Oregon Health Authority

2019 CCO Readiness Review

for

PacificSource Community Solutions - Lane

September 2019

Interim Report

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Overview

Background

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

Methodology

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

Table 1-1—Readiness Review Activities and Timing

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

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

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

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

Phase 1—Critical Areas Readiness Review

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

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

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

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

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

Phase 2—Operations Policy Readiness Review

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

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

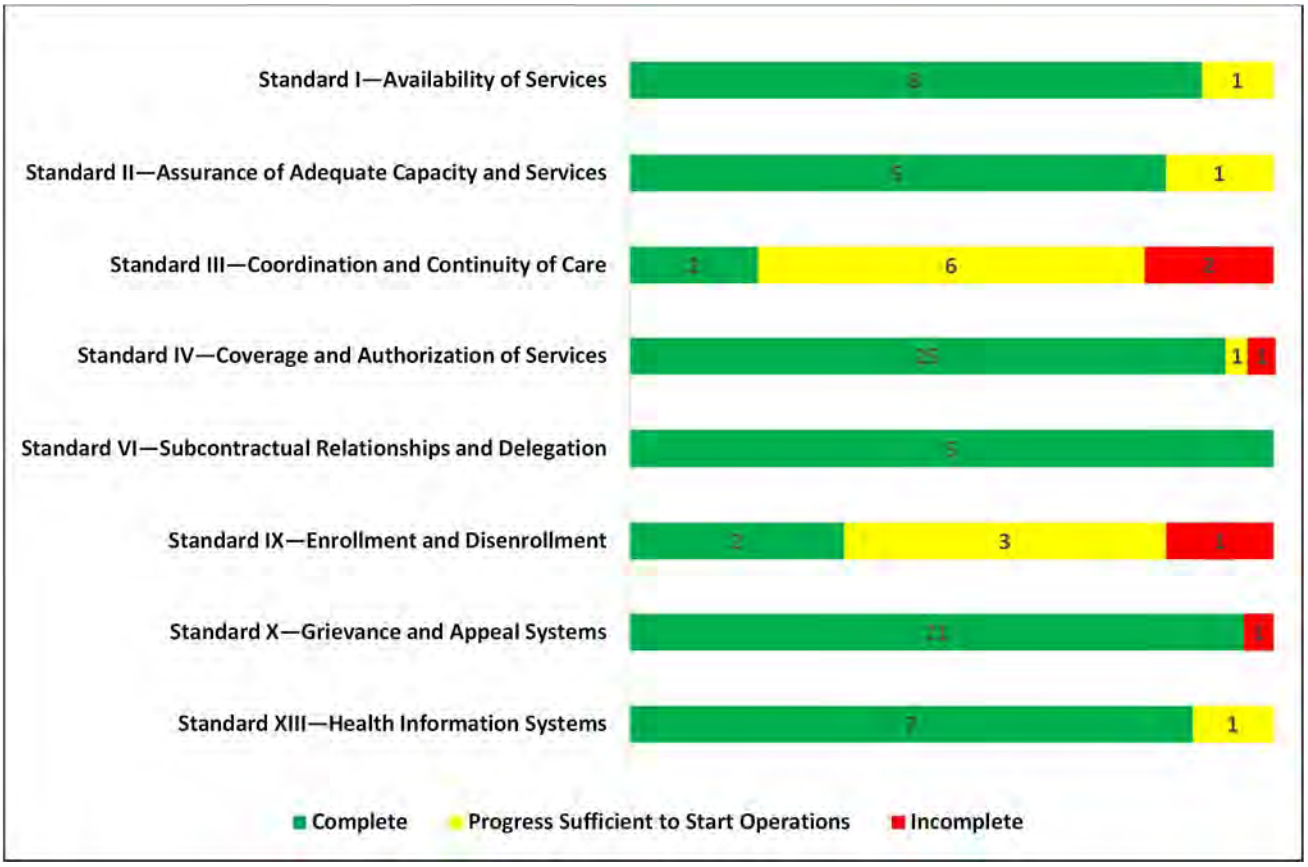
2. Phase 1 Results

Across all eight standards, PSCS-Lane's overall percentage of complete elements is 79.6 percent. The CCO demonstrated:

- *Complete* ratings for 75 of the 93 total elements.
- *Progress Sufficient to Start Operations* ratings for 13 elements across eight standards.
- *Incomplete* ratings for five elements across eight standards, indicating areas of greater deficiency. These areas *require action* to ensure readiness prior to providing services.

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

Figure 2-1—PSCS-Lane Phase 1—Critical Areas Readiness Review Results



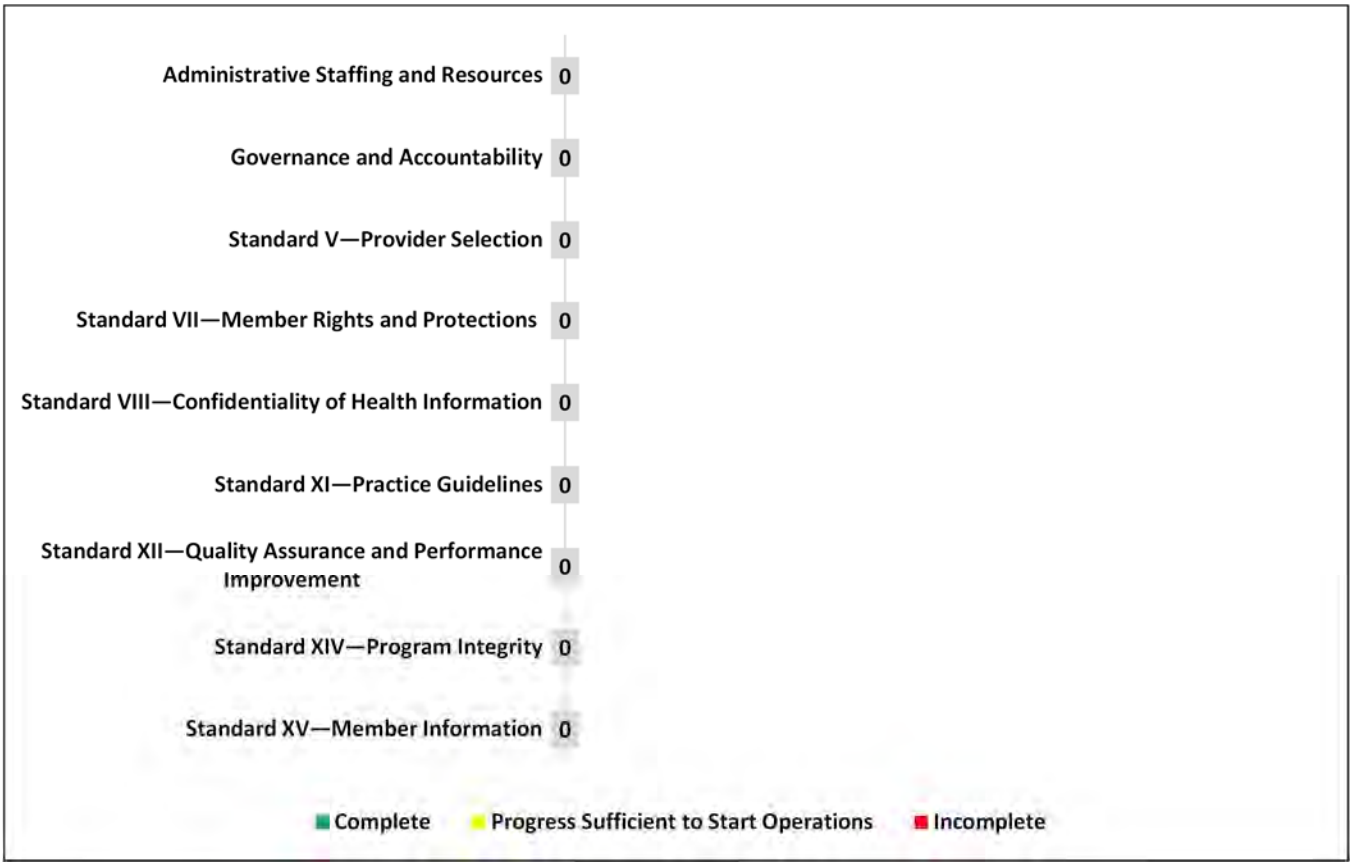
3. Phase 2 Results

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

Across all eight standards, PSCS-Lane'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—PSCS-Lane 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 PSCS-Lane'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)*	• PolicyProcedure - Network Availability PolicyProcedure - Accessibility of Services	☒ 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)*	• PolicyProcedure - Network Availability • Template - 2020 Base Provider Agreement • Template - Dental Subcontractor Agreement • Template - 2020 NEMT Base Agreement w Ex B	☒ 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 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)*	Material - Member Handbook 2020 Template, pg. 15	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	• Material - Provider Manual Current, pg. 19, 27, 46 • PolicyProcedure - Member Access-Specialist Medicaid • Material - Member Handbook 2020 Template, pg. 25	☒ 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)*	• DTP - NON-PAR Provider Workflow	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: The CCO's NON-PAR Provider Workflow document described how the CCO will work with non-contracted providers to render medically necessary covered services to members. However, no documentation was provided that describes how the CCO ensures that members are not charged for services delivered by non-contracted providers.		
Required Actions: The CCO should update its non-participating provider workflow to include the mechanisms ensure that the cost to the member of medically necessary services provided by non-contracted providers is no greater than it would be if services were provided within the network.		
6. The CCO demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services:	• Material - Provider Manual Current, pg. 28 • Material - Member Handbook 2020 Template, pg. 24	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	• PolicyProcedure - Member Access-Specialist Medicaid, pg. 4	☐ 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.		☐ 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	• PolicyProcedure - Accessibility of Services	☒ 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*		
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:	• PolicyProcedure - Accessibility of Services • Work Plan - Access Monitoring Plan	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*		
10. The CCO participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. These efforts must ensure that members have access to covered services that are delivered in a manner that meet their unique needs. *42 CFR §438.206(c)(2)* *Contract: Exhibit B Part 4 (4)(e)*	• Template - 2020 Base Provider Agreement, pg. 4, 5, Attachment C • Provider Manual, pg, 19, 20, 44, 45 • Form - Provider Site Visits • Survey - Interpreter Service Member Survey Questions • Snip - Provider Directory Profile (shows info such as language capability)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

