Oregon Health Authority

2019 CCO Readiness Review

for

Advanced Health

September 2019

Interim Report

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Overview

Background

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

Methodology

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

Table 1-1—Readiness Review Activities and Timing

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

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

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

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

Phase 1—Critical Areas Readiness Review

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

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

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

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

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

Phase 2—Operations Policy Readiness Review

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

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

Results

This report documents results of the Phase 1—Critical Areas Readiness Review and (pending completion of Phase 2 of the RR) Phase 2—Operations Policy Readiness Review for Advanced Health (AH), 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.

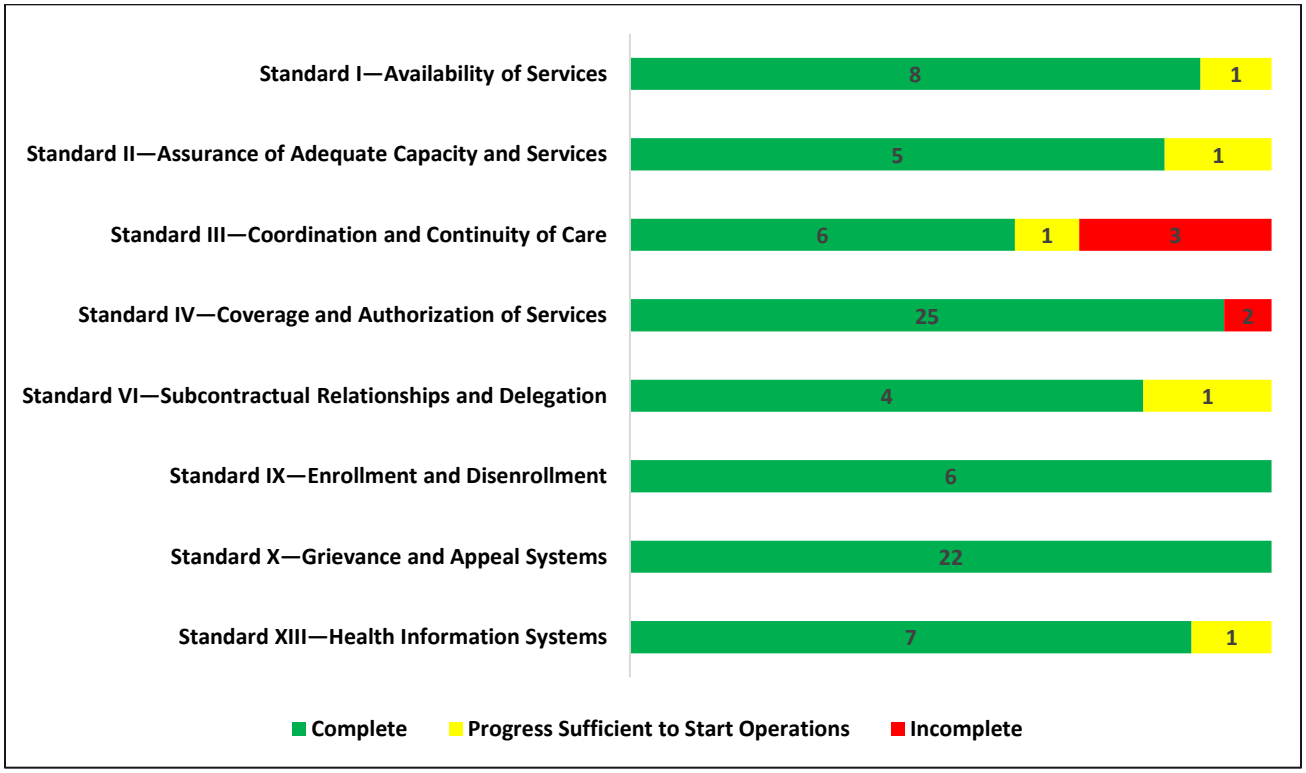
2. Phase 1 Results

Across all eight standards, AH's overall percentage of complete elements is 89.3 percent. The CCO demonstrated:

- *Complete* ratings for 83 of the 93 total elements.
- *Progress Sufficient to Start Operations* ratings for five elements across five standards.
- *Incomplete* ratings for five elements across two 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—AH Phase 1—Critical Areas Readiness Review Results



