Samaritan Health Services (SHS) primary care teams have attested to the following measures and must pass to continue being patient-centered primary care homes. • PCPCH demonstrates a process to offer or coordinate hospice and palliative care and counseling for patients and families who may benefit from these services. • PCPCH has a process to engage patients in end-of-life planning conversations and completes advance directive and other forms such as POLST that reflect patients' wishes for end-of-life care; forms are submitted to available registries (unless patients opt out). • PCPCH has a written agreement with its usual hospital providers or directly provides routine hospital care. **Hospital to PCPCH Service Agreement index** in its entirety **Sample service agreement** in its entirety pg. 1-3 **IHN-CCO Participating Provider Agreement**; Pg. 2; Definitions 1.6 Covered Services; 1.12 Medically Necessary/Medical Necessity	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Pg. 4; Definitions 1.25 provider Manual; 1.26 Quality Improvement Plan Pg. 4-5; Provision of Services 2.2 Standard of Care Pg. 6; Duties of Provider 3.2 Quality Assurance and Utilization Management; 3.6 Referrals of Members and Services **MM-41** in its entirety pg. 1-2 **MM-52** Pg. 1; Definitions 1-6 Pg. 1; Policy Statement Pg. 1; Procedure 1 Pg. 2; Procedure 2-7	
HSAG Findings: The CCO had policies and processes in place to ensure that primary care teams were assisting with member transitions into the most appropriate settings. The CCO submitted a participating provider agreement, however, it did not contain any specific language to ensure specialty service providers are accountable for achieving successful transitions of care. When asked during the remote interview session, CCO staff members identified a concurrent review process they use to ensure successful transitions from a hospital setting.		
Required Actions: HSAG recommends that the CCO develop, implement, and document processes to ensure that hospital and specialty service providers are accountable for achieving successful transitions of 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)*	IHN-CCO has a SFTP server and secure email and fax to transmit information today. IHN-CCO will implement Performance HX(Lexigram) and plan to disseminate information using this method which is accessed through Samaritan Health Plan Provider Portal. **MM-33** Pg. 3; Procedure 4	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	MM-13 Pg. 1; Definitions 1-4 Pg. 2; Procedure 2d, e Pg. 3; Procedure 3b **MM-47** in its entirety pg. 1-4 **IHN-CCO Plan of Care template** **Member Onboarding Workflow** **Screening and Stratification Workflow**	
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)*	**MM-13** Pg. 4; Procedure 7 **MM- 33** Pg. 3; Procedure 7 **MM-44** Pg. 3; Procedure 6 **MM-45** Pg. 3; Procedure 5	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	MM-46 Pg. 3; Procedure 7 **MM-47** Pg. 3; Procedure 7 **MM-52** Pg. 2-3; Procedure 10 **MM-53** Pg. 2-3; Procedure 9 **IHN-CCO Participating Provider Agreement** Pg. 4; Definitions- 1.25 Provider Manual, 1.27 Regional Health Insurance Collaborative ("RHIC") Pg. 6; Duties of Provider- 3.1 Compliance with SHP Policies and Procedures Pg. 11; Medical Records and Confidentiality- 7.2 Maintenance of Records; 7.3 Confidentiality of Records Pg. 26; Attachment to Exhibit- Required Federal Terms and Conditions- 5 HIPPA Compliance	
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)*	**MM-33** in its entirety pg. 1-4 **MM-13** in its entirety pg. 1-4 **MM-44** in its entirety pg. 1-3 **MM-47** in its entirety pg. 1-4 **IHN-CCO Screening and Assessment form** in its entirety **Exhibit B of Dental Contract** in its entirety pg. 1	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Capitol Dental Care Pg. 5; Referrals to Specialists/Alternate Care Procedures- 9 Alternate Care Setting Referrals **ODS Access Policies** Pg. 6-7; OHP Dental Access – Care for Members with Special Needs **Willamette Dental Policy** Pg. 2; Provision of Covered Services/Enrollee Rights Pg. 3-4; Members with Special Health Care Needs **PRC-30** Pg. 3; Procedure 3f **Member Written Workflow** Pg. 3-4; New and Reinstated IHN-CCO Member Onboarding Process Pg. 13-14; Internal Identification of Member Health Needs & Health Risks **Member Onboarding Workflow** **Screening and Stratification Workflow** **AxisPoint Health Narrative for Standard III** pg. 1	
HSAG Findings: The Intensive Case Management and Intensive Care Coordination policy provided by the CCO stated that members identified with high or rising risk receive an assessment to evaluate needs, goals, and barriers. IHN utilizes a Screening and Assessment form to conduct the assessment. During the remote interview session, CCO staff members stated that, currently, not all members with special healthcare needs were being comprehensively assessed. In addition, the Screening and Assessment form was being completed on paper and it was unclear under what situations the form would be used. The Complex Case Management Member Assessment policy stated, and CCO staff members confirmed, that the assessment is conducted by clinical staff within 60 days of identification and 14 calendar days of member consent to participate in the program. CCO staff members stated that they currently track completion of assessments using a Microsoft (MS) Excel spreadsheet. CCO staff members stated that they are in the		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
process of implementing new processes in a care management system with implementation expected in the first quarter of 2020. After reviewing all submitted documents and conducting the remote interview session, the process currently utilized by the CCO and the process they intend to use to conduct the comprehensive assessment going forward remains unclear.		
Required Actions: The CCO should develop, document, and implement mechanisms to comprehensively assess each member identified as needing long-term services and supports (LTSS) or having special healthcare needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring.		
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)*	**MM-44** in its entirety pg. 1-3 **MM-45** in its entirety pg. 1-3 **MM-46** in its entirety pg. 1-3 **IHN-CCO Participating Provider Agreement** Pg. 3; Definitions- 1.21 Primary Care Physician or Primary Care Provider Pg. 4-5; Provision of Services- 2.2 Standard of Care Pg. 6; Duties of Provider- 3.1 Compliance with SHP Policies and Procedures, 3.2 Quality Assurance and Utilization Management, 3.6 Referral of Members and Services **AxisPoint Health Narrative for Standard III** pg. 1	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA
HSAG Findings: While IHN provided written policies and procedures for identifying, assessing, and producing a treatment plan for each member identified as having a special healthcare need, policies were limited in specificity as to how care coordination activities would actually be conducted. For example, the Individualized Care Plan (ICP) policy stated that ICPs will be created using information gathered during the assessment and other available data sources, but it did not state the time frame for completing the ICP following the comprehensive assessment, how the care plan is created or documented, who is responsible for completing and updating the care plan, the time frames for updating the care plan consistent with State and federal requirements, processes for ensuring member involvement in the care planning process, and documentation of sharing care plan information with providers involved in the member's care. CCO staff members stated that care plans are currently completed on paper but that they are in the process of implementing care plan processes in a care management system with implementation expected in the first quarter of 2020.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Required Actions: The CCO should revise policies and procedures for the identification, assessment, and creation of a treatment plan for each member with special healthcare needs to include more specificity as to the processes implemented in care coordination.		
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

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: This element was not applicable for the readiness review.		
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)*	**MM-13** Pg. 2-3; Procedure 2f **CMO Standing Orders** Pg. 2-4; NON-PAR Provider/Facility Requests **Exhibit B of Dental Contract** in its entirety pg. 1 **Capitol Dental Care** Pg. 5; Referrals to Specialists/Alternate Care Procedures- 9 Alternate Care Setting Referrals **ODS Access Policies** Pg. 6-7; OHP Dental Access – Care for Members with Special Needs **Willamette Dental Policy** Pg. 2; Provision of Covered Services/Enrollee Rights Pg. 3-4; Members with Special Health Care Needs **PRC-30** Pg. 3; Procedure 3d i-iii; 3d 5; 3f **IHN-CCO 2020 Draft Handbook**; • Care Helpers; Pg. 9 • Intensive Case Management (Care Coordination Services); Pg. 9-10 • Case Management Services; Pg. 10 • Members Rights and Responsibilities; Pg. 17	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Getting Medical Care; Pg. 23-24 Getting Dental Care; Pg. 36-37	
HSAG Findings: The Intensive Case Management and Intensive Care Coordination policy did not describe the CCO's processes and procedures for ensuring members' direct access to specialists. During the remote interview session, CCO staff members stated that the CCO utilized standing orders that allow appropriately licensed/certified and trained clinical reviewers to approve specific prior authorization requests. Staff members also stated that care coordinators work with the utilization management department to ensure referrals and authorizations are made for members with special healthcare needs. The IHN-CCO 2020 Handbook provided as evidence stated that a referral from the PCP is required for a member to see a specialist (except for women's health, dental, or behavioral health providers). The information stated in the handbook is inconsistent with direct access processes described by the CCO staff members.		
Required Actions: HSAG recommends that the CCO revise policies and procedures to describe how the CCO ensures direct access to specialists for members with special healthcare needs and explain how the different departments within the CCO (Service Authorization, Utilization Management, Care Coordination) work together to ensure direct access. Any member with a special healthcare need determined to need a course of treatment or regular care monitoring should be able to directly access a specialist to limit barriers to receiving needed services. In addition, HSAG recommends that the CCO update its member handbook to be consistent with its direct access policies and procedures.		