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

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

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. The CCO submits documentation to the State, in a format specified by the State, to demonstrate that it complies with the following requirements: a. Offers an appropriate range of preventive, primary care, specialty services, that is adequate for the anticipated number of enrollees for the service area. b. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. *42 CFR §438.207(b)(1-2)* *Contract: Exhibit G*	• PSCS Lane Readiness DSN • PolicyProcedure - Network Availability • Memo - Provider Network Update • Memo – DSN Submission Addendum	☒ 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*	• PolicyProcedure - Medicaid Contract Deliverable • Screenshot – Deliverable Tracking	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: Although CCO policies, procedures, and processed provided evidence of tracking contracted deliverables, documentation did not define the time frames for submitting required capacity reports to the State, including processes for submitting documentation associated with		

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
significant changes in operation. During the remote interview session, CCO staff stated it was in the process of developing system triggers to comply with the timing of reporting.		
Required Actions: HSAG recommends that the CCO updates its policies and procedures to outline the mechanisms submitting provider capacity documentation, including the required time frames outlined in the CCO contract—i.e., upon entering a contract with the State, on an annual basis, and when there is a significant change in operations.		
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)*	• PolicyProcedure - Network Availability	☒ 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)*	• PolicyProcedure - Network Availability	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	• PolicyProcedure - Network Availability	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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)*	• PolicyProcedure - Network Availability	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard II—Assurance of Adequate Capacity and Services	
	Total #
Complete	**5**
Progress Sufficient	**1**
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)*	• Material – Member Handbook 2019.pdf – Page 3 and 21 • Material – Member ID Card.pdf • PolicyProcedure – Transition of Care.pdf • Template - TOC Welcome Letter.pdf • Template - TOC Letter-Medicaid.pdf • https://communitysolutions.pacificsource.com/Member • Template – Member Welcome Letter.pdf	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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)*	• Work Plan – Transitions of Care.pdf • PolicyProcedure - Transition of Care.pdf • PolicyProcedure - Medicaid and Medicare Authorizations.pdf	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: The Transitions of Care work plan and policy provided by the CCO only described processes for the transition of care for members going into and out of the CCO. During the remote interview session, the CCO demonstrated the Transition of Care module in the Dynamo care management system. CCO staff members stated that they coordinate services for members with other entities; however, it was unclear if the CCO had used or implemented a defined process.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Required Actions: HSAG recommends that the CCO update policies, procedures, or workflows to explain how the CCO coordinates services it furnishes to members between settings of care, with services it receives from other health plans or Medicaid fee-for-service (FFS), and with services the members receive from community and social support providers.		
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)*	• PolicyProcedure - Health Assessment • Survey - Adult Wellness Survey • Survey - Child Wellness Survey	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA
HSAG Findings: The Health Assessment policy outlined the process that the CCO will use to conduct initial screenings of each new member's needs. The Wellness Tracking System (WTS) is used for sending, tracking, and storing the surveys. This policy stated that enrollment information is pulled monthly from the WTS and a report is run with new member names and addresses for the initial wellness survey letter. However, during the remote interview session, staff members stated that they generate the report and send out wellness surveys more frequently than once a month. In addition, the policy stated that enrollment data are transferred into WTS monthly; however, one staff member stated it is done weekly and another stated it is done daily. Customer service staff members conduct a welcome call to all newly enrolled members and to inform them that a survey is being mailed. If a survey is not returned, the policy stated that the CCO mails out a second survey 60 days after the initial survey mailing. No other attempts, such as conducting the survey telephonically, are made by the CCO. The CCO's current process did not address how it will conduct the assessment within 30 days of enrollment if the member was referred by a provider, is receiving long-term services and supports (LTSS), or is a member in a priority population for Intensive Care Coordination (ICC) services. Information from the returned surveys is entered in the WTS and the adult surveys are automatically scored and assigned to care coordination/management depending on the score. Child surveys are evaluated for multiple diagnoses, multiple medical visits, and use of adaptive devices, but the policy did not specify who is responsible for reviewing the child survey results, how the review is conducted, or the timeline for that review.		
Required Actions: The CCO should revise its policies, procedures, and processes to ensure best efforts are made to conduct the initial screening of all newly enrolled members within 90 days of enrollment in the CCO. In addition, the CCO should its revise policies, procedures, and processes to ensure that any newly enrolled member receiving Medicaid long-term care (LTC), LTSS, or is a member of a priority population for ICC services completes the initial screening within 30 days of enrollment.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
4. The CCO's service agreements with specialty and hospital providers must: i. Address the coordinating role of patient-centered primary care; ii. Specify processes for requesting hospital admission or specialty services; and iii. Establish performance expectations for communication and medical records sharing for specialty treatments: – At the time of hospital admission; or – At the time of Hospital discharge for the purpose of facilitating after-Hospital follow up appointments and care. *Contract: Exhibit B Part 4 (9)*	• Manual – Provider Manual Current.pdf – Page 37 • Template – 2020 Base Provider Agreement.pdf – Page 5 (h) and Page 7, section 2.8	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: The 2020 Base Provider Agreement template submitted by the CCO contained a statement that "the provider agrees to participate in, cooperate with, and comply with all applicable PacificSource requirements, policies, and procedures, including, but not limited to, those set forth in the PacificSource Provider Manual and those relating to Member grievances; credentialing; utilization review; quality assurance; information and document requests; requesting hospital admission or specialty services; medical records sharing for specialty treatments, at the time of hospital admission or discharge, and for after-hospital follow-up appointments; and medical management program(s). PacificSource agrees to make any such requirements, policies, and procedures available to Provider upon request within 72 business hours." While the CCO attempted to address the requirement, no specific information was included in the service agreement and required the provider to reach out to the CCO and request this information instead of explicitly providing the required information in the contract. In addition, when asked what the CCO's performance expectations for provider communication and medical record sharing were during the remote interview session, staff members could not articulate the CCO's expectations.		
Required Actions: The CCO should update the provider agreements with specialty and hospital providers to include specific information on the coordinating role of patient-centered primary care, the processes for requesting hospital admission or specialty services, and the CCO's expectations for communication and medical records sharing at the time of hospital admission and at the time of hospital discharge to facilitate follow-up appointments and care.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	• PolicyProcedure - Transition of Care.pdf • Template - 2020 Base Provider Agreement.pdf – Page 21	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: The Transition of Care policy submitted by the CCO only discussed processes related to members moving between CCOs and Medicaid FFS. The 2020 Base Provider Agreement submitted did not contain any language that would ensure hospital or specialty service providers are accountable for achieving successful transitions of care. During the remote interview session, staff members stated that they will meet with key providers in the community to discuss member transitions and hospital readmissions; monitor data and reports related to grievances and appeals, admission, and adverse events; and foster collaboration between the utilization management and care management departments to ensure successful member transitions.		
Required Actions: While the CCO was able to articulate some current processes being implemented, HSAG recommends that the CCO develop more defined processes and documentation and/or update the provider agreements to ensure that 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)*	• Template - Member Insight Report • PolicyProcedure - Transition of Care.pdf • Template - TOC Provider Letter.pdf • Work Plan - Transitions of Care.pdf	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: The documents provided by the CCO were limited to transition of care activities for members moving into and out of the CCO and did not explain how and when the CCO shares assessment information with the primary care provider (PCP) or other health plans to prevent duplication		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
of those activities. During the remote interview session, CCO staff members stated that they do share information with providers and other health plans but did not articulate a defined process for doing so.		
Required Actions: HSAG recommends that the CCO develop, document, and implement processes for ensuring that the PCP, the State, or other health plans serving the member receive results of any identification and assessment of the member's needs.		
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)*	• PolicyProcedure - Privacy and Confidentiality • PolicyProcedure - Person or Entity Authentication • PolicyProcedure - Provider Compliance with HIPAA and State Regulations • PolicyProcedure - Business Associate Contracts and Other Arrangements • PolicyProcedure - Members Rights Regarding PHI • PolicyProcedure - Sanction Policy • PolicyProcedure - Use and Disclosure of PHI • PolicyProcedure - Workstation Use and Security	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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	• PolicyProcedure - Intensive Care Coordination Services and Care Management.pdf	☐ Complete