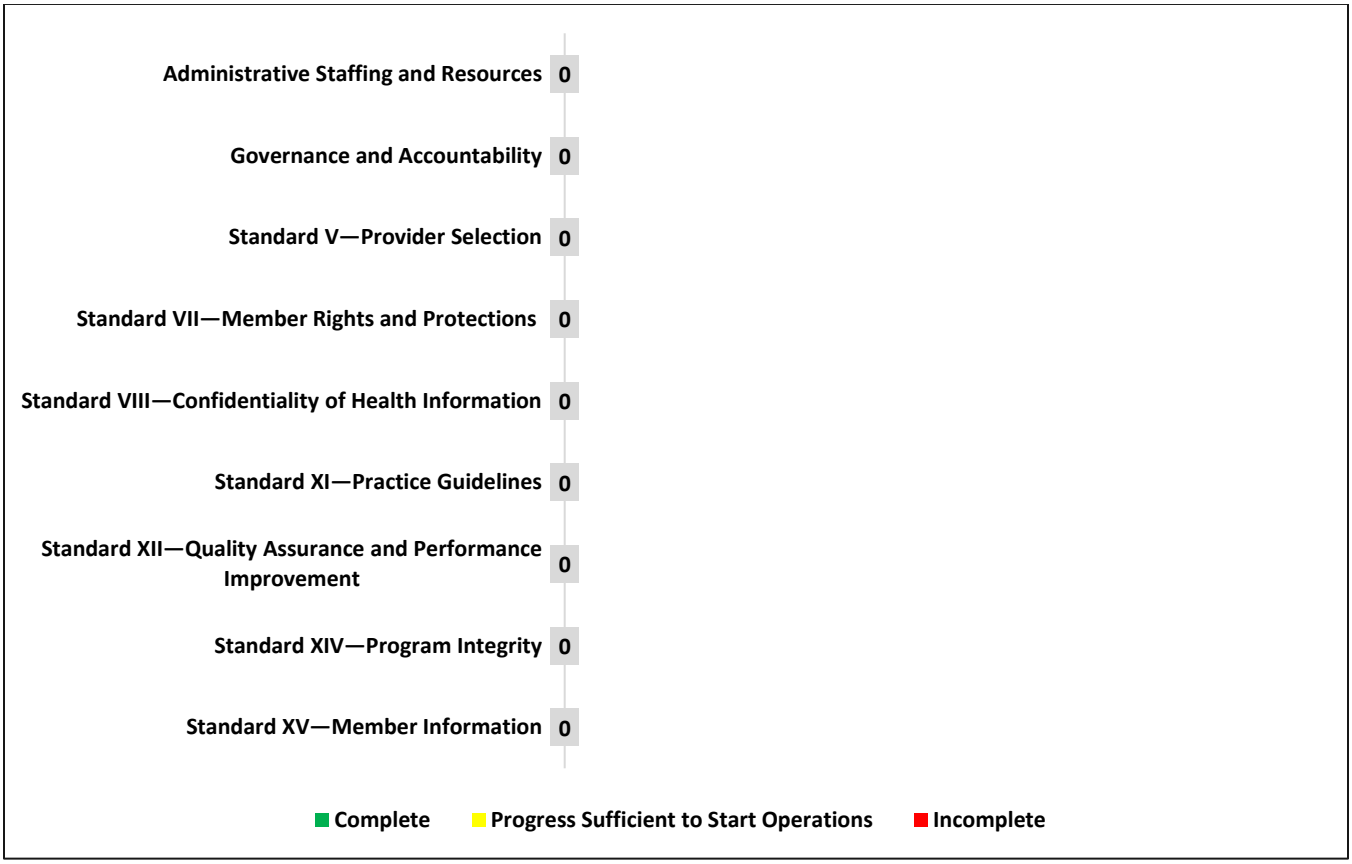
3. Phase 2 Results

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

Across all eight standards, AH'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—AH 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 AH'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)*	*See Availability of Services v2.pdf*, pg. 2, Section – 3.1	☒ 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)*	*See Availability of Services v2.pdf*, pg. 2, Section – 4.1 For evidence of sufficient network capacity, *See 2019 DSN Submission Report – Exhibit G.xlsx* and *See Advanced Health DSN Provider Narrative Report-6-2019.pdf*	☒ 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)*	*See Availability of Services v2.pdf*, pg. 2, Section – 4.2 *See* Member Handbook Screenshot – *Women's Health and Family Planning.png*, Section – Women's Health and Family Planning	☒ 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)*	*See Availability of Services v2.pdf*, pg. 2, Section – 4.3 *See Member Handbook Screenshot – Second Opinion.png*, Section – Second Opinions	☒ 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)*	*See Availability of Services v2.pdf*, pg. 2, Section – 4.4 *See Availability of Services v2.pdf*, pg. 2, Section – 4.4.a	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
6. The CCO demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services: a. In accordance with 42 CFR §431.51(b)(2), members shall not be restricted in freedom of choice of providers of family planning services. b. Therefore, members are permitted to self-refer to any provider for the provision of family planning services, including those not in the CCO's network. *42 CFR §431.51(b)(2)* *42 CFR §438.206(b)(7)* *Contract: Exhibit B Part 2 (6)(b)*	*See Member Handbook – Women's Health and Family Planning.png*, Section – Women's Health and Family Planning *See Availability of Services v2.pdf*, ¶ 4.5 *See Availability of Services v2.pdf*, pg. 3, Section – 4.5a *See Member Handbook – Women's Health and Family Planning.png*, Section – Women's Health and Family Planning *See Availability of Services v2.pdf*, pg. 3, Section – 4.5b	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
7. The CCO ensures its provider network observe the timely access to services provisions and complies with the following requirements: a. Meet and require its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. b. Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid Fee for Service (FFS), if the provider serves only Medicaid enrollees. c. Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary. d. Establish mechanisms to ensure compliance by network providers. e. Monitor network providers regularly to determine compliance. f. Take corrective action if there is a failure to comply by a network provider. *42 CFR §438.206(c)(1)* *Contract: Exhibit B Part 4 (2)(a)* *Contract: Exhibit B Part 4 (13)(b)(3), (4)*		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		
8. The CCO demonstrates that its network includes sufficient specialty behavioral health providers to ensure timely access to covered specialty behavioral health services for the following priority populations in accordance with the timeframes below,	*See Availability of Services v2.pdf*, pg. 3, Section – 4.7 For evidence of sufficient network capacity,	☐ Complete ☒ Progress Sufficient to Start Operations

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
with access prioritized in accordance with OAR 309-019-0135 and 410-141-3220. a. If a timeframe cannot be met due to lack of capacity, the member must be placed on a waitlist and provided interim services within 72 hours of being put on a waitlist. Interim services should be as close as possible to the appropriate level of care and may include referrals, methadone maintenance, compliance reviews, HIV/AIDS testing, outpatient services for substance use disorder, risk reduction, residential services for substance use disorder, withdrawal management, and assessments or other services described in OAR 309-019-0135. b. Pregnant women, veterans and their families, women with children, unpaid caregivers, families, and children ages birth through five years, individuals with HIV/AIDS or tuberculosis, individuals at the risk of first episode psychosis and the I/DD population: Immediate assessment and intake. If interim services are necessary due to capacity restrictions, treatment at appropriate level of care must commence within 120 days from placement on a waitlist. c. IV drug users: Immediate assessment and intake. Admission required within 14 days of request, or, if interim series are necessary due to capacity restrictions, admission must commence within 120 days from placement on a waitlist. d. Opioid use disorder: Assessment and intake within 72 hours. e. Medication assisted treatment: No more than 72 hours for assessment and induction, with efforts to do such as soon as possible.	*See 2019 DSN Submission Report – Exhibit G.xlsx* and *Advanced Health DSN Provider Narrative Report-6-2019.pdf* *See Availability of Services v2.pdf*, pg. 3, Section – 4.7a *See Availability of Services v2.pdf*, pg. 3, Section – 4.7b *See Availability of Services v2.pdf*, pg. 4, Section – 4.7c *See Availability of Services v2.pdf*, pg. 4, Section – 4.7d *See Availability of Services v2.pdf*, pg. 4, Section – 4.7e *See Availability of Services v2.pdf*, pg. 4, Section – 4.7f *See Availability of Services v2.pdf*, pg. 4, Section – 4.7g	☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
f. Children with serious emotional disturbance: Any limits that the Authority may specify in the contract or in guidance. g. Routine behavioral health care for other populations: Seen for an intake assessment within seven days from date of request, with second appointment within 14 days and 4 appointments (including the second appointment) within 48 days. Appointments must be therapeutic in nature and expand beyond administrative activities. *Contract: Exhibit B Part 4 (2)* *Contract: Exhibit M*		
HSAG Findings: The CCO's Availability of Services policy identified timeliness requirements for priority populations and its Contracting policy identified the inclusion of timely appointment monitoring, but there is no detail regarding how the monitoring is carried out or how providers are made aware of the requirements. There are no prescribed efforts to monitor timeliness outside of having some access to facilities and advocates in the community, and retrospective reviews of grievances and complaints.		
Required Actions: HSAG recommends that the CCO clearly identify how it will work with its provider community to ensure timeliness of specialty behavioral health services for priority populations, and ensure provider agreements include timeliness requirements.		
9. The CCO has written policies and procedures that ensure scheduling and rescheduling of member appointments are appropriate to the reasons for and urgency of the visit. The member shall be seen, treated, or referred within the following timeframes: a. *Well care:* Within four (4) weeks from the date of a patient's request. b. *Urgent care:* Within seventy-two (72) hours or as indicated in the initial screening for urgent care. c. *Emergency care:* Immediately or referred to an emergency department depending on the member's condition.	*See Availability of Services v2.pdf* pg. 4, Section – 4.8 *See* Advanced Health Contracting Policies and Procedures Manual.pdf ¶ 4(a)(i)(B)(4) *See* DSN Analysis section 1.3 pgs. 14-16 *Availability of Services v2.pdf*, pg. 4, Section – 4.8a Advanced Health – Privileged Provider Contract – Schedule A-1 – PP – SWOIPA.pdf, section I	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	*Availability of Services v2.pdf*, pt. 4, Section – 4.8.b *Advanced Health – Privileged Provider Contract – Schedule A-1 – PP – SWOIPA.pdf*, section I *Availability of Services v2.pdf*, pg. 4, Section – 4.8.c *Advanced Health – Privileged Provider Contract – Schedule A-1 – PP – SWOIPA.pdf*, section I *Availability of Services v2.pdf*, pg. 5, Section – 4.8.d *AH – Privileged Provider Contract – Schedule A-1 – Dental.pdf* *Availability of Services v2.pdf*, pg. 5, Section – 4.8.e Advanced Health – Privileged Provider Contract – Schedule A-1 – Dental.pdf *Availability of Services v2.pdf*, pg. 5, Section – 4.8.f *Advanced Health – Privileged Provider Contract – Schedule A-1 – Dental.pdf* *Availability of Services v2.pdf*, pg. 5, Section – 4.8.g	
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)*	*See* Availability of Services v2.pdf, pg. 5, Section – 4.9 *Advanced Health PS-8 – Provider Training Plan.pdf*	☒ 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*	*See* Advanced Health Assurance of Adequate Network Capacity Policy and Procedure; Pg. 2, Section – 3.1 As evidence of Advanced Health's most recent submission of documents to meet the State's requirements: *See Advanced Health DSN (Delivery System Network) Provider Narrative Report-6-2019* *See* 2019 DSN Submission Report - Exhibit G Advanced Health has also revised the Attachment 7 DSN provider files from the RFA process, incorporating the recommendations from HSAG's preliminary finding document. *See* Attachment-7-Facility-and-Service-DSN-Provider-File-8-1-2019.xlsx *See* Attachment-7-Individual-DSN-Provider-File-8-1-2019.xlsx	☒ 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:	*See* Advanced Health Assurance of Adequate Network Capacity Policy and Procedure; Pg. 2, Section – 3.2 As evidence of Advanced Health's most recent submission of documents to meet the State's requirements:	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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*	*See* Advanced Health DSN (Delivery System Network) Provider Narrative Report-6-2019 *See* 2019 DSN Submission Report - Exhibit G Advanced Health has also revised the Attachment 7 DSN provider files from the RFA process, incorporating the recommendations from HSAG's preliminary finding document. *See* Attachment-7-Facility-and-Service-DSN-Provider-File-8-1-2019.xlsx *See* Attachment-7-Individual-DSN-Provider-File-8-1-2019.xlsx	
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)*	*See* Advanced Health Assurance of Adequate Network Capacity Policy and Procedure; Pg. 3, Section – 3.3 *See* Advanced Health Assurance of Adequate Network Capacity Policy and Procedure; Pg. 3, Section: Special Notes to these Policies *See* Advanced Health DSN (Delivery System Network) Provider Narrative Report-6-2019 *See* 2019 DSN Submission Report - Exhibit G	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: The CCO's Assurance of Adequate Network Capacity policy and procedure addressed time and distance standards for adult and pediatric primary care, the services of Patient-Centered Primary Care Homes (PCPCHs), behavioral health providers, and oral health providers but it did not include obstetrician/gynecologist (OB/GYN) access. However, the DSN Provider Narrative discussed how OB/GYN services are underrepresented and the efforts taken to address OB/GYN access through new contracting arrangements with clinics that include gynecology providers.		
Required Actions: HSAG recommends that the CCO include OB/GYN access standards in its policy and identify how it addresses deficiencies.		