Standard III—Coordination and Continuity of Care	
	Total #
Complete	**4**
Progress Sufficient	**4**
Incomplete	**2**
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)*	• MM-02. Page 4, Level of Utilization review, 5.a-c. Page 4-5, Outcome determination, 6.a-d. • MM-21. Page 1, Policy. Page 2, Procedure I. Page 3 V. IHN-CCO – Medical Necessity Criteria. Page 4-5 VI. A-I. • RX-10. Page 2, 3, and 4. • RX-3. Page 1-3. • 1-1-2019 Prioritized List of Health Services. Diagnostic Page 162-171. For Diagnostic procedures. • 2019 Prior Approval List_IHNCCO page1 paragraph 1, section Medically appropriate and Emergency services. • IHN_CCO_All Plans_Member Handbook, Covered Dental Benefits, page 37 and 38. • DN-110CCO Dental Benefit Administration. Policy page1, procedure page 1-2 Provider contracting, VII.a. • Dental Contract language Agreement of work. Entire snip it. • PRC-28 Page 1 Procedure 1.e.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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:	• In Oregon, the CCO does not manage long-term services and supports. We maintain an MOU with our LTSS providers. • 2019 Prior Approval List_IHNCCO, see grid Outpatient Rehabilitation services.	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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. *42 CFR §438.210(a)(4)(i-ii)* *Contract: Exhibit B Part 2*	• 2019 MM Plan Final 021119, page 10-1 • MM-21, page 1-2 Policy • MM-52. Page 1-2. • RX-3. Page • In Network services related to family planning do not have limitations or prior authorization requirements. • CMO Standing Orders 06052019 complete document. • MM-13, policy, Procedure- in entirety. • IHN_CCO_All Plans_Member Handbook. Case Management Services, page 10, Covered Dental benefits, page 37-38	☐ NA
HSAG Findings: The documentation submitted by the CCO described its utilization management policies; however, the policies did not specifically describe how prior authorization requests for individuals with chronic conditions or who require LTSS are authorized in a manner that reflects the member's ongoing need for such services and supports.		
Required Actions: HSAG recommends that the CCO revise the applicable policies and procedures to include information that specifically addresses the authorization process for members with chronic conditions or who require LTSS.		
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)*	• CMO Standing Orders 06052019, page 2, 3 • InterCommunity NQTL Analysis to OHA 11-28-18, page 5, 6, 7, 11, 19, 22, 23. • Summary Analysis of Mental Health Parity in Oregon Medicaid. Page 13	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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). *Contract: Exhibit E (22)*	• 2019 Prior Approval List_IHNCCO, see grid Outpatient Rehabilitation services and Mental Health. • InterCommunity NQTL Analysis to OHA 11-28-18, page 8,9,10, 39. • 2019 MM Plan Final 021119, page 18 • IHN_CCO_All Plans_Member Handbook, page 15-16; 24-26; 34; 36	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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. *42 CFR §438.210(a)(5)(i-ii)* *Contract: Exhibit B Part 2 (2)(b)*	• 2019 Prior Approval List_IHNCCO, see header. • MM-21, page 3, 4. • 2019 MM Plan Final 021119, page 4, Intensive Care Coordination page 10, page 12. • IHN_CCO_All Plans_Member Handbook, Covered Dental benefits, page 37-38 • Summary Analysis of Mental Health Parity in Oregon Medicaid. See page 5, 6. Page 13-FFS not highlighted in table for comparison.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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: 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)*	• 2019 MM Plan Final 021119, page 4, 7,15, 16, 17. Inter-Rater Reliability, page 20 • MM-36, definitions and policy, page 1 • MM-02, page 4, 5.a. and 6.b. • MM-37, entire policy. • MM-21, page 4-5, section VI, A-I and last paragraph. • MM Dental Delegate Monitoring Program. Page 15, 3.e Prior authorization. Advantage Dental Page 16-17. Capital dental policy Page 18. ODS Page 19-20. Willamette Dental group page 20. • Pre-Authorization Advantage Dental. Page 2, .2. B. Review of Preauthorization. Page 3. • 3.e.i.1.a. Prior Authorization. Prior authorization policy. Page 1. IV Interrater Reliability, page 2-3	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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)*	• MM-IHN-CCO denial letter, page 1, paragraph 6 • 2019 MM Plan Final 021119, page 18 Financial Incentives • MM-21-, entire policy • IHN_CCO_All Plans_Member Handbook, Physician Incentives, page 16 • Dental contract language Agreement of work. Agreement 1.i,ii,iii,iv. • Dental Contract Language incentives. Page 1,3.5	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	RX-44– entire policy	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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)*	• MM-02 IHN-CCO Authorization Requests, Page 5 Notifications. • 2019 MM Plan Final 021119, Page 17 Denials/Appeals, paragraph 2. • MM-IHN-CCO denial letter, page 3, same letter for Dental and NEMT. • PRC-28. 2. Communications, page 2, a. • 3.e.i.1.a. Prior Authorization 2018.8. Prior authorization policy. Page 1, Prior Authorization procedures, F. • Pre-Authorization. Advantage Dental. Page 3. What Happens if a Pre-Authorization is Approved or Denied. B.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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;	• 2019 MM Plan Final 021119, Page 17, Denials/Appeals, paragraph 1 and 2. • MM-IHN-CCO denial letter, page 1, 2, 3, 4. Same letter for Dental and NEMT. • MM-IHN-CCO denial letter, page 1, Comorbid review noted 4th paragraph.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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; 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		

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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. 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)*		
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)*	• MM-02, page 3, 1.e. • 2019 MM Plan Final 021119, Notification Process, page 16, see table. • 3.e.i.1.a. Prior Authorization 2018.8. Prior authorization policy. Page 2, III Standard and Expedited Decisions, A.i.,ii, • Pre-Authorization Advantage Dental. Page 2- 3. B. Review of Preauthorization B.i.,ii. • MM-IHN-CCO extension letter – entire document	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	• MM-02, page 2-3. 1.e., 3. a-d • 2019 MM Plan Final 021119, Notification Process, page 16, see table. • MM-IHN-CCO extension letter-entire document • 3.e.i.1.a. Prior Authorization 2018.8. Prior authorization policy. Page 2, III Standard and Expedited Decisions, B • Pre-Authorization.pdf Advantage Dental. Page 2-3. B. Review of Preauthorization B.ii.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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)*	• MM-02, page 2-3 Procedure 1.e., 3. a-d • WI-9a Processing Authorization Requests. Highlighted areas. • RX-10 Coverage Determinations. Procedure. Page 2, 3. a. i. • RX-3. Page 2-3.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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.	• MM-02, page 4, Outcome determinations 6.c.ii.3.a.i.1-4, section continues page 5, 5.-8. • Pre-Authorization Advantage Dental. Page 3. What Happens if a Pre-Authorization is Approved or Denied. B.1	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
– 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. – 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)*		
HSAG Findings: The CCO's IHN-CCO Authorization Requests policy included all the elements for this requirement except the following: If probable member fraud had been verified, the CCO gave notice five calendar days before the date of action.		
Required Actions: HSAG recommends that the CCO update its IHN-CCO Authorization Requests policy to include the requirement that the CCO give notice five calendar days before the date of an action when probable member fraud has been verified.		