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*		☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: The Intensive Care Coordination Services and Care Management policy stated that nurse case managers assess complex health issues, chronic conditions, behavioral health, and other special health needs. Member support specialists assist with members who have needs specifically involving service access and/or barriers to social determinants of health. However, the policy did not explain the timelines for completion of the comprehensive assessment, how the assessment is completed (face-to-face, telephonically), or how/where the assessment results are documented. The assessment tool was not provided as part of the evidence submitted by the CCO; however, the CCO was able to provide a demonstration of the assessment module in the Dynamo care management system during the remote interview session. The CCO staff members stated that they try to make contact with members within two days of a referral to care coordination and try to complete the comprehensive assessment within two weeks.		
Required Actions: HSAG recommends that the CCO revise its policies and procedures to include more specificity surrounding the processes and timelines used by the CCO to complete the comprehensive assessment on all members identified as needing LTSS or having special healthcare needs. In addition, HSAG recommends that the CCO implement processes to track and monitor the completion of assessments to ensure that expected timelines for completion are being met.		
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)*	• PolicyProcedure - Intensive Care Coordination Services and Care Management.pdf • Template - ICC Letter to PCP	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: The Intensive Care Coordination Services and Care Management policy stated that the CCO identifies, assesses, and produces a treatment plan for each member identified as having a special healthcare need. The policy was very general and lacked detailed information on the care coordination processes implemented by the CCO. For example, the policy did not explain who is responsible for completing the care plan, how the care plan is created, the time frame for completing the initial care plan, and how the care plan is shared with providers involved in the member's care. During the remote interview session, CCO staff members provided a demonstration of the care management system, Dynamo, and stated that they are in the process of updating modules within the system to allow for additional care coordination procedures. The CCO expects that the development of the new		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
modules will be completed in November 2019 with deployment in January 2020. The care plans were automatically generated based on information captured in the comprehensive assessment tool. Staff members were able to add additional goals/interventions manually.		
Required Actions: HSAG recommends that the CCO revise its care coordination policies and procedures to include more specificity surrounding the processes used by the CCO to identify, assess, and produce a treatment plan for each member with special healthcare needs. HSAG also recommends that the CCO take into consideration the requirements for care/treatment planning and revise processes to ensure that there is evidence of member participation and agreement with the care plan.		
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;		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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))*		
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)*	• PolicyProcedure - Intensive Care Coordination Services and Care Management.pdf • PolicyProcedure - Member Access-Specialist Medicaid	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA
HSAG Findings: According to the Member Access-Specialist Medicaid policy, most specialist visits require a referral from the member's PCP. To ensure direct access, members eligible for intensive care coordination do not need a PCP referral for an initial specialist visit. During the remote interview session, CCO staff members stated that, after an initial specialist visit, if a member continues to need to see the specialist, either the member's PCP or the specialist would submit a request for authorization of additional visits/units.		
Required Actions: The CCO should revise its policies and procedures to ensure that direct access is not limited to members eligible for intensive care coordination and to 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.		

Standard III—Coordination and Continuity of Care	
	Total #
Complete	2
Progress Sufficient	6
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)*	• PolicyProcedure - Clinical Criteria Guidelines.pdf – Page 4 • PolicyProcedure – Medicaid Claims Processing.pdf – Page 1	☒ 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: 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	• PolicyProcedure - Clinical Criteria Guidelines.pdf • PolicyProcedure - Medicaid and Medicare Authorization.pdf • PolicyProcedure - Member Access-Specialist Medicaid.pdf • Material – Provider Manual Current.pdf – Page 28	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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*		
HSAG Findings: The documentation submitted by the CCO described 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)*	• PolicyProcedure - Mental Health and Substance Use Disorder Parity.pdf – Page 3 (green) • Manual - Clinician Training Manual.pdf – Pages 22-23	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
4. The CCO has processes to ensure that any financial requirements or treatment limits to mental health or substance use disorder benefits in any classification are no more restrictive then the financial requirements or treatment limits to medical/surgical benefits in the same classification (whether or not the benefits are furnished by the CCO). *Contract: Exhibit E (22)*	• PolicyProcedure - Mental Health and Substance Use Disorder Parity.pdf – Page 2 (yellow)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	• PolicyProcedure - Clinical Criteria Guidelines.pdf • Manual - Clinician Training Manual.pdf • PolicyProcedure - Mental Health and Substance Use Disorder Parity.pdf – Page 2 (yellow) • Material – Provider Manual Current.pdf – Page 28 • PolicyProcedure - Member Access-Specialist Medicaid.pdf	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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.	• PolicyProcedure – Interrater Reliability Monitoring.pdf • PolicyProcedure - Medicaid and Medicare Authorizations.pdf • PolicyProcedure - Notice of Adverse Benefit Determinations.pdf – Page 3	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*		
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)*	• PolicyProcedure - Medicaid and Medicare Authorizations.pdf – Page 1	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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)*	• PolicyProcedure - DUR Program.pdf	☒ 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)*	• PolicyProcedure - Notice of Adverse Benefit Determinations – Page 3	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
10. The written notice of adverse benefit determination must be consistent with the provisions under 42 CFR 438.10(c) and must include: a. The date of the notice; b. CCO name, address, phone number; c. Name of the member's Primary Care Practitioner, Primary Care Dentist, or behavioral health practitioner, as applicable; d. Member's name, address, and ID number e. Service requested or previously provided and adverse benefit determination the CCO made or intends to make; f. Date of the service or date service was requested by the provider or member; g. Name of the provider who performed or requested the service; h. Effective date of the adverse benefit determination if different from the date of the notice; 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	• PolicyProcedure - Notice of Adverse Benefit Determinations.pdf o Page 2 • Template – NOABD and Rights.pdf	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
documents, records, and other information relevant to the member's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. l. The member's right to request an appeal with the CCO within 60 days of the CCO's adverse benefit determination, including information on exhausting the CCO's one level of appeal described at §438.402(b) and the right to request a State fair hearing (contested case hearing) within 120 days after issuance of the CCO's Notice of Appeal Resolution or where the CCO failed to meet appeal timelines as outlin4ed in 410-141-3230; and the procedures for exercising these rights described in 410-141-3245. m. The circumstances under which an appeal process can be expedited and how to request it. n. The procedures for exercising the rights specified in this standard. 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)*		

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	• PolicyProcedure - Medicaid and Medicare Authorizations.pdf • PolicyProcedure - Notice of Adverse Benefit Determinations.pdf – Page 3-4	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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)*	• PolicyProcedure - Medicaid and Medicare Authorizations.pdf • PolicyProcedure - Notice of Adverse Benefit Determinations.pdf – Page 4	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
13. For all covered outpatient drug authorization decisions, provide notice as described in section 1927(d)(5)(A) of the Act. a. Provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization. *42 CFR §438.210(d)(3)* *Sec. 1927. [42 U.S.C. 1396r-8] (d)(5)(A)* *Contract: Exhibit B Part 2 (3)(j)*	• PolicyProcedure - Pharmacy Benefit Medicaid.pdf – Page 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. – 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.	• PolicyProcedure - Notice of Adverse Benefit Determinations.pdf – Page 3-4	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
– A change in the level of medical care is prescribed by the member's physician. – The notice involves an adverse determination made with regard to the preadmission screening requirements. • If probable member fraud has been verified, the CCO gives notice five (5) calendar days before the date of action. *42CFR438.404(c), 42CFR431.211, 42CFR431.213(a)-(g), 42CFR431.214(a)* *Contract: Exhibit I (3)(c)*		
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)*	• PolicyProcedure - Urgent and Emergency Services.pdf – Page 1 • PolicyProcedure – Urgent Emergent Post-Stabilization.pdf	☒ 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)*	• PolicyProcedure - Urgent and Emergency Services.pdf – Page 2 • PolicyProcedure – Urgent Emergent Post-Stabilization.pdf	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
17. The CCO:	• PolicyProcedure - Urgent and Emergency Services.pdf – Page 2-3 (a-b)	☐ Complete ☐ Progress Sufficient to Start Operations

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
a. Covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the CCO; and b. Does not deny payment for treatment obtained under either of the following circumstances: i. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes 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)*	• PolicyProcedure – Urgent Emergent Post-Stabilization.pdf	☐ Incomplete ☐ NA
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)*	• PolicyProcedure - Urgent and Emergency Services.pdf – Page 2 • PolicyProcedure – Urgent Emergent Post-Stabilization.pdf	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
19. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42 CFR §422.114(d)(2)* *Contract: Exhibit B Part 2 (4)(a)(9)*	• PolicyProcedure - Urgent and Emergency Services.pdf – Page 2 • PolicyProcedure – Urgent Emergent Post-Stabilization.pdf	☒ 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)*	• PolicyProcedure - Urgent and Emergency Services.pdf – Page 2 • PolicyProcedure – Urgent Emergent Post-Stabilization.pdf	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
21. Poststabilization care services are covered and paid for in accordance with provisions set forth at 42 C.F.R. §422.113(c). a. The CCO is financially responsible (consistent with §422.214) for post-stabilization care services obtained within or outside the CCO's network that are pre-approved by a plan provider or other organization representative; 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	• PolicyProcedure - Urgent and Emergency Services.pdf – Page 3 • PolicyProcedure – Medicaid Claims Processing.pdf • PolicyProcedure – Urgent Emergent Post-Stabilization.pdf	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
request to the CCO for pre-approval of further post-stabilization care services; c. The CCO is financially responsible for post-stabilization care services obtained within or outside the CCO's network that are not pre-approved by a plan provider or other organization representative, but administered to maintain, improve, or resolve the member's stabilized condition if: i. The CCO does not respond to a request for pre-approval within 1 hour; ii. The CCO cannot be contacted; or iii. The CCO's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the CCO must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in §422.113(c)(3) is met. d. Must limit charges to members for post-stabilization care services to an amount no greater than what the organization would charge the member if he or she had obtained the services through the CCO's network. For purposes of cost sharing, post-stabilization care services begin upon inpatient admission. *42 CFR §438.114(e)* *42 CFR §422.113(c)(2)(i-iv)* *Contract: Exhibit B Part 2 (4)(a)(6&8)*		