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
4. Adult & Pediatric Specialty Care Access Standards— Time and Distance: a. In urban areas - Thirty (30) minutes or thirty (30) miles from the personal residences of members. b. In rural areas – Sixty (60 minutes) or sixty (60) miles from the personal residence of members. *42 CFR §438.68* *42 CFR §438.206(c)(1)(i)* *Contract: Exhibit B (2)(a)*	*See* Advanced Health Assurance of Adequate Network Capacity Policy and Procedure; Pg. 3, Section – 3.3 *See* Advanced Health Assurance of Adequate Network Capacity Policy and Procedure; Pg. 3, Section: Special Notes to these Policies *See* Advanced Health DSN (Delivery System Network) Provider Narrative Report-6-2019 *See* 2019 DSN Submission Report - Exhibit G	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
See Advanced Health Assurance of Adequate Network Capacity Policy and Procedure; Pg. 3, Section – 3.3		
See Advanced Health Assurance of Adequate Network Capacity Policy and Procedure; Pg. 3, Section: Special Notes to these Policies		
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)*	*See* Advanced Health Assurance of Adequate Network Capacity Policy and Procedure; Pg. 3, Section – 3.3 *See* Advanced Health Assurance of Adequate Network Capacity Policy and Procedure; Pg. 3, Section: Special Notes to these Policies *See* Advanced Health DSN (Delivery System Network) Provider Narrative Report-6-2019 *See* 2019 DSN Submission Report - Exhibit G	☒ 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.	*See* Advanced Health Assurance of Adequate Network Capacity Policy and Procedure; Pg. 3, Section – 3.3 *See* Advanced Health Assurance of Adequate Network Capacity Policy and Procedure; Pg. 3, Section: Special Notes to these policies	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
42 CFR §438.68 *42 CFR §438.206(c)(1)(i)* *Contract: Exhibit B (2)(a)*	*See* Advanced Health DSN (Delivery System Network) Provider Narrative Report-6-2019 *See* 2019 DSN Submission Report - Exhibit G	

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)*	Advanced Health subcontracts case management through the PCPCH. Assignments will be made based on the Members PCP location and their specialty needs. (a) Members currently are notified by mail of their assigned PCP. Starting in 2020 for CCO 2.0, members will receive a letter welcoming them to their case management team. *See Primary Care Case Management Policies and Procedures.pdf*. *See* 4.1(a), 4.3, Attachment 9.6 (b) Transitions of care between MCO's are spelled out in the *Member Transition Plan.pdf*. Transitions of care for Advanced Health's policies and Procedures are in the *Primary Care Case Management Policy and Procedures.pdf*. See *Primary Care Case Management Policies and Procedures.pdf* 4.1(b)(iv)(f), 4.3 (a)(ii) and *Member Transition Plan.pdf* on levels of care 4.4(d). See *Member Transition Plan.pdf* sections 1-4.	☒ 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;	Advanced Health coordinates the services it furnishes to members: a. Coordination between settings of care is addressed in *Primary Care Case Management Policy and Procedure.pdf*. 4.1(b)(iv), 4.4(d), and *Care Coordination Policy and Procedures.pdf* 4.6(a)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	b. Procedure 4.1(b)(vi), 4.1(f), and Care Coordination with services members receive from other plans is addressed in *Primary Care Case Management Policy and Procedure.pdf* 4.6(b,c) c. Coordination between Advanced Health and FFS Medicaid is addressed in *Primary Care Case Management Policy and Procedure.pdf* 4.1(f), *Care Coordination Policy and Procedures.pdf* 4.6 (b,c). d. Critical to case management and care coordination are interface and coordination activities with community and social service providers. Advanced Health addresses this policy/procedure/function at: See *Care Coordination Policy and Procedures.pdf* 4.5 (d)(iii), 4.6(f)(g) See *Primary Care Case Management Policy and Procedure.pdf* 4.1(b)(i)(ii), 4.3 (g), 4.4(e) See *Member Transition Plan.pdf* sections 1-4.	
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)*	Currently, Advanced Health sends a Health Risk Assessment with a follow up phone attempt to all new enrollees within 90 days. To comply with CCO 2.0, Advanced Health will complete the requirement within 30 days with additional health risk screening questions to identify the special healthcare needs populations. See *Primary Care Case Management Policy and Procedures.pdf*. 4.3 (a, b, c, d) Attachment 9.1, 9.2, 9.3, 9.4(Flowchart)	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: According to the Primary Care Case Management policy and procedures, AH will contact all newly enrolled members to complete a health risk assessment (HRA) screening and will complete the HRA within 30 days of enrollment and annually thereafter, or within 10 days of provider referral. The HRA is either mailed to the member or completed over the phone. Customer service staff members and navigators will attempt to contact members no fewer than three times by two different methods (mail and phone) within 30 days. HSAG reviewed the current HRA tool being used by AH; it was very basic and only included seven "yes" or "no" questions. During the remote interview session, AH staff members stated that they will be revising the HRA and the process for the completion, tracking, and reporting of HRAs once they implement a new care management system. At the time of the remote interview session, AH had not yet selected a care management system.		
Required Actions: While AH has current processes to conduct the initial screening, HSAG recommends that the CCO create or adopt a more robust health risk screening tool to ensure adequate identification of newly enrolled members with special healthcare needs. In addition, HSAG recommends that the CCO revise its policies and procedures to be consistent with its final contract with OHA and the processes used once a new care management system has been implemented.		
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)*	See *Advanced Health - Privileged Provider Contract* ¶ 2.12.5 Pg.13 Advanced Health will ensure that all specialty and hospital providers are contracted to coordinate care with PCPCHs, refer for hospital and specialty services, and share medical records, as evidenced by an excerpt of its specialty provider contract (*Specialty Provider Contract Key Provisions.pdf* pgs. 9-15). i. See *Primary Care Case Management Policy and Procedures.pdf*. See 4.1 (b) for guidance regarding the patient centered primary care (*Primary Care Case Management Policy and Procedures.pdf*) and See *Care Coordination Policy and Procedures.pdf* 4.5(f), 4.6 (a)	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	ii. See "Utilization Review of Hospital Length of Stay" for the procedure regarding how facilities request hospital admission or specialty services *iii.* See *Primary Care Case Management Policy and Procedures.pdf*. See 4.4. *See Care Coordination Policy and Procedures.pdf* 4.5(f), 4.6 (a)	
HSAG Findings: AH provided a Privileged Provider agreement, which stated that the provider shall cooperate with AH with respect to all integration and care coordination activities undertaken pursuant to OAR 410-141-3160 and shall follow policies and procedures with respect thereto. AH also provided a Network Provider Agreement, which stated that the provider shall, to the extent possible, coordinate care with PCPCHs in a timely manner using electronic health information technology to the maximum extent feasible. Aside from that language, the provider agreements did not specify the process for requesting hospital admission or specialty services, or 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, but rather, contained general language that the provider would follow AH policies and procedures. This approach placed the burden on the provider to seek out the information and did not appear to meet OHA's intent for the provider agreement requirements.		
Required Actions: The CCO should update its service agreements with specialty and hospital providers to include all provisions as required in the contract with OHA.		
5. The CCO has processes in place to ensure that: a. Hospitals and specialty service providers are accountable for achieving successful transitions of care. b. Primary care teams are responsible for transitioning members out of hospital settings into the most appropriate, independent, and integrated care settings, including home and community-based as well as hospice and other palliative care settings. *Contract: Exhibit B Part 4 (9)*	*See* Advanced Health's *Primary Care Case Management Policy and Procedure.pdf*, 4.4(d)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	See *Care Coordination Policy and Procedure.pdf* Pg 8, 4.6 (b,c). Pg 7, 4.5 d(iv). See *Primary Care Case Management Policy and Procedure.pdf*. 4.1 (b)(vi) *Member Transition Plan.pdf*	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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)*	See *Advanced Health's HIPAA Privacy Manual.pdf* See *Care Coordination Policy and Procedure.pdf* Pg 8, 4.6 (g). See *Primary Care Case Management Policy and Procedure.pdf*. *See* 4.1 (e), 4.4(i)	☒ 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	See *Primary Care Case Management Policy and Procedure.pdf*. *See* 4.2 (b)	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete