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)*	• IHN_CCO_2019_All Plans_Member Handbook, Page 3 Words to know, #4 and #7. Covered Medical Benefits, page 25, Medical Emergencies, page 28, Out of Town Emergencies, page 29, paragraph 1 & 2. Crisis and Urgent Mental Health Services, page 34, Mental Health Emergencies and Crises, page 34-35. • 2019 MM Plan Final 021119, Service Types, Emergency services, page 13 • MM-02. Definitions page 1, 7., page 2, 11. • 2019 Prior Approval List_IHNCCO, page 1,paragraph 4 *Emergency Services	☒ 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)*	• IHN_CCO_All Plans_Member Handbook, Care after an Emergency, page 29 • CMO Standing Orders 06052019, Non-Par Provider/Facility Requests, page 3 Office Visits (Medical) second bullet point • IHN.17.004.AM. Policy statement, page 2, Procedure, page 2, Education members 7., page 3, a. i,1.	☒ 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:	• IHN_CCO_All Plans_Member Handbook, Billing information, page15. Covered Medical Benefits grid. Page 25 • 2019 Prior Approval List_IHNCCO, page 1, *Emergency Services • MM-41. Page 1 purpose and Policy statement	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
i. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes 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)*	• IHN.17.004.AM, Definitions, page 1, #1., Procedure section 8-10	
HSAG Findings: The documents submitted by the CCO contained the required information for this element, with one exception. The documents did not specifically include a statement that the CCO does not deny payment for emergency services when "a representative of the CCO instructs the member to seek emergency services." During HSAG's telephonic interview, CCO staff members indicated that they cover all emergency services without exception.		
Required Actions: HSAG recommends that the CCO update the applicable policies to indicate that the CCO covers and pays for emergency services when a representative of the CCO instructs the member to seek emergency services.		
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)*	• IHN.17.004.AM, Definitions, page 1, #1., Procedure section 8-10 • MM-02 IHN-CCO. Definitions, page 1, 7.a-c.	☐ 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 policies submitted by the CCO did not specify that the organization covers emergency services when the provider fails to notify the CCO within 10 calendar days of the member's screening and treatment date.		
Required Actions: HSAG recommends that the CCO update the applicable policies to include language that it will not refuse coverage of emergency services if the provider fails to notify the CCO within 10 calendar days of the member's presentation for services.		
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)*	• IHN_CCO_All Plans_Member Handbook, Billing information, page15. Section: What should I do if I get a bill? Page 15-16. Section: When will I have to pay for medical services on OHP? Page 16 • IHN.17.004.AM, Definitions, page 1, #1., Procedure section #8-10 • IHN-CCO Participating Provider Agreement. Page 6, 3.4 Member Hold Harmless	☒ 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)*	• 2019 Prior Approval List_IHNCCO, page 1, *Emergency Services • MM-41, page 1 Definitions, 3.	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: The documentation submitted by the CCO did not address the requirement that the attending emergency physician or provider is responsible for determining when the member is sufficiently stabilized for transfer or discharge.		
Required Actions: HSAG recommends that the CCO update the applicable policies to specifically state that the attending emergency physician or provider is responsible for determining when the member is sufficiently stabilized for transfer or discharge.		

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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; 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.	• IHN_CCO_2019_All Plans_Member Handbook, Care after an Emergency, page 29. • 2019 Prior Approval List_IHNCCO, page 1, *Emergency Services • MM-41, entire document • IHN_CCO_All Plans_Member Handbook, Billing information, page15. Section: What should I do if I get a bill? Page 15-16. Section: When will I have to pay for medical services on OHP? Page 16. Covered Medical Benefits grid. Page 25 • IHN.17.004.AM,. Purpose page 1.	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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. *42 CFR §438.114(e)* *42 CFR §422.113(c)(2)(i-iv)* *Contract: Exhibit B Part 2 (4)(a)(6&8)*		
HSAG Findings: The policies submitted by the CCO did not specifically address the requirements of this element. However, the Emergency and Post Stabilization policy included a statement that the CCO, "…ensures that IHN-CCO pays for Emergency and Post-Stabilization services that meet the prudent layperson standard." In addition, during the telephonic interview with HSAG, the CCO indicated that they pay for post-stabilization services and monitor these services through the CCO's concurrent review program.		
Required Actions: HSAG recommends that the CCO update the applicable policies to include specific language regarding coverage of post-stabilization services as defined by 42 CFR and its contract with the State.		
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)*	• MM-41, entire document • 2019 Prior Approval List_IHNCCO, page 1, *Emergency Services • IHN_CCO_All Plans_Member Handbook, Covered Medical Benefits grid. Page 25	☐ 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 documents submitted by the CCO did not specifically address the elements of this post-stabilization services requirement element.		
Required Actions: HSAG recommends that the CCO update the applicable policies to include specific language regarding when its responsibility for coverage of post-stabilization services that were not pre-approved ends, as defined by 42 CFR and its contract with the State.		
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)*	• PRC-28. Procedure page 2, 3. Standard/Expedited Services. Benefit Adjudication, page 2, 5. a-c, i. • PRC-29. Page 1, Procedure, 2. • 2016-Program-Guide RIDELINE, Scheduling a Ride page 7 and 8. • NEMT Contract Language-assignment of work. Entire screen print.	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA
HSAG Findings: The CCO did not submit written policies and procedures regarding non-emergent medical transportation (NEMT) services nor did it submit policies describing how it oversees the quality of services provided by its NEMT delegate. During the telephonic interview with HSAG, the CCO indicated that they are developing a quality assurance oversight process for its NEMT providers to by implemented by January 1, 2020.		
Required Actions: The CCO should develop written policies and procedures regarding NEMT services, including how it will assess the quality of services provided by its NEMT vendor.		
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)*	• 2016-Program-Guide RIDELINE, page 2. Page 7 • OCW Call Contract language. Entire screen print. • 2016-Program-Guide-Spanish, entire document in spanish, page 7.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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	• IHN.17.004.AM, Procedure, page 2, 3., 4.	☐ Complete

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	• MM_Dental Delegate Monitoring Program. Pertaining to out of network or emergent dental needs. Page 11, 3.d.v, page 12, 3.d.v. Page 13,3.d.v	☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA
HSAG Findings: The CCO included a section regarding urgent and emergent dental services in its member handbook. However, the policies and procedures the CCO submitted for this element did not specifically address when emergent or urgent dental conditions should be provided in an ambulatory dental office setting and when emergent dental services should be provided in a hospital setting.		
Required Actions: The CCO should update the applicable policies and procedures to include a description of 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.		
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)*	• CP-26. Entire policy • Lincoln County Mental Health (IHN) Scorecard 201903, row 4 and 6 • Linn County Mental Health (IHN) Scorecard 201903, row 4 and 6. • Benton County Mental Health (IHN) Scorecard 201903, row 4 and 6. • Crisis Prevention, Response and Mobile Crisis. Procedures, Crisis Intervention and Services, page 1-2, 1.,2., 3. • Crisis Services Policy. Policy page 1-3 • Attachment 30 Policy 405 LCHC BHCS. Policy page 1. Procedure- Crisis Services General page 3-4 A.1.,2.a-b,3.,4.a-f • CMHP Monitoring – Lincoln Summary of Findings. Entire document	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• CMHP Monitoring – Summary of Findings Benton 3. Entire document • CMHP Monitoring – Summary of Findings Linn. Entire document • IHN-CCO_SHP CMHP Review Checklist Benton 2019 3. Entire document • IHN-CCO_SHP CMHP Review Checklist Lincoln 2019 2. Entire Document • IHN-CCO_SHP CMHP Review Linn 2019 – Final. Entire document	
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)*	• Crisis Prevention, Response and Mobile Crisis. Page 2 Crisis Response Services 1-2. Mobile Crisis Services, 1-2 • Attachment 30 Policy #405 LCHC Behavioral Health Crisis Services. Mobile Crisis, page 4, 5. a-d • Crisis Services Policy. Mobile Crisis Services. Page 2 and 3	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services	
	Total #
Complete	**18**
Progress Sufficient	**7**
Incomplete	**2**
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)*	**CP-26 Delegated Entity Oversight and Monitoring, "Policy" Section.**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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)*	**CP-26 Delegated Entity Oversight and Monitoring, I. Pre-Delegation Requirements, Section II. Written Agreements**	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: The Delegated Entity Oversight and Monitoring policy states that all agreements with delegates will be written, specify the subcontracted work and reporting responsibilities, be in compliance with State and federal requirements, and incorporate the appropriate provisions based on the scope of work subcontracted. While the policy stated that the Compliance Department may use the Pre-Delegation Checklist to ensure that all required provisions are in the subcontract, IHN did not provide that checklist or a subcontractor agreement template as part of the desk review.		
Required Actions: While the submitted policy provided evidence that IHN understands the requirements of the subcontractor written agreements, HSAG was unable to confirm that all required elements are contained in the agreements as a base/template agreement was not provided. HSAG recommends that IHN 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)*	**CP-26 Delegated Entity Oversight and Monitoring, Section I. Pre-Delegation Requirements**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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. *Contract: Exhibit B Part 4(13)(a)(12-14)*	**CP-26 Delegated Entity Oversight and Monitoring, Section V. Oversight and Monitoring, b. Auditing**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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)*	**CP-26 Delegated Entity Oversight and Monitoring, Section V. Oversight and Monitoring, Subsection II. Risk Assessment and Auditing, Subsection C. Corrective Action**	☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element was not applicable for the readiness review.		