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	• PolicyProcedure - Urgent and Emergency Services.pdf – Page 2 • PolicyProcedure – Urgent Emergent Post-Stabilization.pdf	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
23. The CCO has written policies and procedures that describe the process for receiving member requests, approving non-emergent medical transportation (NEMT) services, and scheduling, assigning, and dispatching providers. *Contract: Exhibit B Part 2 (4)(b)*	• PolicyProcedure - Non-Emergent Medical Transportation.pdf • Work Plan - NEMT Brokerage Onboarding.pdf	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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)*	• Work Plan – NEMT Call Center.pdf • PolicyProcedure - Non-Emergent Medical Transportation.pdf • Call Center operations will be defined in the NEMT Contract, Exhibit B, meeting these requirements.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
25. The CCO has written policies and procedures for Emergency Dental Services and Urgent Care Services for Emergency Dental Conditions that describe when treatment of an emergency or urgent dental condition should be provided in an ambulatory dental office setting and when emergency dental services should be provided in a hospital setting. *Contract: Exhibit B Part 2 (4)(k)(2)*	• PolicyProcedure - Medicaid and Medicare Authorizations.pdf – Page 8 • PolicyProcedure - Accessibility of Services.pdf	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA
HSAG Findings: The CCO included a section titled "Getting Urgent or Emergency Dental Care" 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)*	• PolicyProcedure – Urgent and Emergent BH Services.pdf – Page 1 & 2 (blue highlights) • Material - ED Crisis Access Monitoring.pdf	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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)*	• PolicyProcedure – Urgent and Emergent BH Services.pdf – Page 2 (yellow highlight) • Material - ED Crisis Access Monitoring.pdf	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services	
	Total #
Complete	25
Progress Sufficient	1
Incomplete	1
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)*	• PolicyProcedure – Delegation Oversight.pdf – Page 2 • Template – 2020 NEMT Base Agreement w Ex C.pdf – Page 2 of Exhibit C • Template – Dental Subcontractor Agreement.pdf – Page 7, section 11; Page 13, section 2.2.1; Page 42, section 6	☒ 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.	• PolicyProcedure – Delegation Oversight.pdf – Page 3 • PolicyProcedure – Medicaid Contract Deliverable.pdf • Template - 2020 NEMT Base Agreement w Ex B – Page 13, Exhibit B • Template – Dental Subcontractor Agreement.pdf	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• 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)*		
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)*	• PolicyProcedure – Delegation Oversight.pdf – Page 1 • Template - Subcontractor Pre-Delegation Assessment Notice.pdf Note: The language stating "…any time the CCO enters into a new subcontractor agreement." was modified in the most recent CCO Draft Contract Update (rev 7.9.19). PSCS updated its policy to reflect the most current contract language.	☒ 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)*	• PolicyProcedure – Delegation Oversight.pdf – Page 5 • Template – NEMT Audit Engagement Letter.pdf • PolicyProcedure - Delegation Oversight UM.pdf • DTP - Delegation Oversight UM.pdf – Updates will be made for new CCO regions • Screenshot - Delegate Oversight Tool UM.jpg	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
5. Whenever deficiencies or areas of improvement are identified, the CCO and subcontractor shall take corrective action. *Contract: Exhibit B Part 4(13)(a)(15-17)*		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		
6. The Contractor must provide to OHA, annually and within 30 days of any change in subcontractor, the Subcontractors and Delegated Entities Report. The report should identify any activities the Contractor has agreed to perform under the contract that have been subcontracted or delegated, and include information related to the subcontracted work including: • The legal name of the Subcontractor; • The scope of work being subcontracted; • Copies of ownership disclosure form, if applicable; • Copies of all written agreements with Subcontractors to ensure all contracts meet the requirements outlined in 42 CFR 438.230; • Any ownership stake between the Contractor and Subcontractor. *Contract: Exhibit B Part 4(13)(a)(5-6)*	• PolicyProcedure – Delegation Oversight.pdf – Page 2	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

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

Standard VI—Subcontractual Relationships and Delegation	
	Total #
Complete	**5**
Progress Sufficient	**0**
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)*	• PolicyProcedure - Enrollment and Disenrollment.pdf, pg. 1	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
2. The CCO shall not request disenrollment because of an adverse change in the member's health status, or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the CCO seriously impairs the entity's ability to furnish services to either this particular member or other members). *42 CFR §438.56(b)(2)* *Contract: Exhibit B Part 3 (6)(a)(4)*	• PolicyProcedure - Enrollment and Disenrollment.pdf, pg. 2	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IX—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: Although the Enrollment and Disenrollment policy identified that the CCO will not request disenrollment because of an adverse change in a member's health status, or because of the member's utilization of medical services, it did not include 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) as specified in federal requirements.		
Required Actions: HSAG recommends that the CCO update its policies and procedures to ensure that all the federal requirements in this element are included in the documentation.		
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)*	• PolicyProcedure - Enrollment and Disenrollment.pdf, pg. 2	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IX—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: The Enrollment and Disenrollment policy specified that the CCO may request disenrollment if a member is uncooperative or disruptive, except where this is a result of the member's special needs or disability; and commits fraudulent or illegal acts. While the policy did not specify that the CCO may request disenrollment if a member 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 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, these disenrollment reasons were included in the member handbook.		
Required Actions: HSAG recommends that the CCO update its policies, procedures, and other member information materials to include reasons for disenrollment and ensure they are consistent across all CCO documentation, policies, and procedures.		
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. 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)*	• Material - Member Handbook Current, pg. 36	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IX—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: The member handbook did not specify that the CCO allows a member to request disenrollment for cause, at any time, only that a Medicare member can change or leave the CCO at any time. Although "without cause" situations for disenrollment were identified in the member handbook for b.(i.–iii.) of this element, it did not include b.(iv.) as required by federal requirements.		
Required Actions: HSAG recommends that the CCO update the disenrollment information in the member handbook to include all the requirements identified in this element to be consistent with federal requirements.		
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)*	• Quick Guide - Medicaid Out of Area Notices.pdf	☒ 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 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	• PolicyProcedure - Enrollment and Disenrollment.pdf, pg. 2	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA

Standard IX—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*		
HSAG Findings: While the Enrollment and Disenrollment policy did not include the reasons defining a "cause" for disenrollment as defined by sub-elements a.–e. of this element. The member handbook, however, did identify that a member's enrollment could end if the member moves out of the plan's service area, however, it still did not include sub-elements b.–e. for this element.		
Required Actions: HSAG recommends that the CCO update its policies, procedures, and other member information materials to include all required "cause for disenrollment" reasons and ensure that they are consistent amongst the various documents.		

Standard IX—Enrollment and Disenrollment	
	Total #
Complete	**2**
Progress Sufficient	**3**
Incomplete	**1**
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*	• PolicyProcedure – Grievance and Appeals System.pdf – header of the policy.	☒ 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)*	• PolicyProcedure – Grievance and Appeals System.pdf, pg. 12, 16 • Template – NOABD and Rights • Material – Member Handbook Current, pg. 39 - 41	☒ 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 service, requirements for medical necessity,	• PolicyProcedure – Grievance and Appeals System.pdf (a) Page 1 (b) Page 1	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	(c) Page 1 (d) Page 3 #9 (c) (e) Page 3 #9 (c) (f) Page 1 (g) Page 1	☐ 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)*	• PolicyProcedure – Grievance and Appeals System.pdf – Page 1	☒ 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)*	• PolicyProcedure – Grievance and Appeals System.pdf – Page 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)*	• PolicyProcedure – Grievance and Appeals System.pdf – Page 8, #1	☒ 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)*	• PolicyProcedure – Grievance and Appeals System.pdf – Page 11, 5 – Page 12, 6 (a)&(b)	☒ 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)*	• PolicyProcedure – Grievance and Appeals System.pdf – Page 6 #4 (a), Page 13 #7 (a)	☒ 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)*	• Duplicate of question #7 above.	☐ 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. c. Notice to the member must be in a format and language that may be easily understood by the member.	• PolicyProcedure – Grievance and Appeals System.pdf (a) Page 8, (2)(a) (b) Page 8, (2)(b) (c) Page 9, (1)(a)	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
42 CFR §438.408(a)-(b)(1), (d)(1) *Contract: Exhibit I (2)(h)*		
HSAG Findings: The CCO submitted its Grievance and Appeals System policy, which included the requirement that the CCO either notify the member of its grievance decision or acknowledge receipt of the grievance within five days. However, the policy also included a statement that, "When informing members of the CCO's decision, the CCO may provide its decision related to oral grievances either orally or in writing." 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 and Appeals System policy, prior to January 1, 2020, to reflect the contract requirement that it respond in writing to all grievances (including those received orally).		
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)*	• PolicyProcedure – Grievance and Appeals System.pdf – Page 7, (8)	☒ 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:	• PolicyProcedure – Grievance and Appeals System.pdf – Page 6, #4 (d) A – Last bullet – page 7, C (#4 from previous, d. C)	☒ 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)*		
13. The CCO's appeal process must provide: a. That oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the member or the provider requests expedited resolution. b. The member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The CCO must inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in §438.408(b) and (c) in the case of expedited resolution. c. The member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the CCO (or at the direction of	• PolicyProcedure – Grievance and Appeals System.pdf a. Page 12, (4)(a)(b), 6(a) b. Page 13, 7(h)(A) c. Page 13, 7(h)(B) d. Page 13 (8)(a)-(c)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	• PolicyProcedure – Grievance and Appeals System.pdf a. Page 13, (9) b. Page 15, (3) and (3)(b) c. Page 14, (13)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
15. The CCO may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: • The member requests the extension; or	• PolicyProcedure – Grievance and Appeals System.pdf a. Page 12, (3)(b) b. Page 12, (3)(b)(A)	☒ Complete ☐ Progress Sufficient to Start Operations