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)*	See Attachment 9.3 of *Primary Care Case Management Policy and Procedures.pdf* for evidence of Advanced Health's Health Risk Assessment (HRA)	☐ NA
HSAG Findings: AH's Primary Care Case Management policy and procedures stated that members identified as having a special healthcare need or needing long-term services and supports (LTSS) will be referred to the appropriate Intensive Care Coordination/Exceptional Needs Care Coordination team for a higher level of care coordination. The policy only referenced the completion of the initial HRA for all newly enrolled members and did not document any processes for the completion of the comprehensive assessment. During the remote interview session, AH staff members stated that they do not have processes in place yet to conduct the assessment and have not selected the care management system AH will implement. In addition, AH staff members stated that they may delegate completion of some of the comprehensive assessments to the PCPCHs.		
Required Actions: The CCO should implement policies, procedures, systems, and tracking mechanisms to conduct a comprehensive assessment on each member identified as needing LTSS or having a special healthcare need. In addition, if the CCO chooses to delegate this function to PCPCHs, the CCO should execute subcontractor/delegation agreements as the completion of the comprehensive assessment is a required managed care function.		
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)*	See *Primary Care Case Management Policy and Procedures.pdf*. *See* 4.2 (b), 4.3(c)(ii) See Care Coordination Policy and Procedures.pdf 4.3(b,c), 4.5(d)	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA
HSAG Findings: While the CCO provided two care coordination policies, they were general in nature and did not explain the processes used by the CCO to conduct the required care coordination activities. During the remote interview session, CCO staff members stated that they plan on revising the policies and procedures once AH selects and implements a care management system.		
Required Actions: The CCO should revise policies and procedures to include specificity as to how the CCO identifies, assesses, and produces a treatment plan for each member identified as having a special healthcare need.		

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

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Required Actions: None.		
13. For members with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, the CCO must have policies or procedures in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. *42 CFR §438.208(c)(4)* *Contract: Exhibit B Part 4 (2)(f)(2)*	See *Care Coordination Policy and Procedure.pdf* Pg 7, 4.4 (d). See *Primary Care Case Management Policy and Procedures.pdf*. *See* Pg 7, 4.4 (b) See *Covered and Non-Covered Services Policy.pdf* in Standard "Coverage and Authorization of Services" pg. 2, ¶ 9,	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care	
	Total #
Complete	**6**
Progress Sufficient	**1**
Incomplete	**3**
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)*	Advanced Health, in accordance with 42 CFR 428.210, and in accordance with State contract, provides covered services that are consistent with benefits received through Fee-For-Service Medicaid, are sufficient in amount duration and scope to reasonably achieve the purpose for which services are furnished. *See Utilization Review Policy.pdf* which provides an outline of State rules and the Contract, see pg. 1, paragraph 1 of this policy. *See Utilization Review Policy.pdf* pg. 3, paragraph 3 noting that Utilization Reviewers follow policy stating services will not be arbitrarily denied or reduced because of diagnosis, type of illness, or condition of the beneficiary.	☒ 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	Advanced Health allows application of appropriate limits, such as medical necessity or utilization control, on services by following the basis of criteria applied under the State plan. Any limits set will take into consideration the Member's needs, any ongoing or chronic conditions or those Members requiring long-term services and supports to ensure services furnished are in an amount the will reasonably achieve their purpose. *See Utilization Review Policy.pdf*, which provides an outline of State rules and our Contract with the State to make this clear to staff. 2 a & b (i) (ii) (iii): *See* pg. 1, paragraph 1	☒ 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*		
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)*	Advanced Health will comply with restrict or limit treatment authorizations, payment of claims, or amount of treatment authorized in a way that is classified separately or more restrictive than medical/surgical benefits. *See Covered and Non-covered Services Policy.pdf* Pg 1, Paragraph 3. Advanced Health adheres to the referenced policies and procedures and communicates those standards to utilization review staff, as evidenced by Advanced Health's favorable NQTL mental health parity assessment (*Advanced Health NQTL Analysis.pdf*)	☒ 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)*	In accordance with federal regulations CFR § 438.905 and CFR § 438.910, Advanced Health will not impose aggregate lifetime spending limits on mental health or substance abuse treatment. *See Covered and Non-covered Services Policy.pdf* Pg 1, Paragraph 3.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
5. The CCO must furnish medically necessary services as defined in the Contract and in a manner that:	Medically necessary services will not be more restrictive than the State Medicaid programs,	☒ Complete

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	including quantitative and non-quantitative treatment limits as indicated in State statutes and regulations, the State Plan, and other State policy and procedures. Such services will be covered to address prevention, diagnosis, treatment of a member's disease, condition, and/or disorder that results in health impairment and /or disability. Allowing members to achieve age-appropriate growth and development and to attain, maintain, or regain function capacity. The following Policy provides an outline of State rules statutes and regulations for staff to follow: *See Covered and Non-Covered Services Policy.pdf* 5a: *See* page 1 paragraph 1, 5b (i) (ii) (III): *See* page 1, paragraph 2	☐ 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. 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	Advanced Health receives Prior Authorization (PA) service requests from providers seeking approval for services to be rendered. PAs are received and reviewed for initial and continuing services. All PAs are reviewed following a consistent mechanism. *See* Utilization Review of Prior Authorization Requests Procedure, which provides guidance to seasoned and new reviewers to ensure a consistent application of reviewed criteria for authorization decisions. All review staff have the ability to consult with the requesting provider when needed and as	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	appropriate. *See Utilization Review of Prior Authorization Requests Procedure.pdf*: 6 a & b: pg. 2, "Utilization Reviewer (UR)" 6 c: pg. 2, paragraphs 2 and 3, highlighted in yellow; pg. 2, "Newly employed UR personnel", ensures new reviewers are supported while learning the review process and State guidelines.	
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)*	The utilization management of services at Advanced Health are structured to promote Member's health by taking into consideration the Member's needs while reviewing prior authorization requests. No incentives are provided to our provider network or internal employees when utilization controls are administered. *See Utilization Review Policy.pdf* indicating how this policy informs the reviewers of this rule; 7: *See Utilization Review Policy.pdf*, pg. 2, paragraph 6, which outlines the rules for our staff reviewers. *See Utilization Review of Prior Authorization Requests Procedure.pdf*, page 2, paragraph 1, (under the Utilization Reviewer tool bulleted list) - this instructs reviewers to consider any treatment for a condition that is below the funding line, for any member, to determine if this will lead the reviewer to approve and cover the requested treatment or services; thus, indicating that our focus of reviewing is to work to approve, not to inappropriately deny, limit or discontinue medically appropriate services.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
8. The CCO operates a drug utilization review program that complies with the requirements described in section 1927(g) of the Act and 42 CFR part 456, subpart K. *42 CFR §438.3(s)(4)* *Contract: Exhibit B Part 2 (4)(g)(2)*	Advanced Health operates a drug utilization review (DUR) program that complies with the requirements of 1927(g) of the Social Security Act and 42 CFR part 456, subpart K. The Advanced Health Pharmacy and Therapeutics committee fulfills the regulatory requirements of the DUR board. The Advanced Health DUR program consists of retrospective and prospective DUR and an educational component for pharmacists and providers. DUR reports are reviewed by the Committee no less than quarterly, and a report is submitted to the Oregon Health Authority containing required information as specified by the State or federal regulation annually. *See Pharmacy and Therapeutics Committee Charter.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)*	Advanced Health reviewers immediately notify the requesting provider of any decision to their requested service via fax. A decision that leads to a denial of a service authorization request, or an authorization of a service in an amount, duration, or scope that is less than requested, the review will fax the provider an Authorization Letter, which includes a "Note Line" describing the reason for the reduction or denial. The member is also notified of such a decision through a Notice of Adverse Benefit Determination Letter. *See Notice of Adverse Benefit Determination – Policy.pdf*: 9) pg. 1, paragraph 1, describing the rule requirement 42 CRF 438.404.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	See Utilization Review of Prior Authorization Request-Procedure.pdf, pg. 2, paragraph 3, which states the process the reviewer must take to inform the requesting provider and the enrollee. See *NOA Letter Summary Sample.pdf*, *Monthly Auth Audit Sample.pdf*, and *Monthly Authorization Audit Process.pdf*. These reports review all Denied and Modified codes entered in the review process. These reports are reviewed daily to ensure the NOA Letter are sent to our members in a timely manner following State rules. Advanced Health also performs a Monthly Authorization Audit, which randomly assesses 60 authorizations to ensure quality within our process of notifying our providers and our enrollees of any adverse decisions.	
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;	Advanced Health utilizes a Notice of Adverse Benefit Determination Letter, consistent with the provisions under 42 CFR 438.10, which was created with the guidance of our 2 Community Advisory Councils (CAC). With approval through the State, NOA Letter supports our members in understanding why a decision to reduce or deny a requested service or treatment was made and how they can Appeal the decision. Please view our ***Notice of Adverse Benefit Determination-Policy.pdf,*** under **Policy heading** highlighted in **yellow**, which lists all items necessary	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
f. Date of the service or date service was requested by the provider or member; g. Name of the provider who performed or requested the service; h. Effective date of the adverse benefit determination if different from the date of the notice; i. Whether the CCO considered other conditions if the service was below the funding line of the OHP Prioritized List of Health Services; j. The reasons for the adverse benefit determination, including reference to the specific statutes and administrative rules to the highest level of specificity for each reason and specific circumstances identified in the notice that include, but is not limited to: k. The right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. l. The member's right to request an appeal with the CCO within 60 days of the CCO's adverse benefit determination, including information on exhausting the CCO's one level of appeal described at §438.402(b) and the right to request a 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	to meet the provisions under the State rule and to guide our internal staff.	