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	**CP-26 Delegated Entity Oversight and Monitoring, Section VI. Required Reporting, Subsection II. Medicaid- InterCommunity Health Plan**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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;		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• Deficiencies identified through compliance monitoring of the entity; or • Any other for-cause termination. *Contract: Exhibit B Part 4(13)(b)(4)*		
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		

Standard VI—Subcontractual Relationships and Delegation	
	Total #
Complete	**4**
Progress Sufficient	**1**
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)*	a. ED-10 IHN Daily and Monthly File Policy a. Page 1 b. Policy c. #4 b. ED-10 IHN Daily and Monthly File Policy a. Page 1 b. Policy c. #5 c. ED-11 IHN-CCO Member Disenrollment Policy a. Page 2 b. First paragraph	☒ 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)*	2. ED-11 IHN-CCO Member Disenrollment Policy a. Page 2 b. Procedure c. #4	☒ 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)*	3. ED-11 IHN-CCO Member Disenrollment Policy 1. Page 2 2. Paragraph 2 3. #1-4	☒ 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. ED-11 IHN Member Disenrollment Policy a. Page 1 b. Policy c. #1 b. (i) ED-11 IHN Member Disenrollment Policy a. Page 1 b. Policy c. #2(a)	☒ 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)*	(ii) ED-11 IHN Member Disenrollment Policy d. Page 1 e. Policy f. #3 (iii) ED-11 IHN Member Disenrollment Policy g. Page 1 h. Policy i. #4 (iv) ED-11 IHN Member Disenrollment Policy j. Page 1 k. Policy l. #5	
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)*	i. ED-11 IHN Member Disenrollment Policy a. Page 2 b. Procedure c. #1 ii. ED-11 IHN Member Disenrollment Policy a. Page 2 b. Procedure c. #1	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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	a. ED-11 IHN-CCO Member Disenrollment Policy a. Page 1 b. Policy c. #6 b. ED-11 IHN-CCO Member Disenrollment Policy a. Page 1 b. Policy c. #7	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IX—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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. *42 CFR §438.56(d)(2)* *Contract: Exhibit B Part 3 (6)(b)(3)(a)(ii)*	c. ED-11 IHN-CCO Member Disenrollment Policy a. Page 1 b. Policy c. #8 d. ED-11 IHN-CCO Member Disenrollment Policy a. Page 1 b. Policy c. #9 e. ED-11 IHN-CCO Member Disenrollment Policy a. Page 1 b. Policy c. #10	

Standard IX—Enrollment and Disenrollment	
	Total #
Complete	**6**
Progress Sufficient	**0**
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*	• AT-02, page 1, Section: Procedure, last paragraph • AT-02, page 2, paragraph 1	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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)*	• GA-02, page 1, section-Policy #2 • AT-02, page 3, paragraphs: 2 and 3 • AT-02, page 8, Section: Conclusion of an appeal #5	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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	• AT-02, page 1, Definitions #1 • AT-02 page 2, paragraph 2	☒ Complete ☐ Progress Sufficient to Start Operations

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*		☐ Incomplete ☐ NA
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)*	AT-02, page 1, Definitions #2	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	• GA-02, page 1, Definitions 1 • GA-02 page 1, Section: Policy #1	☒ 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. *42 CFR §438.402(c)(2)(i), (c)(3)(i)* *Contract: Exhibit I (2)(a)*	• GA-02, page 4, #5 • GA-02, page 6, Section: Grievance Timeframes	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ 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)*	• AT-02, page 6, section Appeal Validation • AT-02, page 3, paragraph 1	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
8. The CCO must acknowledge receipt of each grievance and appeal. *42 CFR §438.406(b)(1)* *Contract: Exhibit I (4)(a)(1)*	GA-02, page 4, Section 5(c)(i) AT-02, page 1, Definitions #3	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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)*		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
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.	GA-02, pages 4 and 5, section 5 (f)(i)(ii), (g)(i)(ii)(iii)(1) GA-02, page 5, section 6(a) GA-02, page 6, #8	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*		
HSAG Findings: The CCO submitted its Grievance/Complaint Policy & Procedure that included the requirement that the CCO either notify the member of his or her grievance decision or acknowledge report of the grievance within five days. However, the CCO did not acknowledge that it must resolve each grievance in writing, including those received orally. This requirement is reflected in the CCO's contract with the State effective January 1, 2020.		
Required Actions: The CCO should revise its Grievance/Complaint Policy & Procedure, prior to January 1, 2020, to reflect the contract requirement that it respond in writing to all grievances (including those received orally). Additionally, the CCO should ensure that grievance processes are updated to incorporate the new requirement.		
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 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)*	• GA-02, pages 3 and 4, #3 (a, b, c, d) • AT-02, page 5, Section: IHN-CCO ensures that the following are provided to member, member's authorized representative, and providers regarding on how to file appeals and grievances, #3	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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:	• GA-02, page 2, Section: Procedure; 1st sentence #s 1 & 2 • AT-02, page 8, Section: Levels of Authority for Decision Making on Appeals, #1(a) and #2(a) • AT-02, page 5, #4 and #7 • AT-02, page 6, #18	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• 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)*		
HSAG Findings: The IHN Appeals Policy and Procedure indicated that a physician who has the appropriate clinical expertise reviews "…all appeals whose initial adverse decision was based on a lack of medical necessity…". The policy did not include specific information regarding: (1) an individual with the appropriate clinical expertise making decisions on a grievance regarding the denial of an expedited resolution of an appeal; or (2) a grievance or appeal that involves clinical issues.		
Required Actions: HSAG recommends that the CCO revise its Appeals Policy and Procedure to include the following detail: (1) an individual with the appropriate clinical expertise makes decisions on a grievance regarding the denial of an expedited resolution of an appeal; and (2) an individual with the appropriate expertise makes decisions on a grievance or appeal that involves clinical issues.		
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	• AT-02, page 5, Section: IHN-CCO ensures that the following are provided to member, member's authorized representative, and providers regarding on how to file appeals and grievances #1 • AT-02, pages 5 and 6, #9, and # 13 • AT-02, page 8, Section: Conclusion of an appeal #1	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*		
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)*	AT-02, page 7, Section: Appeal Time Frames, subsection: Standard Appeal, #1 AT-02, page 7, Section Appeal Time Frames, subsection: Expedited Appeal #1 AT-02, page 8, Section Conclusion of an appeal #2 AT-02, page 6, #14	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: The IHN Appeals Policy and Procedure did not indicate that, for notice of an expedited resolution, the CCO must make reasonable efforts to provide oral notice of the resolution. The policy included the following statement; however, it did not meet the intent of the requirement: "All decisions are communicated to the member or member's representative and the associated providers through written correspondence; some decisions may also be communicated verbally. e.g. 'urgent' requests…".		
Required Actions: HSAG recommends that the CCO revise its Appeal Policy and Procedure to include a statement that, for notice of an expedited resolution, the CCO makes reasonable effort to provide oral notice of resolution.		
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. • 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	• AT-02, page 6, # 19 and # 20 • AT-02, page 7, Section: Appeal Time Frames, subsections: Standard appeal # 2 (a)(b)(c); Expedited appeal # 2 (a)(b)(c) • AT-02, page 7, statement above Section: Duration of Continued Benefits.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*		
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. – 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)*	AT-02, page 8, section: Conclusion of an appeal # 1, # 3 (a) (b), and #4 AT-02, page 1, Definitions #5 AT-02-page 6, #12	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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)*	• AT-02, page 8, Section: Conclusion of an appeal #3 (b) • AT-07, page 2, section: Hearing Requirements #1 • AT-07, pages 1 and 2, section: Procedure # 3 (a)(b)(c)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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. – 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)*	• AT-02, page 7, paragraph 1 • AT-02, page 6, #22 • AT-02, page 8, #2 (b)(i)(ii)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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.	• AT-02, page 3, paragraph 5 (a)(b) • AT-02, page 5, Section: What can you appeal and request continuation of benefits, #s1-4	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
– 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)*		
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.	AT-02, page 7 Section: Duration of Continued Benefits, #s 1-3	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR §438.420(c)* *Contract: Exhibit I (6)(c)*		
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)*	• AT-02, page 8, Section: Conclusion of an appeal #4	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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)*	• AT-02, pages 8 and 9, Section Implementation of Reserved Appeal Resolution, #s 1 & 2	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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; • 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)*		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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. • 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)*	• Provider Manual, pages 30 and 31 • AT-02, page 2-paragraph 1 • AT-02, page 6, Section: Appeal Validation • GA-02, page 6, Section: Grievance Timeframes • AT-02, page 8, Section: Conclusion of an appeal #3 • AT-02, pages 5 and 6, Section: IHN-CCO ensures that the following are provided to member, member's authorized representative, and providers regarding on how to file appeals and grievances #3, #11, #12, and #13. • AT-02, page 8, Section: Conclusion of an appeal #4	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: The CCO's provider manual contained limited information regarding the grievance, appeals, and State fair hearing process. This was acknowledged by the CCO during the remote interview. During that interview, the CCO indicated that the provider manual was in the process of being revised to contain the necessary information and would be distributed to its provider network prior to January 1, 2020.		
Required Actions: The CCO should, as indicated, update its provider manual to include the required information regarding grievance, appeals, and State fair hearing process.		