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• 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 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)*	c. Page 12, (3)(b)(B) d. Page 12, (3)(c) e. Page 12, (3)(c)(A) f. Page 12, (3)(c)(B) g. Page 16, (4) & (5) h. Page 16, (1)	☐ Incomplete ☐ NA
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.	• PolicyProcedure – Grievance and Appeals System.pdf • Page 14, (13)(a) – Page 14, (13)(b) – Page 14, (13)(b)(C) – Page 14, (13)(b)(D)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
– 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)*		
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)*	• PolicyProcedure – Grievance and Appeals System.pdf – Page 14, (14) – Page 17, (13)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
18. The CCO maintains an expedited review process for appeals, when the CCO determines, or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. The CCO's expedited review process includes: • The CCO ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.	• PolicyProcedure – Grievance and Appeals System.pdf – Page 15, (1) – Page 15, (2) – Page 16, (5) – Page 16, (5)(a) – Page 16, (5)(b)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• If the CCO 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)*		
19. The CCO provides for continuation of benefits/services while the CCO-level appeal and the State fair hearing (contested case hearing) are pending if: • The member files timely* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the CCO mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal in accordance with required timeframes.	• PolicyProcedure – Grievance and Appeals System.pdf – Page 18 - 19 – Page 19 (1) – Page 19 (2) – Page 19, 2nd bullet – Page 19, 3rd bullet – Page 19, 4th bullet	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
**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. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR §438.420(c)* *Contract: Exhibit I (6)(c)*	• PolicyProcedure – Grievance and Appeals System.pdf – Page 19, (1)(c) – Page 19 (1)(c)(D)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
21. If the final resolution of the appeal is adverse to the member, that is, upholds the CCO's adverse benefit determination, the CCO may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. *42 CFR §438.420(d)* *Contract: Exhibit I (6)(d)*	• PolicyProcedure – Grievance and Appeals System.pdf – Page 19, (4)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
22. Effectuation of Reversed appeal resolutions: • If the CCO or the State fair hearing (contested case hearing) officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the CCO must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than seventy-two (72) hours from the date it receives notice reversing the determination. • If the CCO or the State fair hearing (contested case hearing) officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the CCO or the State must pay for those services, in accordance with State policy and regulations. *42 CFR §438.424* *Contract: Exhibit I (7)*	• PolicyProcedure – Grievance and Appeals System.pdf – Page 14, (11)(12) – Page 19, (2)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
23. The CCO maintain records of all member grievances and appeals. The record must be accurately maintained in a manner accessible to the State and available upon request to CMS. The record of each member grievance or appeal must contain, at a minimum, all of the following information: • A general description of the reason for the appeal or grievance; • The date received; • The date of each review or, if applicable, review meeting;		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• Resolution at each level of the appeal or grievance, if applicable; • Date of resolution at each level, if applicable; • Name of the covered person for whom the appeal or grievance was filed, member ID number, and date the member filed the grievance or appeal; • Notations of oral and written communications with the member; and • Notations about appeals and grievances the member decides to resolve in another way if the CCO is aware of this. *42 CFR §438.416* *Contract: Exhibit I (9)*		
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		
24. The CCO provides the information about the grievance appeal, and fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing (contested case hearing) after the CCO has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes.	• PolicyProcedure – Grievance and Appeals System.pdf – Page 5 • Material – Provider Manual Current, Page 48-49, and 51	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

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

Standard X- Grievance and Appeal Systems	
	Total #
Complete	**21**
Progress Sufficient	**0**
Incomplete	**1**
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)*	• PolicyProcedure - Health Information Systems, pg 1	☒ 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.	• PolicyProcedure - Health Information Systems, pg 2 • Flow Chart - Claims and Encounters	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
42 CFR §438.242(b)(1)		☐ NA
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)*	• PolicyProcedure - Health Information Systems, pg 1 a. PolicyProcedure - Network Availability, pg 1 b. PolicyProcedure - Enrollment and Disenrollment, pg 3 c. PolicyProcedure - Medicaid Encounter Data, pg 1	☒ 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)*	• PacificSource has established an internal provider data governance team to oversee the current data quality processes and to recommend new areas of focus as needs arise. Meetings are held once a month. Reference 'Work Group - Provider Data Governance Team' for additional details regarding this team. a-b. Reference 'PolicyProcedure - Monitoring Provider NPI Data,' 'PolicyProcedure –Monitoring Provider Directory Data' and the following narratives for examples of how PacificSource evaluates, validates, and verifies provider data: • Medicaid Provider and Facility Monitoring – Monthly – A random selection of 100 Medicaid providers and 40 facilities are reviewed against the source of truth to verify completeness and accuracy.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Contract: Exhibit J(3)	• Multiple Address Monitoring – Monthly – Using Quest Cloud information, PacificSource targets providers who have a large number of multiple addresses to ensure our records are accurate. Sampled providers are sent to our Provider Service team for them to make calls to the applicable provider. PacificSource removes all Provider addresses determined to be no longer valid. • OIG/SAM/Medicaid Sanction Monitoring – Monthly – Using Streamline Verify all providers and facilities are verified against the OIG exclusion list, SAM and state Medicaid Sanction lists. • Unauthorized Facets Monitoring – Monthly – Using SSRS report we verify who accessed provider data in Facets and report any unauthorized users. c-d. • DTP - COB Medicaid Application Checklist • PolicyProcedure - Enrollment and Disenrollment, pg 3 • PolicyProcedure - Medicaid Encounter Data, pg 2 • Example - Monitoring Encounter Data	
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)*	• PolicyProcedure - Health Information Systems, pg 1	☒ Complete ☐ Progress Sufficient to Start Operations

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Contract: Exhibit J(3)(g)		☐ 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 iii. The date on which the services were furnished iv. The amount of the payment made by the member, if any, for the services		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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*	PolicyProcedure – Contingency Plans a. pg. 2 §4.1 b. pg. 2 §4.2 c. pg. 3 §4.3 d. pg. 3 §4.4 Examples: a. DTP – Backup Plan, pgs. 3-5 b-d. Screenshot - IT Disaster Recovery Plan - Cover Page	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: The CCO's documentation included an overarching policy and procedure outlining the requirements and processes associated with the CCO's contingency plans that addressed the objectives, organizational structure, and maintenance/testing protocols associated with data backups, disaster recoveries, emergency modes of operations, and regular evaluations of data criticality. However, while the CCO's backup plan policy was submitted for review, only an image of the cover page to its IT Disaster Recovery Plan (dated June 9, 2017) was provided. During HSAG's remote interview, the CCO's staff members verbally identified that the plan was last updated in March 2018. Although CCO staff members indicated that they anticipated no major systems changes would result from the expansion to subsequent service areas, the business continuity/disaster recovery (BC/DR) plan should be reviewed and updated to ensure the applicability of the policy to all PSCS service areas.		
Required Actions: HSAG recommends that the CCO's most up-to-date BC/DR plan be submitted for review to confirm it applies to all PSCS service areas		
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		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA

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

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*		
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.		

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Required Actions: None.		
13. The CCO shall participate in OHA's HIT Advisory Group (HITAG) at least once annually. *Contract: Exhibit J(2)(e)*		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element will be reviewed by the OHA HIT for the readiness review.		
Required Actions: None.		
14. The CCO shall document and report to OHA, annually, on how HIT is used to support contracted providers by providing: a. Information (at least quarterly) on measures used in the VBP arrangements b. Accurate and consistent information on patient attribution c. Information on patients requiring intervention and the frequency of that information 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)*	• PacificSource shares information on performance of measures used in Value Based Payment arrangements (when applicable). Beginning in June of the measurement year, monthly, information is shared as part of the provider risk arrangements. Reference 'DTP – Example Cap Dashboard.' • PacificSource also shares Quality Incentive Metric (QIM) reports. Reference 'DTP - QIM Tracking and Reporting,' and 'DTP - eCQM Tracking and Reporting.' • PacificSource utilizes a Member Insight platform to identify and report on gaps in care needing intervention. Reference 'Example – Member Insight Report.'	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	• PacificSource utilizes an internally developed platform called Member Insight to report each of the required population health elements. This report is shared with the applicable contracted provider through PacificSource's Provider Web portal, InTouch for Providers. Reference 'Example – Member Insight Report' and 'Screenshot - InTouch for Provider Links.' • PacificSource is currently developing a 'Care Program Identification Algorithm' to be available for internal use in 2020 and for external provider use in 2021. The algorithm combines claims based information used in Member Insight including gaps in care with EDIE/Premanage ED and Inpatient visits including history for new members, OPIP Childhood Complexity scoring, health risk assessment information, LACE Readmission algorithm, prospective risk information as well as other information to risk stratify members for care management programs.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

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 PSCS-Lane's Provider Capacity Reports were good with minimal data quality issues.