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
in 410-141-3230; and the procedures for exercising these rights described in 410-141-3245. m. The circumstances under which an appeal process can be expedited and how to request it. n. The procedures for exercising the rights specified in this standard. o. The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the member may be required to pay the costs of these services. *42 CFR §438.404(b)* *Contract: Exhibit I (3)(b)*		
11. For standard authorization decisions, the CCO shall provide notice as expeditiously as the member's condition requires and within 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days: a. The member, or the provider, requests extension; or b. The CCO justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest. *42 CFR §438.210(d)(1)(i-ii)* *Contract: Exhibit B Part 2 (3)(h)*	Standard authorization requests are always considered for the possibility of an expedited review. The Pending Team will review the request and consider the enrollee's diagnosis and requested service. If Pending Team member believes reviewer should be concerned then the reviewer receives notification and the authorization is identified with a "Red Box." This process allows the reviewer to review the request ahead of other PAs in their work queue and to determine if there is a need to expedite their decision. If the reviewer believes the request is a Standard request then the State rule and Contract are followed as such. Please view our: ***Timeframe for Decision – Policy.pdf*, page 1 titled Standard Authorization Decision,** which supports 11 a & b in guiding the reviewer in the process.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	If the primary reviewer is out of the office a back-up team member or the Manager of Medical Services will ensure a timely review of the authorization request.	
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)*	As the Pending Team receives an Expedited Request they notify the reviewer, create a Status of "1" to indicate High Priority and place a "Red Box" next to the authorization number. The reviewer then follows the State Rule for Expedited review. Please see ***Timeframe for Decision-Policy.pdf*, page 2 titled Expedited Authorization Decision,** which supports our reviewers in understanding the State rule and meets required action 12 a. If the primary reviewer is out of the office a back-up team member or the Manager of Medical Services will ensure a timely review of the authorization request.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
13. For all covered outpatient drug authorization decisions, provide notice as described in section 1927(d)(5)(A) of the Act. a. Provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization. *42 CFR §438.210(d)(3)* *Sec. 1927. [42 U.S.C. 1396r-8] (d)(5)(A)* *Contract: Exhibit B Part 2 (3)(j)*	Advanced Health responds to outpatient drug prior authorization requests, including provider administered drugs (PAD), within 24 hours of receipt consistent with state and federal requirements. *See Pharmacy Authorization Requests- Timeframes Policies and Procedures.pdf*: Policies and Procedures sections 3.0 and 4.0.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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. – 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.	Advanced Health will provide notice at least ten (10) days before the date of action for reduction, suspension, or termination of a previously authorized Medicaid-covered service. A Notice of Action can be mailed less than ten days prior to but not later than 10 days prior to the date the Adverse Benefit Determination takes effect. Please see our policy: ***Notice of Adverse Benefit Determination.pdf,*** **meeting required action 14 (page 2 in blue highlight).** This policy provides guidance to Pending Team member responsible for mailing the NOABD Letter. If probable member fraud has been verified, Pending Team Member will be notified and instructed to generate a NOABD Letter to be mailed not less than 5 days before the date of the Adverse Benefit Determination when facts are verified, if possible through secondary sources. Please review ***Notice of Adverse Benefit Determination-Policy.pdf,*** **page 2 last bullet on the page**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	Advanced Health covers Emergency Services without a Prior Authorization requirement or limits on what constitutes an Emergency Medical Condition, on the basis of diagnosis or symptoms of the member. Thus allowing the immediate medical or dental care to our members without concern of whether or not the qualified provider is in our network. Please review our ***Crisis, Urgent and Emergency Services – Policy.pdf,*** page 2 titled **Emergency services,** which provides our reviews an understanding that all emergency services are covered to evaluate and stabilize our member.	☒ 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)*	Advanced Health covers Post-stabilization Care Services without a prior authorization. Such services are in our member's best interest whether in network out of network. Post Stabilization Services maintains, improves, or resolves our Member's stabilized condition. The below policies allow our reviewers a resource to understand the importance of these services without any barriers to our members care toward stabilization of their health. • ***Crisis, Urgent and Emergency Services - Policy.pdf*** 16) **page 2 titled Post-stabilization** • ***Post Stabilization Care Services- Policy.pdf*** 16) met with entire document	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
17. The CCO: a. Covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the CCO; and b. Does not deny payment for treatment obtained under either of the following circumstances: i. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes 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)*	Advanced Health does not require a prior authorization for emergency services. We will not deny, but must pay for a claim for Emergency Services, regardless of whether the Provider that furnishes the services has a contract with Advanced Health. We will not deny payment for treatment obtained with a Member has an Emergency Medical or Dental Condition, this includes cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of Emergency Medical or Dental Condition. All emergency services are available to our members without barrier to their care. To support our position and our staff's understanding please review to our internal policy: ***Crisis, Urgent and Emergency Services Policy.pdf*, page 1 paragraph 1 below the Policy heading.**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ 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)*	All emergency services are available to our members without barrier to their care. Advanced Health does not require a prior authorization for emergency services. To support our position and our staff's understanding please review to our internal policies: • ***Crisis, Urgent and Emergency Services Policy.pdf*** 18a) page 1 in green • ***Covered and Non-Covered Services Policy.pdf*** 18b) page 2 paragraph 3 under **Policy Title green**	☒ 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)*	All emergency services are available to our members without barrier to their care. Advanced Health does not require a prior authorization for emergency. The Member seeking emergency medical care shall not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the member. To clearly support our staff please review our internal policy: ***Covered and Non-Covered Services Policy.pdf*** 19) page 2 paragraph 3 under **Policy Title** in blue	☒ 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)*	All emergency services are available to our members without barrier to their care. Advanced Health does not require a prior authorization for emergency services and the attending emergency physician is looked at as the provider actually treating the member and responsible for determining when the member is stable. Based on this criteria Advance Health is responsible for payment. Please review: ***Crisis, Urgent and Emergency Services-Policy.pdf*** 20) page 1 2nd paragraph under **Policy Title** in blue showing clear indication of our commitment to provide barrier free emergency care to our members.	☒ 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	Advanced Health covers Post-stabilization Care Services without a prior authorization. Such services are in our member's best interest whether in network out of network. Post Stabilization Services maintains, improves, or resolves our Member's stabilized condition. The below policies allow our reviewers a	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
within or outside the CCO's network that are pre-approved by a plan provider or other organization representative; b. The CCO is financially responsible for post-stabilization care services obtained within or outside the CCO's network that are not pre-approved by a plan provider or other organization representative, but administered to maintain the member's stabilized condition within 1 hour of a request to the CCO for pre-approval of further post-stabilization care services; c. The CCO is financially responsible for post-stabilization care services obtained within or outside the CCO's network that are not pre-approved by a plan provider or other organization representative, but administered to maintain, improve, or resolve the member's stabilized condition if: i. The CCO does not respond to a request for pre-approval within 1 hour; ii. The CCO cannot be contacted; or iii. The CCO's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the CCO must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in §422.113(c)(3) is met. 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	resource to understand the importance of these services without any barriers to our members care toward stabilization of their health. The following Policy makes this clear to staff: ***Post Stabilization Care Services – Policy.pdf*** 21a) page 1 paragraph 1 under **Policy Title** yellow 21b-d) under **Policy Title** in blue	☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*		
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)*	Advanced Health does not require a Prior Authorization for post-stabilization services, regardless of whether the Member obtains the services within our network area. Our **Post *Stabilization Care Services-Policy.pdf*** reviews the State Rules providing a clear understanding of when Advanced Health is no longer financially responsible for post stabilization care services, that have not been pre-approved. **Please view:** **page 2 last paragraph in yellow**	☒ 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)*	Advanced Health has incorporated its policies and procedures related to member NEMT requests and approval, scheduled, assigning, and dispatching of providers into its Privileged Provider Contract with Bay Cities Brokerage, our NEMT provider. Please refer to "*AH- Privileged Provider Contract – Schedule A-1 – NEMT.pdf*" pg.4 in green Please also review the following internal workflow from Bay Cities Brokerage describing their authorization, approval, scheduling, assigning, and	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	dispatching process for member who are on Advanced Health: "In the Trip Booking screen, verify that the appointment is an approved and OHP covered service. Is the appointment an OHP Covered Service? If YES: Proceed to scheduling transport If NO: Advise the client that the appointment is not covered by OHP and issue a denial using the Policy 104 – DENIAL of Service - Fill out all the information required by TripSpark and SAVE the trip so that the system may assign the BOOKING-ID, which is a unique number for tracking purposes. Did the BookingID generate when you saved the trip? If YES: Move on to assigning to a provider If NO: Notify Brokerage Administrator to have the trip regenerated so a BookingID will be assigned. - Once you have a completed trip on Tripspark, the Scheduling CSR will assign the transport to a provider using the scheduling module.	