Standard X- Grievance and Appeal Systems	
	Total #
Complete	**18**
Progress Sufficient	**2**
Incomplete	**2**
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)*	IHN-CCO will be implementing a Health Information Systems policy to ensure IHN-CCO is able to collect, analyze, integrate and report data sufficient to meet contractual requirements. • DS-21 IHN-CCO HIT and Data Requirements (entire policy)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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)*	IHN-CCO will be implementing a Health Information Systems policy to ensure IHN-CCO and delegated entities collect the necessary data elements to enable mechanized claims processing and information retrieval systems operated by the State. • DS-21 IHN-CCO HIT and Data Requirements (entire document)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	IHN-CCO collects member and provider data and stores this data in our core operational system, Facets. In addition, data that originates through our delegated entities is brought into our data warehouse, Empower Health Plan Extended Reporting (hpXr). This includes dental and pharmacy claims. • DS-21 IHN-CCO HIT and Data Requirements, Pg. 1 & 2; Section 2 • RE-15 IHN-Encounter Data Management Policy (entire document)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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)*	• DS-21 IHN-CCO HIT and Data Requirements (entire policy) • RE-15 IHN-Encounter Data Management Policy (entire document)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	• DS-21 IHN-CCO HIT and Data Requirements (Pg. 2, Section 6)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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.		
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		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*		
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. 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)*		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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*	1. SHP Disaster Recovery Plan (DRP) (entire document) 2. DS-18 Health Information Systems Monitoring and Oversight (entire document) 3. Admin-20 DR BC Plan (entire document)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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. 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)*		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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 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)*		☐ 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.		
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:	• DS-20 OHA HIT Reporting Requirements (entire document)	☒ Complete

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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 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)*		☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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 arrangements for the population(s) addressed in the arrangement(s). *Contract: Exhibit J (2)(k)(8)*	• DS-20 OHA HIT Reporting Requirements (entire document)	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: IHN's responses and documentation provided evidence of its current and future objectives for the collection of population health data. Documentation included database diagrams and reporting templates as well as a comprehensive set of draft policies and procedures (currently under development) for implementation in January 2020. IHN demonstrated the collection of population health data through a number of databases including, but not limited to, IHN's Facets system, EHR provider feeds, and data obtained from the Regional Health Information Collaborative. IHN staff members documented and reported the CCO was also currently working on incorporating additional information on social determinants of health variables through its work with providers to capture an expanded set of population health centered ICD-10 codes as well as data from UniteUs. IHN		

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
used this information in its health plan and member-focused operations, and to calculate and report on provider Value Based Payment performance. IHN also used this information in support of its current risk stratification algorithm, which segmented its population for placement in IHN's care management programs. Using this stratification system, IHN placed its members in one of four categories—i.e., low risk, rising risk, high risk, complex. However, while risk stratification information is used for internal processes, it is not currently available to its providers, although future reports will include this information based on discussions during the remote interview session.		
Required Actions: HSAG recommends that IHN finalize development and implementation of its OHA Health Information Technology (HIT) Reporting Requirements policy and procedure once the CCO has finalized its processes for ensuring the use of HIT to support population health management. Additionally, while risk stratification information is currently available within IHN, it is recommended that the CCO identify and implement the mechanisms necessary to share risk stratification information with providers.		

Standard XIII—Health Information Systems	
	Total #
Complete	**7**
Progress Sufficient	**1**
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 IHN's Provider Capacity Reports were good with minor errors associated with the individual practitioner file.

Table B-1—IHN 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	100.0	100.0	
Address #1	100.0		
Provider's Capacity	2.5	100.0	
City	99.9		
Status of Medicaid Contract	100.0	100.0	
County	99.9		
Credentialing Date	67.3	100.0	65.8
DMAP (Medicaid ID)	97.8	100.0	
Provider First Name	100.0		

DSN Data Field	DSN Quality Metrics		
	% Present	% Valid Format	% Valid Values
Group/Clinic Name	98.7		
Non-English Language 1	1.9		
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	100.0	100.0	
PCP Indicator	100.0	100.0	
PCPCH Tier	8.1	0.0	
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	99.9	
Provider Taxonomy	100.0	100.0	100.0
Zip Code	99.9		

In general, all key DSN data fields in the individual practitioner capacity report were populated except for Credentialing Date for which only 67.3 percent of the records contained a value. More importantly, while credentialing date formatted correctly in 100 percent of the records where it was present, only 65.8 percent of the records contained valid values (i.e., date within three years). Of note, only 1.9 percent of providers were associated with a non-English language.

Table B-2—IHN 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		
Status of Medicaid Contract	100.0	100.0	
County	100.0		
DMAP (Medicaid ID)	64.0	100.0	
Facility NPI	100.0	100.0	100.0
Phone Number	100.0		

DSN Data Field	DSN Quality Metrics		
	% Present	%Valid Format	% Valid Values
Provider Category	100.0	100.0	100.0
Provider Service Category	84.3	100.0	100.0
Facility TIN	100.0	100.0	
Facility or Business Taxonomy	100.0	99.9	99.8
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 the exception of two data fields—i.e., DMAP ID (64.0 percent) and Provider Service Category (84.3 percent). Overall, the average completeness across all data fields was 96.0 percent.