Table B-1—PSCS-Lane 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	91.5	100.0	
City	100.0		
Status of Medicaid Contract	100.0	100.0	
County	100.0		
Credentialing Date	93.4	100.0	99.3
DMAP (Medicaid ID)	99.9	91.2	

DSN Data Field	DSN Quality Metrics		
	% Present	% Valid Format	% Valid Values
Provider First Name	100.0		
Group/Clinic Name	100.0		
Non-English Language 1	3.3		
Non-English Language 2			
Non-English Language 3			
Provider Last Name	100.0		
Provider Network Status	100.0	100.0	
Provider NPI	99.9	100.0	100.0
Number of Members Assigned to PCPs	0.0	0.0	
PCP Indicator	100.0	100.0	
PCPCH Tier	34.8	100.0	
Phone Number	100.0		
Provider Category	100.0	100.0	100.0
Provider Service Category	100.0	100.0	100.0
Provider TIN	100.0	99.8	
Provider Taxonomy	100.0	100.0	100.0
Zip Code	100.0		

In general, all key DSN data fields in the individual practitioner capacity report were populated and contained valid formats and values. However, none of the provider records included information on number of members assigned to PCP. Overall, the average completeness across both required and conditional[B-1] data fields was 87.9 percent, and 100 percent when excluding conditional fields. Of note, only 3.3 percent of providers were associated with a non-English language.

Table B-2—PSCS-Lane 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		

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

DSN Data Field	DSN Quality Metrics		
	% Present	%Valid Format	% Valid Values
City	100.0		
Status of Medicaid Contract	100.0	100.0	
County	100.0		
DMAP (Medicaid ID)	99.2	98.6	
Facility NPI	99.3	100.0	99.8
Phone Number	100.0		
Provider Category	100.0	100.0	100.0
Provider Service Category	100.0	100.0	99.9
Facility TIN	99.3	99.7	
Facility or Business Taxonomy	99.3	99.6	99.6
Zip Code	100.0		

Overall, key DSN data fields in the facility and service provider capacity report were present and populated with valid formats and values. Overall, the average completeness across all data fields was 99.8 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—PSCS-Lane 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	2,576	23.1	1,617	62.8	959	37.2
Specialty Provider	5,473	49.1	4,061	74.2	1412	25.8
Dental Service Provider	145	1.3	120	82.8	25	17.2
Mental Health Provider	2,242	20.1	1,753	78.2	489	21.8
SUD Provider	152	1.4	70	46.1	82	53.9

Provider Specialty Category	Total		Contract Status = Yes		Contract Status = PEND	
	Number	Percent	Number	Percent	Number	Percent
Certified or Qualified Health Care Interpreters	1	0.0	1	100.0	0	0.0
Traditional Health Workers	557	5.0	212	38.1	345	61.9
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
Facility/Service Practitioners						
Hospital, Acute Psychiatric Care	7	0.6	4	57.1	3	42.9
Ambulance and Emergency Medical Transportation	123	11.2	118	95.9	5	4.1
Federally Qualified Health Centers	22	2.0	14	63.6	8	36.4
Home Health	13	1.2	6	46.2	7	53.8
Hospice	0	0.0	0	0.0	0	0.0
Hospital	38	3.5	28	73.7	10	26.3
Imaging	0	0.0	0	0.0	0	0.0
Indian Health Service and Tribal Health Services	9	0.8	5	55.6	4	44.4
Mental Health Crisis Services	18	1.6	15	83.3	3	16.7
Community Prevention Services	34	3.1	27	79.4	7	20.6
Non-Emergent Medical Transportation	1	0.1	1	100.0	0	0.0
Pharmacies	678	61.9	622	91.7	56	8.3
Durable Medical Providers	114	10.4	101	88.6	13	11.4
Post-Hospital Skilled Nursing Facility	22	2.0	15	68.2	7	31.8
Rural Health Centers	9	0.8	9	100.0	0	0.0
School-Based Health Centers	4	0.4	4	100.0	0	0.0
Urgent Care Center	4	0.4	3	75.0	1	25.0

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, PSCS-Lane's individual provider capacity demonstrated network coverage of required physical health (primary and specialty), oral health, and mental health and substance use disorder providers. Additionally, within the individual practitioner data three specialty categories were not represented—i.e., alcohol/drug providers; health education, health promotion, health literacy providers, and palliative care. Of the 17 required facilities and services, only two provider service categories had a count of zero—i.e., hospice and imaging services.

Provider Accessibility

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

Table B-4—PSCS-Lane 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	2,576	2,472	96.0	120	4.7
Specialty Provider	5,473	5,449	99.6	242	4.4
Dental Service Provider	145	67	46.2	29	20.0
Mental Health Provider	2,242	2,241	100.0	39	1.7
SUD Provider	152	152	100.0	2	1.3
Certified or Qualified Health Care Interpreters	1	1	100.0	1	100.0
Traditional Health Workers	557	557	100.0	19	3.4
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	**11,146**	**10,939**	**98.1**	**452**	**4.1**

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.

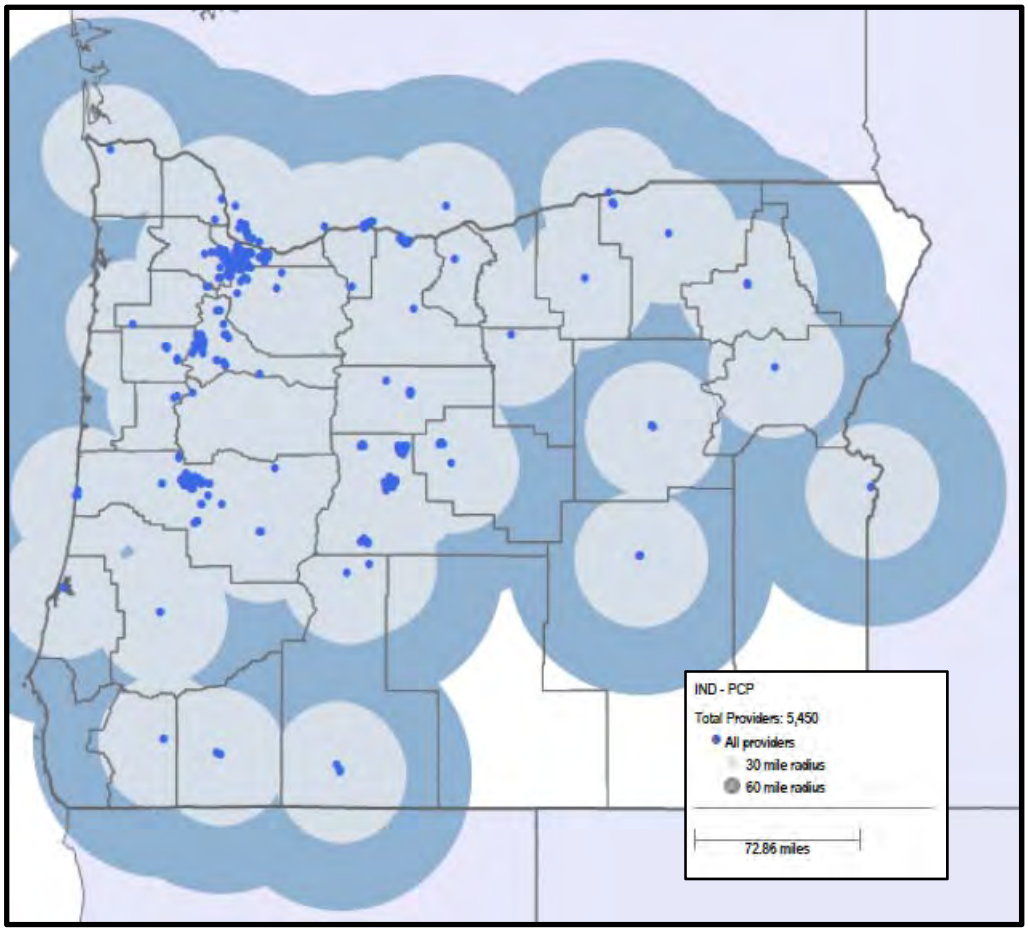
Overall, 98.1 percent of PSCS-Lane's provider network was accepting new patients. Of the core specialty categories, only dental providers had less than 90 percent of providers accepting new patients (i.e., 46.2 percent). Of its individual practitioners, PSCS-Lane identified 4.1 percent who spoke a language other than English. Overall, 4.7 percent of PCPs and 4.4 percent specialty providers were

associated with non-English language while 20.0 percent of dental providers indicated they spoke a non-English language.