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Once the trip is selected, the scheduling module will automatically take into account the mileage and the provider's rates and will generate the cheapest 5 providers with their Itineraries to avoid over-booking. o Once the lowest cost provider is selected, the scheduler will then assign the transport to the cheapest provider. Out of Town Transports: -Clients who are requesting Out of Network Transport will need to have the following verifications complete - Fill out the appropriate "bid" sheet with all appointment information - Call expected facility and verify that the client does indeed have an appointment on the requested date and time - If appointment is verified, document who you spoke with under edit booking and on the bid sheet -If appointment cannot be verified notify the member that the appointment cannot be verified and we	

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	cannot schedule the booking until the transport can be verified with the doctor's office. -Once trip has been authorized, schedule using Manage Bookings screen and complete the trip -Upon the completed scheduling, the brokerage must call 3 providers and obtain bid prices from and then whichever provider wins the overall bid will receive the ride information. "	
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)*	Advanced Health has incorporated details and expectations for the NEMT Call Center into its Privileged Provider Contract with Bay Cities Brokerage, our NEMT provider. Please refer to "*AH- Privileged Provider Contract – Schedule A-1 – NEMT.pdf*" pg.1 in yellow	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
25. The CCO has written policies and procedures for Emergency Dental Services and Urgent Care Services for Emergency Dental Conditions that describe when treatment of an 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)*	Advanced Health coordinates and preauthorizes Dental Services that must be performed in an outpatient Hospital, ASC, due to the age, disability or medical condition of the member. Reviewer of authorization requests ensures Dental Provider aware of all emergency and urgent dental care by calling Advantage Dental Customer Service to ensure coordination of care. Please see our internal policy: ***Urgent and Emergency Dental Services Policy.pdf,*** **page 1 and 2 all yellow highlights,** which provides the reviewing staff guidance on when services are performed in a dental office setting or as Hospital dentistry.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	*See Crisis, Urgent and Emergency Services Policy.pdf* Pg 2 in grey highlights.	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA
HSAG Findings: The CCO's Crisis, Urgent and Emergency Services policy included a definition of "crisis line" and "mobile crisis outreach team." It did not, however, describe the CCO's processes to ensure member access to these services.		
Required Actions: The CCO should develop a written policy and procedure pertaining to this requirement. The policy should include information regarding member access to an emergency response system that provides immediate, initial, or limited duration responses for emergency behavioral health situations.		
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)*	*See Crisis, Urgent and Emergency Services Policy.pdf* Pg 2 in grey highlights.	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA
HSAG Findings: The CCO's Crisis, Urgent and Emergency Services policy included a definition of "mobile crisis outreach team." It did not, however, describe the CCO's processes to ensure member access to these services.		
Required Actions: The CCO should implement a process to ensure that all members have access to mobile crisis services.		

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

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. Notwithstanding any relationship(s) that the CCO may have with any subcontractor, the CCO maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. *42 CFR §438.230(b)(1)* *Contract: Exhibit B Part 4(13)*	Advanced Health enters into certain "Privileged Provider Agreements" with selected entities ("Privileged Providers" referred to in this tool as "subcontractors") that qualify, based on pre-contractual evaluation, for the "privilege" of carrying out certain Advanced Health duties under Monitoring by Advanced Health. Regardless of this arrangement, Advanced Health retains ultimate responsibility for these activities. See Advanced Health Contracting Policies and Procedures Manual, § E(1)(a)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
2. All contracts or written arrangements between the CCO and any subcontractor must be submitted to OHA annually and within 30 days of addition of a subcontractor and must include: • The delegated activities or obligations, and related reporting responsibilities. Contractor shall not fully subcontract the provision of Behavioral Health services and Care Coordination to another entity. • The subcontractor agreement to perform the delegated activities and reporting responsibilities specified in compliance with the CCO's obligations. • The contract or written arrangement must either provide for revocation of the delegation of activities or obligations or specify other remedies in instances where the State or CCO determine that the subcontractor has not performed satisfactorily.	The privileges that may be delegated do not include the provision of Behavioral Health or Care Coordination. See Privileged Provider Agreement, Schedules E1, E2, E3, E4 and E5. Privileged Provider Agreement, §§ 2.1, 2.3.2 Privileged Provider Agreement, §§ 2.3.3; 5.2.4, 5.4, pg. 21 and 5.7 Advanced Health's Privileged Provider contracts and contain all of the specifically required provisions as outlined in Sec. 12 of Ex. B, Part 4, as follows: (a) termination and remedial action: §§ 5.2, 5.4, 5.7 (b) revocation of delegation: § 2.3.3 (c) payments and withholds: §§ 7.1, 8.1.2, and Schedules for each Privileged Provider, which will set forth the compensation and comply with the applicable requirements.	☐ 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)*	(d) Valid Claims: §§ 2.11; 3.3. (e) applicable Law: § 2.10; Schedule D. (f) cooperation with Agencies: § 3.2.4; see definition of "Agencies" in §1.2. (g) make facilities etc. available: §3.2.5; App. 3, §15. (h) respond to info requests: § 3.2.5. (i) audit rights: §§ 3.2.5; 3.2.6; App. 3, § 15 (j) specific right to audit if fraud suspected: § 3.2.5; Schedule D, App. 3, § 15 (unlimited Agency audit rights). (k) FWA policies and procedures alignment: Schedule D, §1(i). (l) Monitoring: §§ 3.2, 4.2, 5.7. (m) access to care: § 2.11.15. (n) Report TPL: §4.	
HSAG Findings: The Privileged Provider Contract template included all required elements except the fact that, if the CCO is not paid or eligible for payment by OHA for services provided, the subcontractor will not be paid or eligible for payment either.		
Required Actions: HSAG recommends that the CCO update the template agreement to include all requirements for written agreements.		
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)*	*See* Contracting Policies and Procedures Manual ¶2.(a)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	*See* Contracting Policy and Procedure Manual ¶4 *See* Contracting Policy and Procedure Manual ¶4.(a)(v)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
5. Whenever deficiencies or areas of improvement are identified, the CCO and subcontractor shall take corrective action. *Contract: Exhibit B Part 4(13)(a)(15-17)*	*See* Contracting Policy and Procedure Manual ¶4(b)(i) *See* Privileged Provider Agreement, § 5.7, which provides a detailed process for corrective actions.	☐ 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;	*See* Contracting Policy and Procedure Manual ¶2.(d)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• Any ownership stake between the Contractor and Subcontractor. *Contract: Exhibit B Part 4(13)(a)(5-6)*		
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)*	*See* Contracting Policy and Procedure Manual ¶2.(d) *See* Contracting Policy and Procedure Manual ¶4.(c)(iv)	☐ 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	**4**
Progress Sufficient	**1**
Incomplete	**0**
Not Applicable (NA)	**2**