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—IHN 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	249	3.1	249	100.0	0	0.0
Specialty Provider	7,459	93.4	7,459	100.0	0	0.0
Dental Service Provider	77	1.0	77	100.0	0	0.0
Mental Health Provider	0	0.0	0	0.0	0	0.0
SUD Provider	203	2.5	203	100.0	0	0.0
Certified or Qualified Health Care Interpreters	0	0.0	0	0.0	0	0.0
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	0	0.0	0	0.0	0	0.0
Palliative Care	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
Facility/Service Practitioners						
Hospital, Acute Psychiatric Care	25	5.2	25	100.0	0	0.0
Ambulance and Emergency Medical Transportation	259	54.0	259	100.0	0	0.0
Federally Qualified Health Centers	8	1.7	8	100.0	0	0.0
Home Health	10	2.1	10	100.0	0	0.0
Hospice	0	0.0	0	0.0	0	0.0
Hospital	35	7.3	35	100.0	0	0.0
Imaging	0	0.0	0	0.0	0	0.0
Indian Health Service and Tribal Health Services	0	0.0	0	0.0	0	0.0
Mental Health Crisis Services	0	0.0	0	0.0	0	0.0
Community Prevention Services	0	0.0	0	0.0	0	0.0
Non-Emergent Medical Transportation	1	0.2	1	100.0	0	0.0
Pharmacies	13	2.7	13	100.0	0	0.0
Durable Medical Providers	118	24.6	118	100.0	0	0.0
Post-Hospital Skilled Nursing Facility	8	1.7	8	100.0	0	0.0
Rural Health Centers	3	0.6	3	100.0	0	0.0
School-Based Health Centers	0	0.0	0	0.0	0	0.0
Urgent Care Center	0	0.0	0	0.0	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, IHN's individual provider capacity demonstrated network coverage of required physical health (primary and specialty), oral health, and substance use disorder providers. However, no mental health providers were documented within the provider capacity report although these providers were likely categorized as SUD providers. Additionally, the individual practitioner data did not include documentation of certified or qualified health care interpreters; traditional health workers; alcohol/drug providers; health education, health promotion, health literacy providers, or palliative care providers.

Additionally, of the 17 required facilities and services, several provider service categories had a count of zero, including hospice, imaging services, Indian Health Service and Tribal Health Services, mental health crisis services, community prevention services, school-based health centers, and urgent care centers.

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—IHN 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	249	234	94.0	13	5.2
Specialty Provider	7,459	7,282	97.6	129	1.7
Dental Service Provider	77	76	98.7	0	0.0
Mental Health Provider	0	0	0.0	0	0.0
SUD Provider	203	202	99.5	0	0.0
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	0	0	0.0	0	0.0
Palliative Care	0	0	0.0	0	0.0
TOTAL	**7,988**	**7,794**	**97.6**	**142**	**1.8**

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.

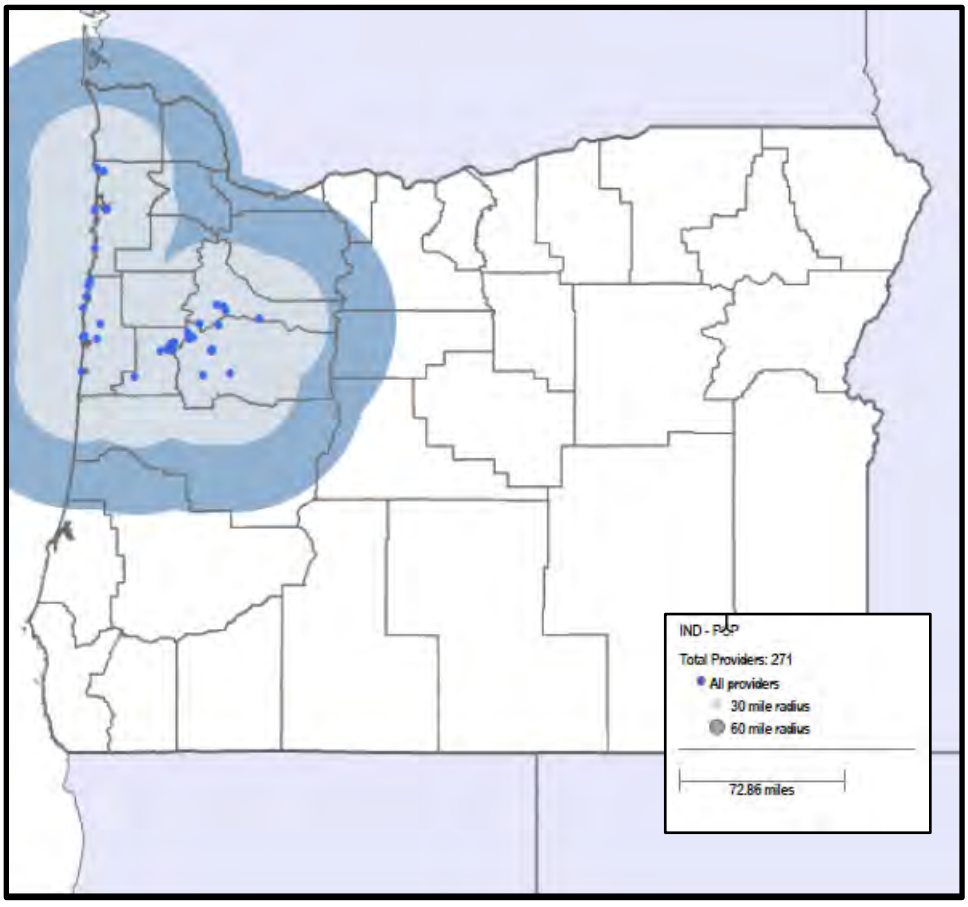
[2] Specialty Category designations specifying *adult* and *pediatric* providers were combined and deduplicated by NPI to preventing counting providers within a specialty category more than once.

Overall, 97.6 percent of IHN's provider network was accepting new patients. All represented core specialty categories (PCP, specialists, dental providers, and SUD providers) exhibited provider networks with more than 90 percent of its contracted providers accepting new patients. Of its individual practitioners, only 1.8 percent noted speaking a language other than English with primary care providers and specialty providers reporting 5.2 percent and 1.7 percent, respectively, speaking a non-English language.

Geographic Distribution

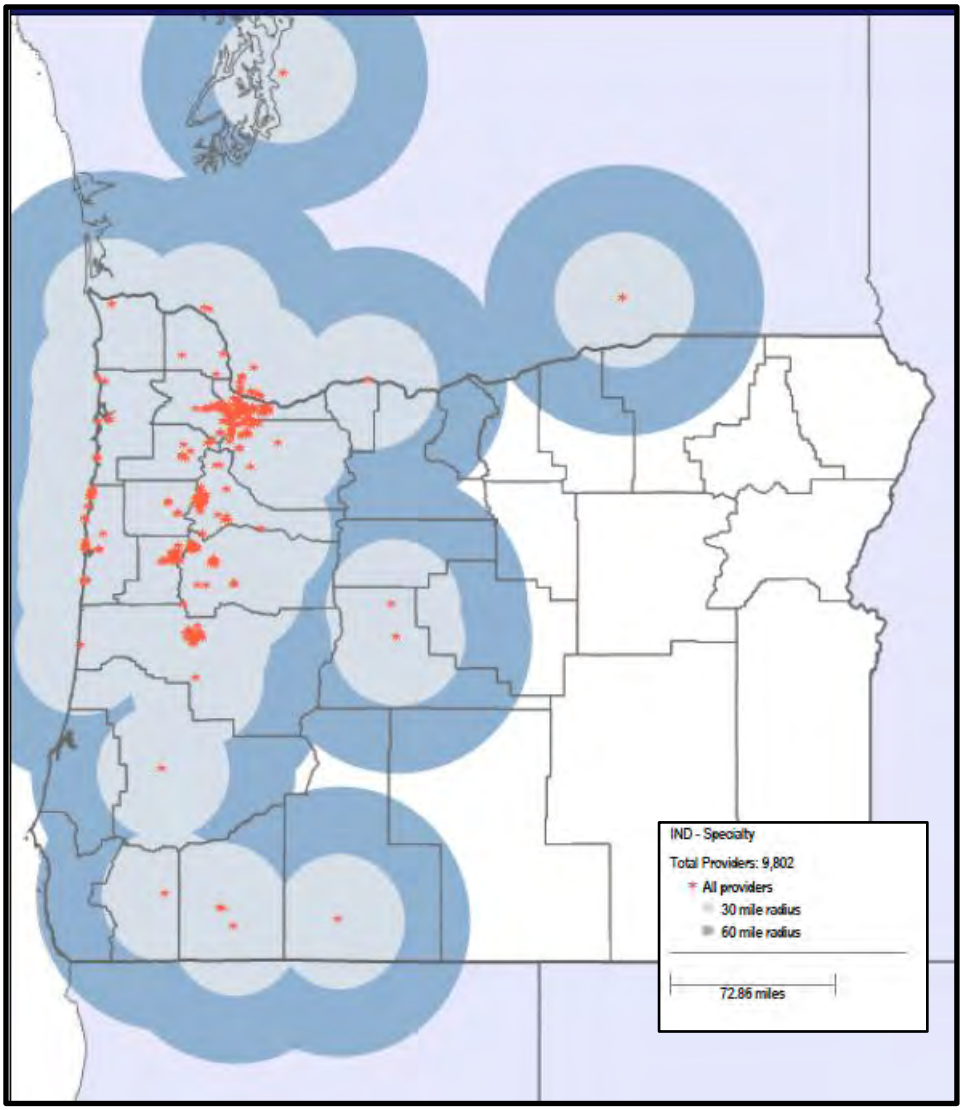
The geographic distribution of providers relative to member populations assessed whether or not the practitioner and facility locations were spread proportionately across the beneficiary population. Since beneficiary data was not available at the time of this analysis, the geospatial maps display the 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 IHN's service area (i.e., Benton County, Lincoln County, and Linn County), are classified as rural with the exception of the areas surrounding Corvallis/Philomath and Albany.