Geographic Distribution

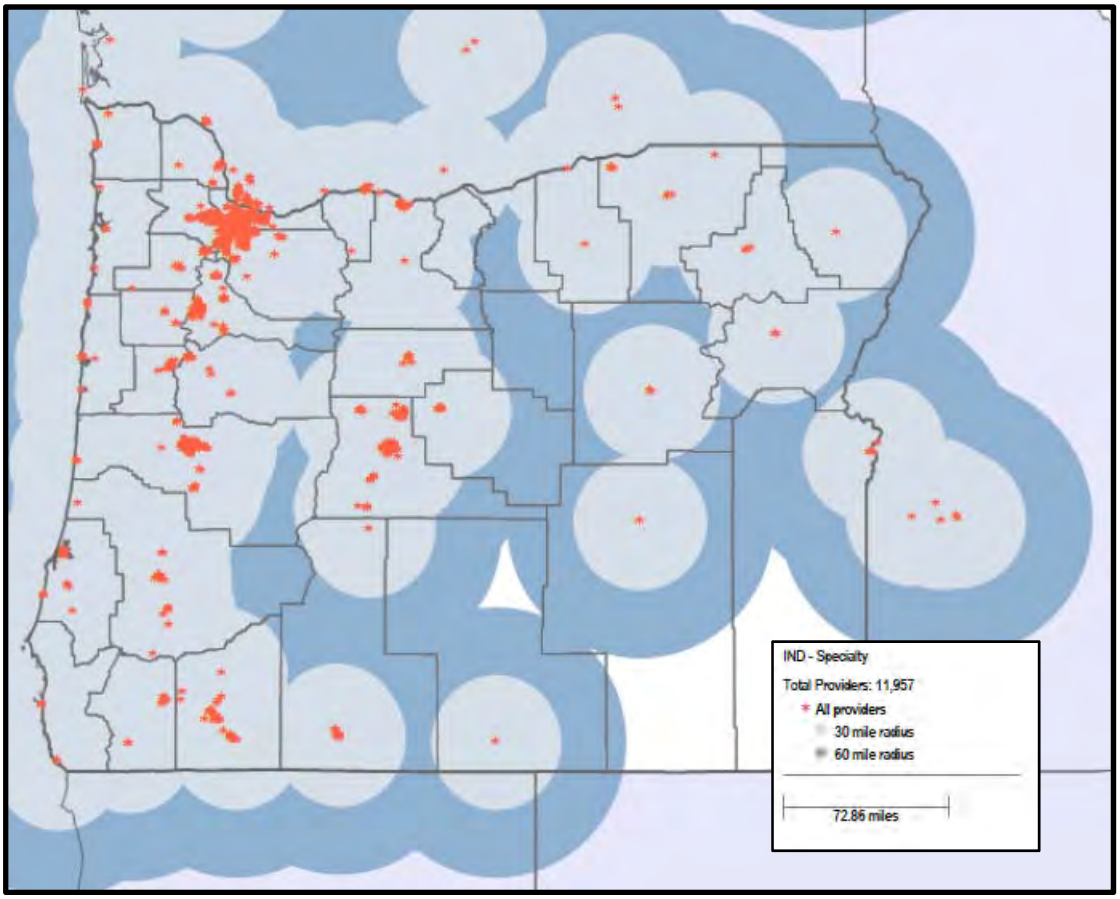
The geographic distribution of providers relative to member populations assessed whether or not the practitioner and facility locations were spread proportionately across the beneficiary population. Since beneficiary data was not available at the time of this analysis, the geospatial maps display the 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. All of the zip codes within PSCS-Lane's service area (i.e., Lane County) are classified as rural except for the area surrounding Eugene and Springfield, Oregon.

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



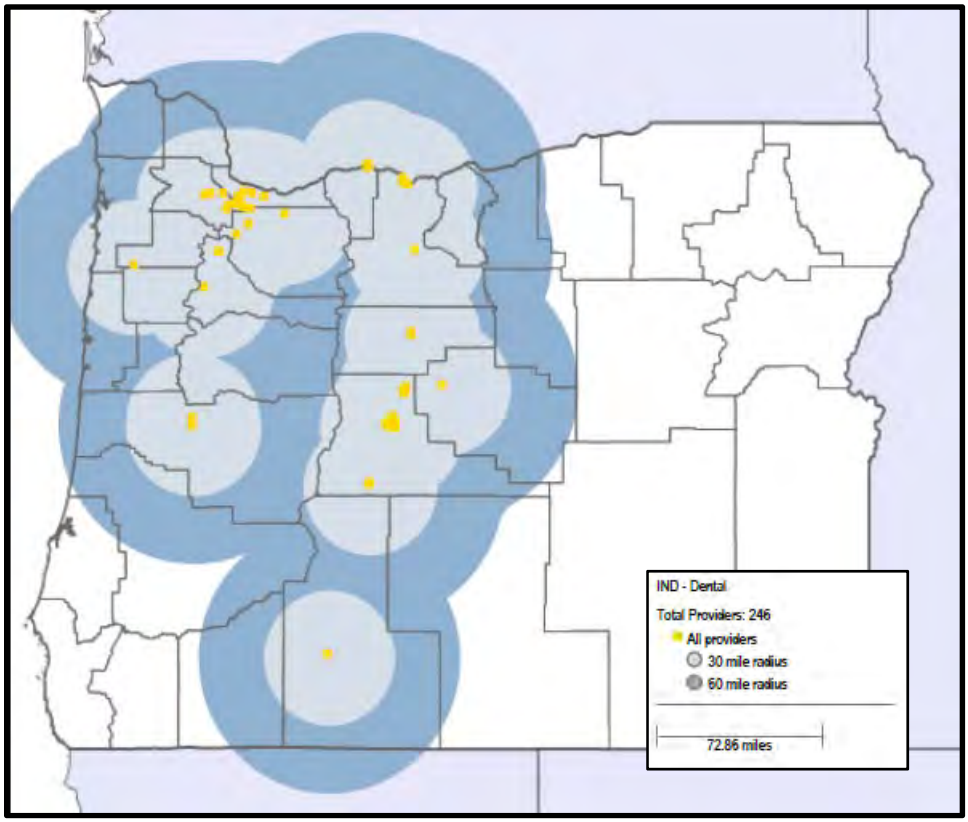
As shown in Figure B-1, the distribution of PSCS-Lane's network of PCPs is sufficient to cover the CCO's service area. All of the CCO's service area are within 30 miles of a primary care provider.

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



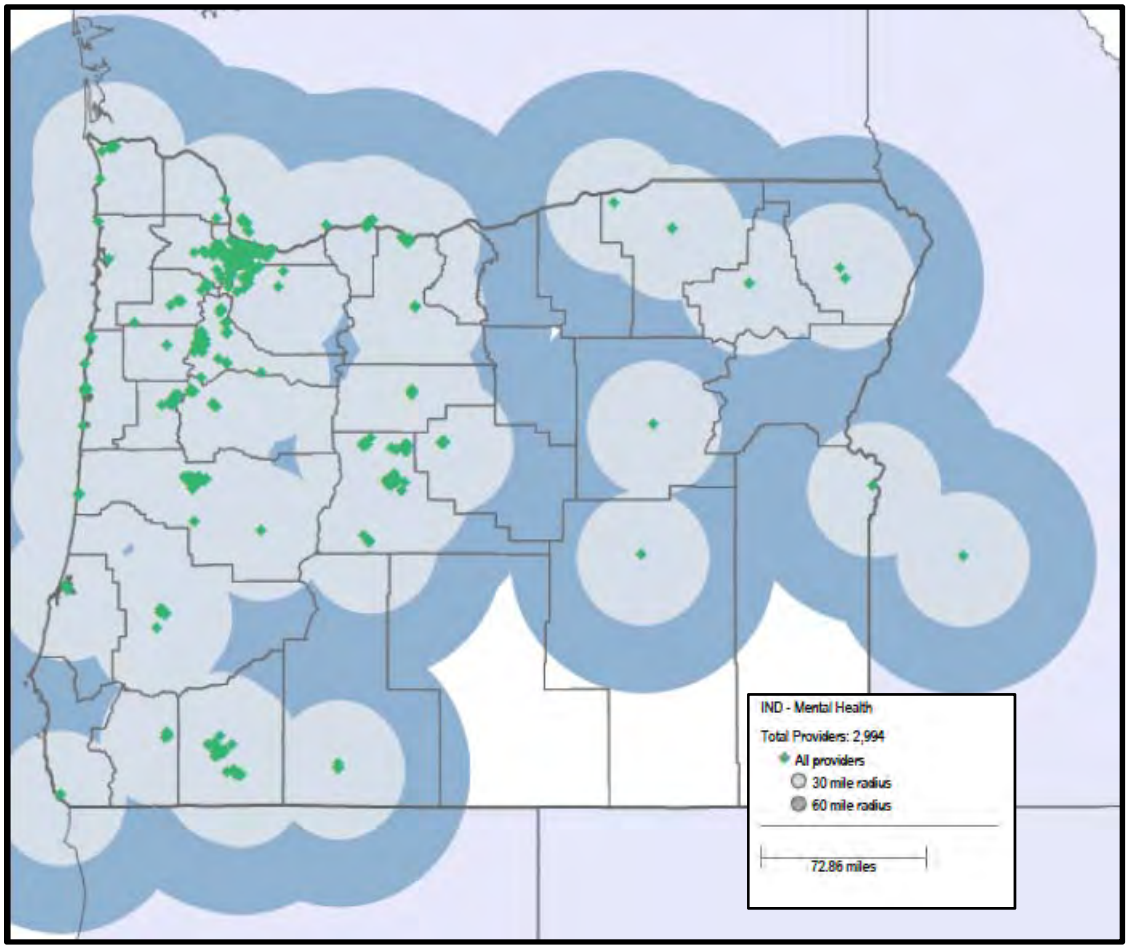
As shown in Figure B-2, the distribution of PSCS-Lane's specialty providers is sufficient to cover the CCO's service area. Most of the CCO's service area are within 30 miles of a specialty provider, and all areas are within 60 miles.