Standard IX—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. In compliance with 42 C.F.R. §438.3(d), the CCO: a. Shall accept individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), up to the limits set under the Contract. b. Shall not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll. c. Shall not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability. *42 CFR §438.3(d)(1-4)* *Contract: Exhibit B Part 3 (6)(a)(2-3)*	In Oregon, the Oregon Health Authority (OHA) has exclusive authority to assign Medicaid beneficiaries to CCOs. No CCO has the authority to refuse to Enroll a Member and therefore has no opportunity to discriminated against potential enrollees. The following Policies and Procedures make this clear to staff: 1a: Member Enrollment and Disenrollment (HIMS) Policies and Procedures, *Procedures*, pg. 2, Sections – 4.1, 4.3; Member Enrollment and Disenrollment (Member Services) Policies and Procedures, *Procedures*, pg. 2, Section – 4.2 1b-c: Member Enrollment and Disenrollment (Member Services) Policies and Procedures, *Procedures*, pg. 2, Section – 4.3 Non-discrimination requirements are covered in Advanced Health's Employee Handbook (see attached), for which employees undergo regular training (see attached sign-in sheet).	☒ 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	Advanced Health requests for Disenrollment are rare. Nevertheless, the Policies and Procedures limit these events to appropriate situations and provide a procedure for processing such requests. 2: Member Enrollment and Disenrollment (Member Services) Policies and Procedures, *Procedures*, pg. 3,	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IX—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the CCO**	**Score**
furnish services to either this particular member or other members). *42 CFR §438.56(b)(2)* *Contract: Exhibit B Part 3 (6)(a)(4)*	Section – 4.4. For how such requests are processed, see *Procedures*, pg. 3, Section – 4.6 These requirements will be covered in Advanced Health's 2020 Employee Handbook (see attached CCO 1.0 Handbook for reference), for which employees undergo regular training (see attached training record). Advanced Health can demonstrate the rarity of Member Disenrollment by the output of its internal report *Member Disenrollment Report* (see attached). The report identifies members identified as eligible in OHA's most recent 834 file who are not identified as eligible in Advanced Health's system. The query (Member Disenrollment Report – Query) used to populate the report is attached for review.	
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	Advanced Health requests for Disenrollment are rate. Nevertheless, the Policies and Procedures limit these events to appropriate situations and provide a procedure for processing such requests. 3a-d: Member Enrollment and Disenrollment (Member Services) Policies and Procedures, *Procedures*, pg. 3, Section – 4.5. For how such requests are processed, see *Procedures*, pg. 3, Section – 4.6	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IX—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*		
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)*	Advanced Health's circumstances for a Member's request to Disenroll follow the CFR and the Contract 4a-b. Member Enrollment and Disenrollment (Member Services) Policies and Procedures, *Procedures*, pg. 3-4, Section – 4.7 *See* CCO Disenrollment form OHP 416.pdf	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IX—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	Advanced Health's procedures for a Member's request to Disenroll follow the CFR and the Contract. 5i-ii: Member Enrollment and Disenrollment (Member Services) Policies and Procedures, *Procedures*, pg. 3, Section – 4.7	☒ 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 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,	Advanced Health's definition of "cause" follows the CFR and the Contract. 6a-e: Member Enrollment and Disenrollment (Member Services) Policies and Procedures, *Procedures*, pg. 4, Section – 4.8	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IX—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*		

Standard IX—Enrollment and Disenrollment	
	Total #
Complete	**6**
Progress Sufficient	**0**
Incomplete	**0**
Not Applicable (NA)	**0**

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. The CCO develops and implements a grievance system for members that includes an appeals process, a grievance process, and a process to access the State's fair hearing system as specified in rule (subpart F). If the CCO is responsible for sending notice of action, they must notify members in a timely manner. *42 CFR §438.228(a)* *Contract: Exhibit I*	Advanced Health has developed and implemented a member grievance system that included an appeal process, a grievance or complaint process, and a process for accessing the State's fair hearing system. Advanced Health's member grievance system also includes a process for timely notification of members in the event of an adverse benefit determination. Refs. are to the *Grievance and Appeals System Procedures Manual.pdf* § 1(p.3) § 2 (p. 6) § 2(b) (p. 3) § 4 (p.14) § 5 (p.17) See also the attached files constituting Advanced Health's 2019 Q1 grievance report submission to OHA in compliance with the reporting requirements of the 2019 CCO Contract, Exhibit I: *Grievance System Report 2019 Q1.pdf* *2019 Q1 Grievance and Appeal Log.xlsm* *2019 Q1 NOABD Sample.pdf*	☒ 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	§ 2 Grievance Procedure for a "Member" definition is, "A person enrolled in Advanced Health." *Grievance and Appeals System Procedures Manual* § 4(a) (p. 14) § 5(p. 17)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	*Grievance and Appeals System Procedures Manual* § 4(j)(ii)(B) (p.16)	
3. The CCO defines an Adverse Benefit Determination as: a. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. b. The reduction, suspension, or termination of a previously authorized service. c. The denial, in whole or in part, of payment for a service. d. The failure to provide services in a timely manner, as defined by the State. e. The failure of the CCO to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. f. For a resident of a rural area with only one CCO, the denial of a member's request to exercise his or her right,	*Grievance and Appeals System Procedures Manual* Definitions, pg. 1, Section 1 – Adverse Benefit Determination	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*		
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)*	*Grievance and Appeals System Procedures Manual* Definitions, § 2 – pg. 2, Appeal	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
5. The CCO defines Grievance as an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. • Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievances include the member's right to dispute an extension proposed by the CCO to make an authorization decision. *42 CFR §438.400(b)* *RFA: Appendix A (H)(57)*	*Grievance and Appeals System Procedures Manual* Definitions, § 5 – pg. 2, Grievance	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	*Grievance and Appeals System Procedures Manual* § 1(d) – to Advanced Health, pg. 4 § 2(a) – to Advanced Health or OHA, pg. 7	☒ 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)*	*Grievance and Appeals System Procedures Manual* § 4(c), pg. 14 § 4(a), pg. 14 § 4(b), pg. 14	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
8. The CCO must acknowledge receipt of each grievance and appeal. *42 CFR §438.406(b)(1)* *Contract: Exhibit I (4)(a)(1)*	*Grievance and Appeals System Procedures Manual* § 4(a), pg. 14 Advanced Health's template for complaint acknowledgement is attached: *Complaint Acknowledgment.2018.pdf* Advanced Health's template for appeal acknowledgement is attached: *Appeal Ack Regular.08.12.pdf*	☒ 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	*Grievance and Appeals System Procedures Manual* § 4(c), pg. 14 § 4(a), pg. 14	☐ Complete ☐ Progress Sufficient to Start Operations