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



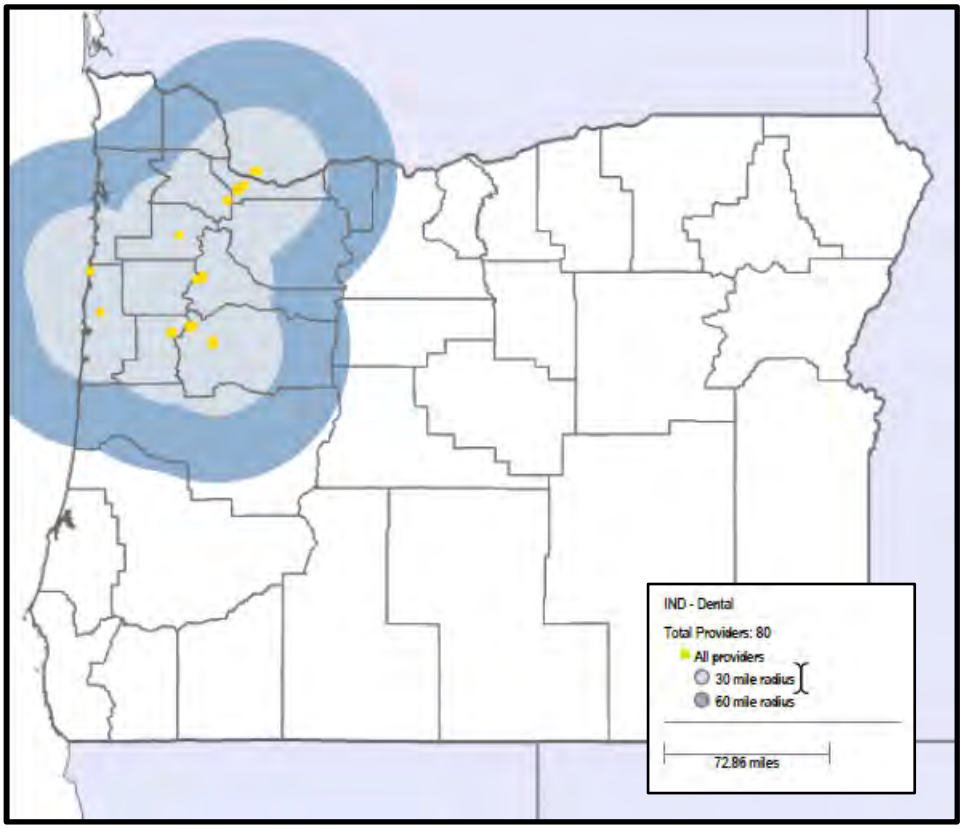
As shown in Figure B-1, the distribution of IHN's network of PCPs is sufficient to cover the CCO's service area. Most of the regions in the CCO's service area are within 30 miles of a primary care provider, except for rural parts of eastern Linn County where provider coverage is within 60 miles of the nearest primary care provider.

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



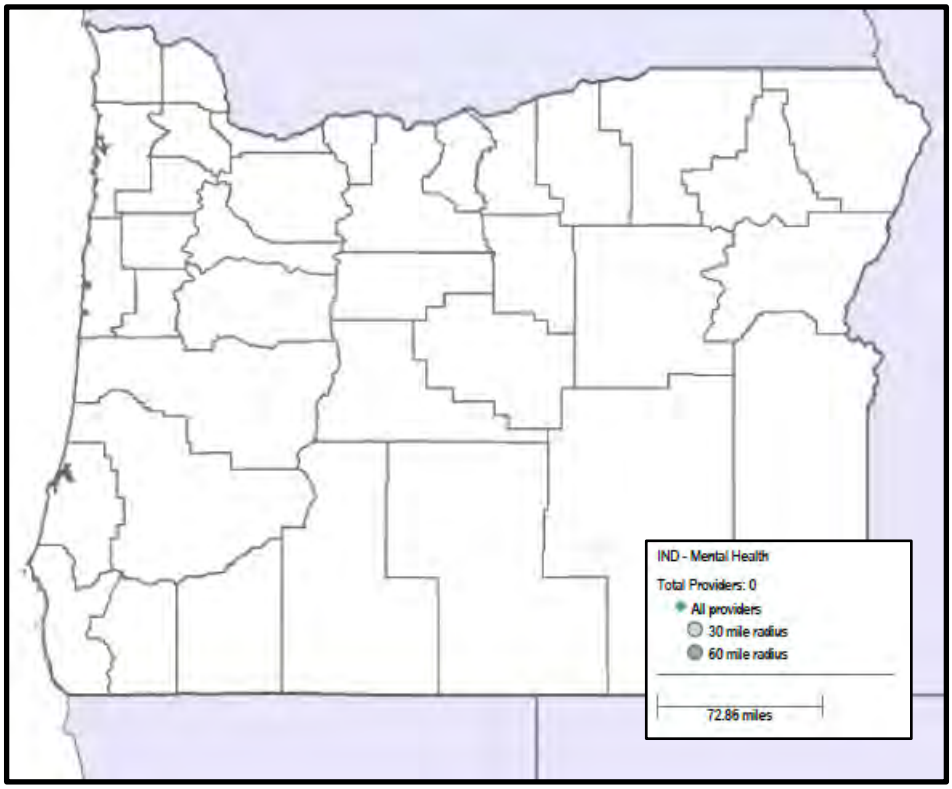
As shown in Figure B-2, the distribution of IHN's specialty providers is sufficient to cover the CCO's service area. Most of the regions in the CCO's service area are within 30 miles of a specialty provider, except for rural parts of eastern Linn County where provider coverage is within 60 miles of the nearest specialty provider.