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



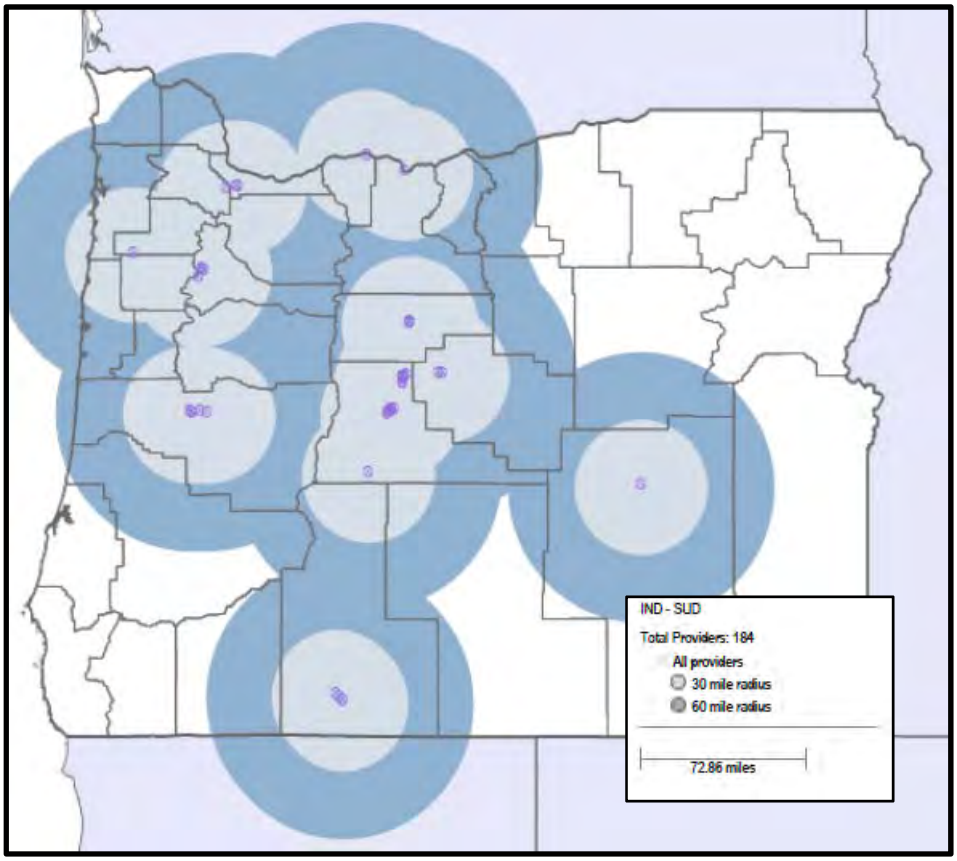
As shown in Figure B-3, the distribution of PSCS-Lane's dental service providers is sufficient to cover the CCO's service area. While urban locations in the CCO's service area are within 30 miles of a dental service provider, the entire county is within 60 miles of a dental provider.

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



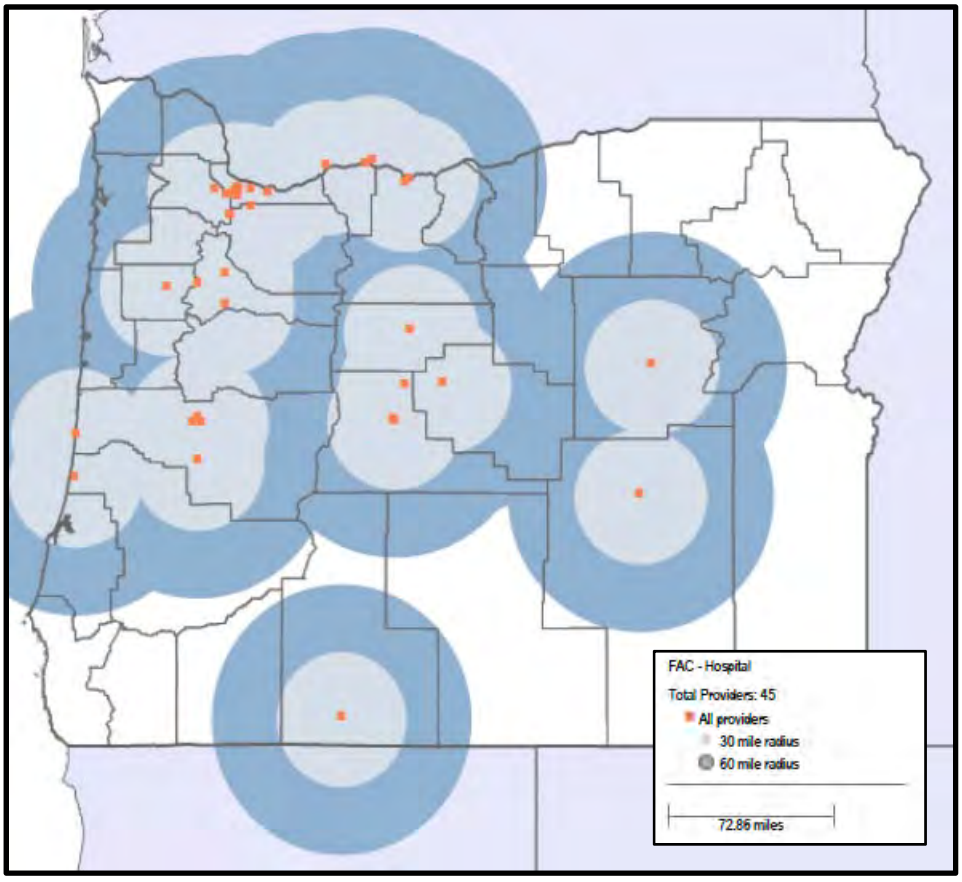
As shown in Figure B-4, the distribution of PSCS-Lane's mental health providers is sufficient to cover the CCO's service area. Nearly all of the CCO's service area is within 30 miles of a mental health provider, and all areas are within 60 miles.

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



As shown in Figure B-5, the distribution of PSCS-Lane's SUD providers is sufficient to cover the CCO's service area. While urban locations in the CCO's service area are within 30 miles of a SUD provider, the entire county is within 60 miles of a SUD provider.

Figure B-6—PSCS-Lane Phase 1—Geographic Distribution of Hospitals



As shown in Figure B-6, the distribution of PSCS-Lane's hospital facilities is sufficient to cover the CCO's service area. Most of the CCO's service area is within 30 miles of a hospital and all areas are within 60 miles.

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

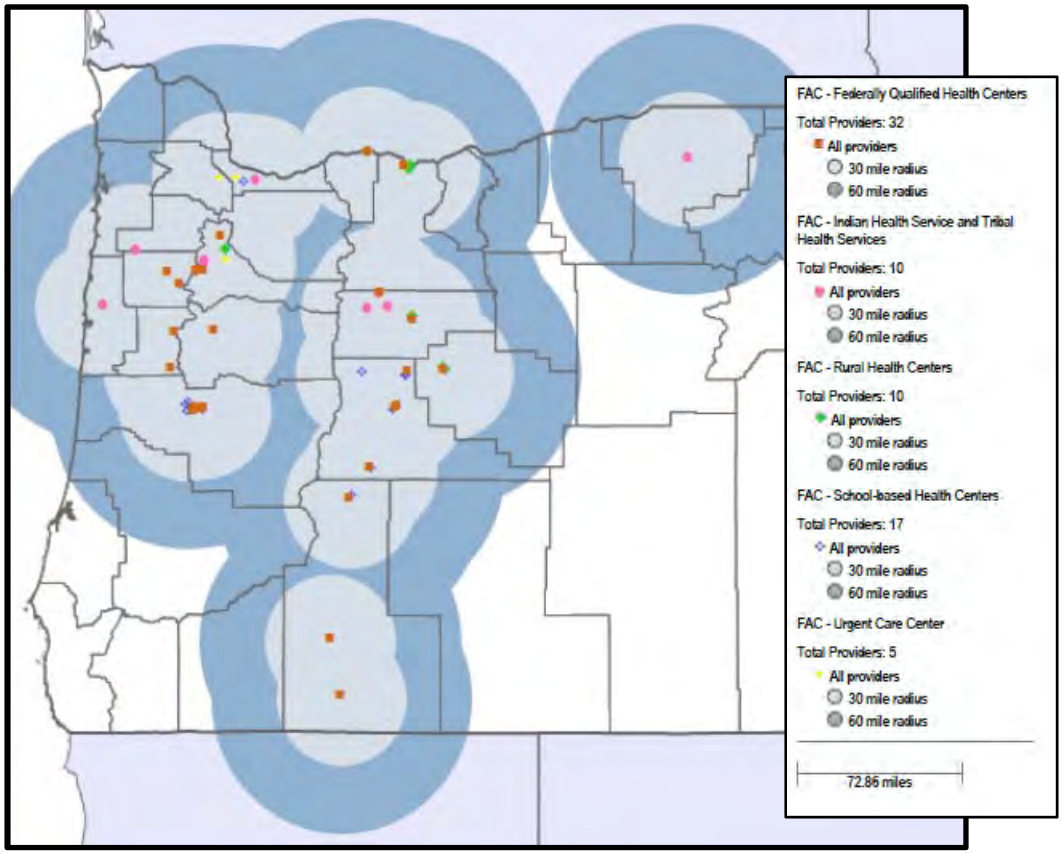


Figure B-7 displays the distribution of several clinic-based facilities within PSCS-Lane's service areas, including FQHCs, Indian Health Services and Tribal Health Services, Rural Health Centers, School-Based Health Centers, and Urgent Care Centers. The map shows that the distribution of clinic-based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

Appendix C. Phase 2 Evaluation Tool

[Pending completion of the Phase 2 RR]