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



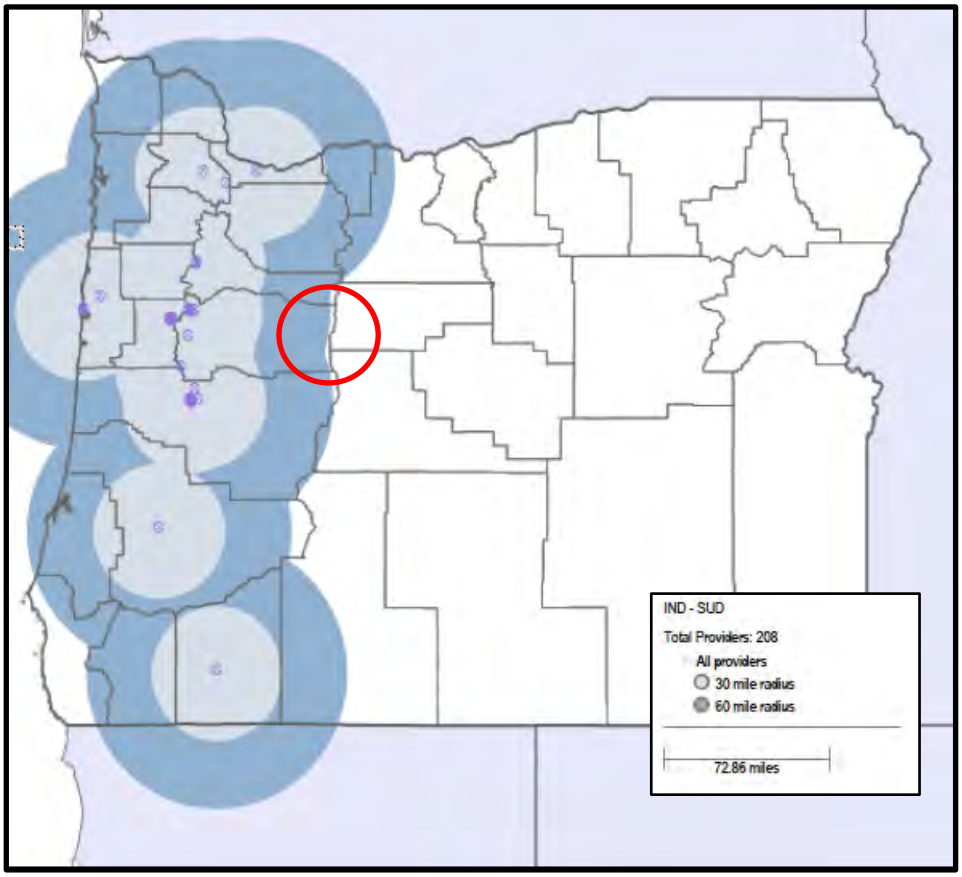
As shown in Figure B-3, the distribution of IHN's dental service providers is sufficient to cover the CCO's service area. Most of the regions in the CCO's service area are within 30 miles of a dental provider, except for rural parts of eastern Linn County and southern Lincoln County where provider coverage is within 60 miles of the nearest dental provider.

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



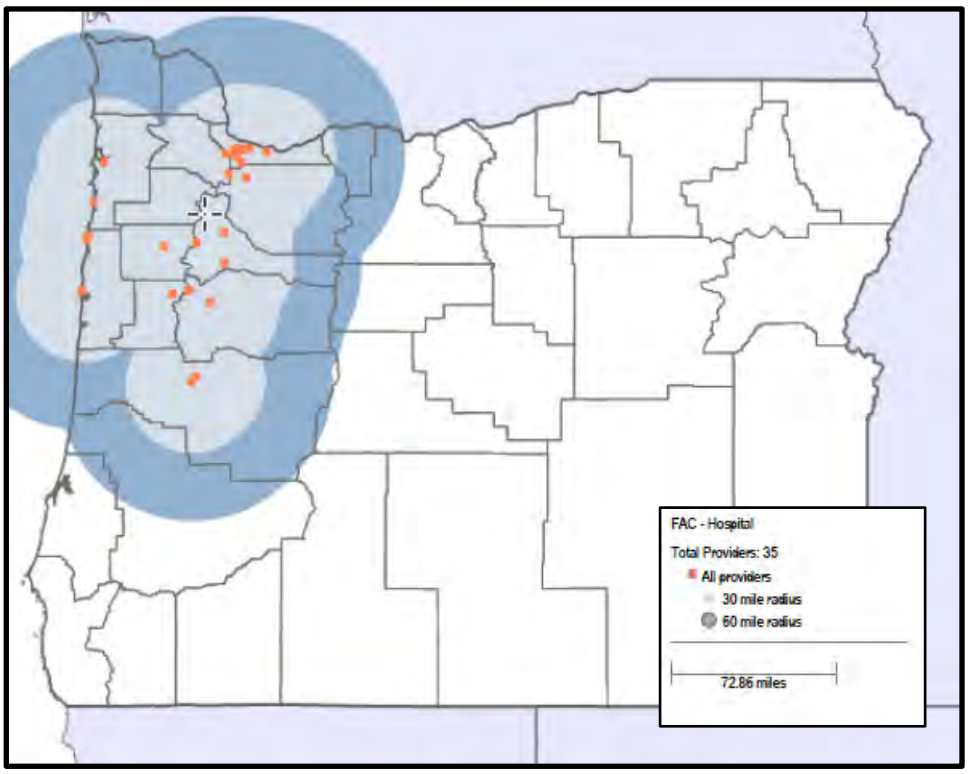
As noted earlier and shown in Figure B-4, no mental health providers were submitted in the IHN's provider capacity report.

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



As shown in Figure B-5, the distribution of IHN's SUD providers is sufficient to cover the CCO's service area except for a small portion of eastern Linn County. In general, most regions of the service area are within 30 miles of a SUD provider with much of eastern Linn County within 60 miles of the nearest SUD provider.

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



As shown in Figure B-6, the distribution of IHN's hospital facilities is sufficient to cover the CCO's service area. Most of the regions in the CCO's service area are within 30 miles of a hospital, except for rural parts of eastern Linn County where coverage is within 60 miles of the nearest hospital.

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

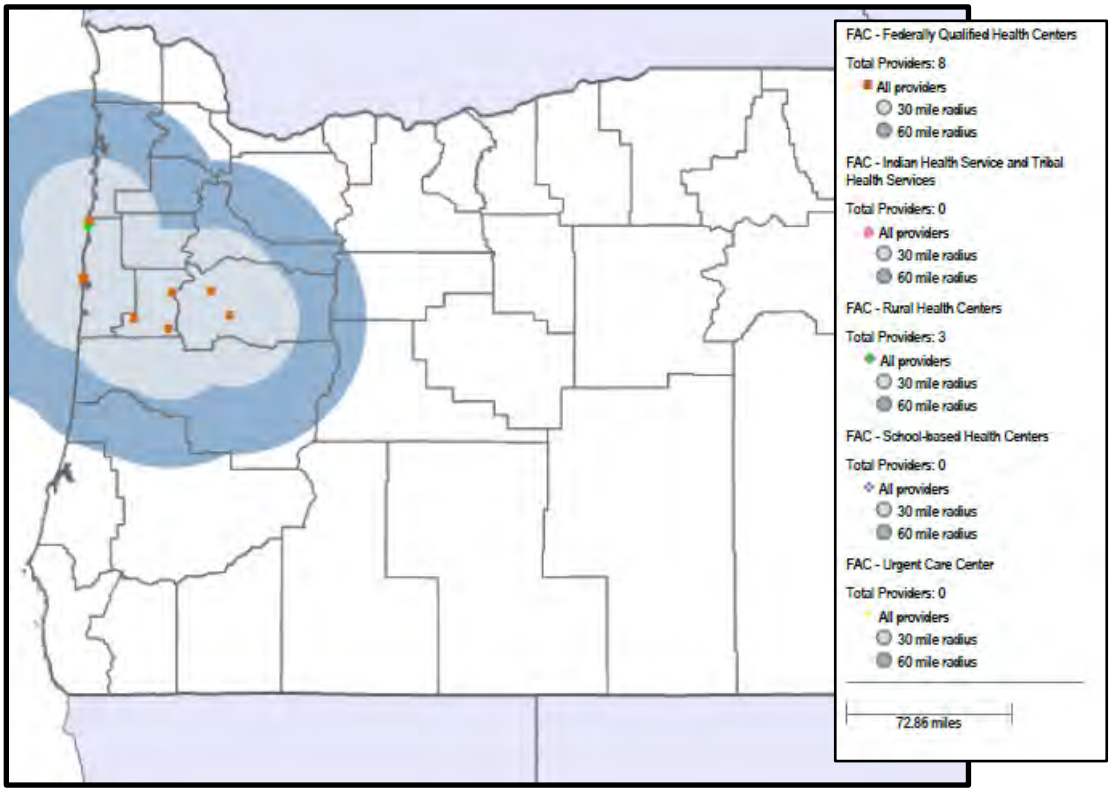


Figure B-7 displays the distribution of several clinic-based facilities within IHN's service areas, including FQHCs, Indian Health Services and Tribal Health Services, Rural Health Centers, School-Based Health Centers, and Urgent Care Centers. The map shows that the distribution of clinic-based facilities 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]