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	§ 4(b), pg. 14 See attached appeal request form: *Appeal.AHR Req OHP 2018 form.pdf*	☐ Incomplete ☒ NA
HSAG Findings: This element was a duplication of element #7.		
Required Actions: None.		
10. The CCO resolves each grievance in writing and provides notice as expeditiously as the member's health condition requires. Within five (5) business days from the date of the CCO's receipt of the grievance, the CCO: a. Notifies the member that a decision on the grievance has been made and what the decision is; or b. Acknowledges receipt of the grievance and notifies the member that there will be a delay in the CCO's decision of up to 30 days. c. Notice to the member must be in a format and language that may be easily understood by the member. *42 CFR §438.408(a)-(b)(1), (d)(1)* *Contract: Exhibit I (2)(h)*	*Grievance and Appeals System Procedures Manual* §§ 2(a)(i); (a)(ii),j pg. 7 *Grievance and Appeals System Procedures Manual* § 2(a)(ii), pg. 7 *Grievance and Appeals System Procedures Manual* § 1(b), pg. 3 Also see attached templates for: Complaint resolution - *Complaint Resolution form 2018.pdf* Complaint acknowledgement - *Complaint Acknowledgment.2018.pdf* Complaint delay - *Complaint Delay.pdf* In our current process, Advanced Health provides a written resolution for all grievances received in writing and an oral response for all grievances received orally. Advanced Health is fully prepared to implement the process changes necessary to respond	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	to all complaints in writing by the end of 2019. We plan to implement the change in October 2019.	
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)*	*Grievance and Appeals System Procedures Manual* § 1(h), pg. 5	☒ 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: • 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	*Grievance and Appeals System Procedures Manual* § 1(e)(ii)(1), pg. 4 § 1(e)(ii)(2), pg. 4 §§ 4(d), pg. 14, and 2(a)(iii)(D), pg. 7 § 2(a)(iii)(D), pg. 7 §§ 4(d), pg. 14, and 2(a)(iii)(D), pg. 7 § 1(e)(ii)(3), pg. 4	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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 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.	*Grievance and Appeals System Procedures Manual* § 3(c)(v)(A)-(C), pg. 11 § 4(f)(i)-(ii), pg. 14-15 § 4(f)(iii), pg. 15 § 4(g), pg. 15	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
42 CFR §438.406(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)*	*Grievance and Appeals System Procedures Manual* § 4(h), pg. 15 § 4(h)(i), pg. 15 § 4(h)(iii), pg. 15 § 4(i), pg. 16 § 4(i)(iii)-(v), pg. 16 See also the attached notice of appeal resolution template: *NOAR Regular 2019 Adv Health.pdf*	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
15. The CCO may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: • The member requests the extension; or • The CCO shows (to the satisfaction of the State, upon request) that there is need for additional information and how the delay is in the member's interest. • 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.	*Grievance and Appeals System Procedures Manual* § 4(h)(iv), pg. 15 § 4(b)(iv)(A), pg. 15 § 4(b)(iii)(B), pg. 15 § 4(h), pg. 15 § 5(a), pg. 17	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
– 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)*	See also the attached template letter for an appeal delay, *Appeal Delay.pdf,* and the complaint form, *Complaint Form DHS.OHA he3001.pdf*	
16. The written notice of appeal resolution must include: The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing (contested case hearing), and how to do so. – The right to request that benefits/services continue while the hearing is pending, and how to make the request. – 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)*	*Grievance and Appeals System Procedures Manual* § 4(j)(i), pg. 16 § 4(j)(ii)(B), pg. 16 § 4(j)(ii)(C), pg. 16 § 4(j)(ii)(E), pg. 17 See also the attached notice of appeal resolution template, *NOAR Regular 2019 Adv Health.pdf,* and the Administrative Hearing Request form, *AHR MSC 443 form 2018.pdf.*	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	*Grievance and Appeals System Procedures Manual* § 4(j)(ii)(B), pg. 16 § 5(a), pg. 17 The parties to the Contested Case Hearing are established by State administrative rules, and cannot be established by or changed by Advanced Health. See also the attached notice of appeal resolution template, *NOAR Regular 2019 Adv Health.pdf,* and the Administrative Hearing Request form, *AHR MSC 443 form 2018.pdf.*	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
18. The CCO maintains an expedited review process for appeals, when the CCO determines, or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. The CCO's expedited review process includes: • The CCO ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. • If the CCO denies a request for expedited resolution of an appeal, it must: – Transfer the appeal to the time frame for standard resolution. – Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and	*Grievance and Appeals System Procedures Manual* § 6(a), pg. 18 § 6(b), pg. 19 § 6(e)(i), pg. 19 § 6(e)(ii), pg. 19 See the attached template letter for an approved request to expedite an appeal, *Appeal Ack Expedited Request APPROVED.pdf,* and the template for a denied request to expedite an appeal, *Appeal Ack Expedited Request DENIED.pdf.*	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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. **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)*	*Grievance and Appeals System Procedures Manual* § 7(b), pg. 20 § 7(c)(i)(B), pg. 20 § 7(a)(i), pg. 19 § 7(a)(iii), pg. 19 § 7(b)(iii), pg. 20 § 7(b)(iv), pg. 20 § 7(b)(i), pg. 20	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
20. If, at the member's request, the CCO continues or reinstates the member's benefits while the appeal or State fair hearing (contested case hearing) is pending, the benefits must be continued until one of following occurs: • The member withdraws the appeal or request for State fair hearing. • The member fails to request a State fair hearing and continuation of benefits within 10 calendar days after the CCO sends the notice of an adverse resolution to the member's appeal. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR §438.420(c)* *Contract: Exhibit I (6)(c)*	*Grievance and Appeals System Procedures Manual* § 7(c), pg. 20 § 7(c)(i)(A), pg. 20 § 7(c)(i)(B), pg. 20 § 7(c)(ii)(B), pg. 20	☒ 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)*	*Grievance and Appeals System Procedures Manual* § 7(c), pg. 20 § 7(c)(i)(A), pg. 20 § 7(c)(i)(B), pg. 20 § 7(c)(ii)(B), pg. 20	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
22. Effectuation of Reversed appeal resolutions: • If the CCO or the State fair hearing (contested case hearing) officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the CCO must authorize or provide the disputed services promptly and as expeditiously as the member's	*Grievance and Appeals System Procedures Manual* § 7(e)(i), pg. 20 § 7(e)(ii), pg. 21	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*		
23. The CCO maintain records of all member grievances and appeals. The record must be accurately maintained in a manner accessible to the State and available upon request to CMS. The record of each member grievance or appeal must contain, at a minimum, all of the following information: • A general description of the reason for the appeal or grievance; • The date received; • The date of each review or, if applicable, review meeting; • Resolution at each level of the appeal or grievance, if applicable; • Date of resolution at each level, if applicable; • Name of the covered person for whom the appeal or grievance was filed, member ID number, and date the member filed the grievance or appeal;		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• 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. • 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	*Grievance and Appeals System Procedures Manual* § 1(k), pg. 5 § 1(k)(i), pg. 5 § 1(k)(ii), pg. 5 § 1(k)(iii), pg. 5 § 3(c)(v), pg. 11 §§ 3(c)(v)(A), pg. 11; 2(b)(iii), pg. 8 § 7(b)(i), pg. 20 § 3(c)(viii), pg. 11	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
(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)*	See also, *Advanced Health - Privileged Provider Contract - FOR EXECUTION.pdf* Pg 10 – 2.11.2, 2.11.3, and 2.11.4 Pg. 17 – 3.5.6 Pg. 24 – 6.3.1	

Standard X- Grievance and Appeal Systems	
	Total #
Complete	**22**
Progress Sufficient	**0**
Incomplete	**0**
Not Applicable (NA)	**2**

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. The Contractor shall maintain a health information system that collects, analyzes, integrates, and reports data sufficient to support program requirements, including but not limited to: Utilization of services a. Claims and encounters b. Grievances, appeals and hearing records c. Disenrollment for other than loss of Medicaid eligibility d. Member characteristics i. Race ii. Ethnicity iii. Preferred Language iv. Names and phone numbers of the member's PCP or clinic v. Attestation of member rights and responsibilities e. Client Process Monitoring Systems Forms data using the Measures and Outcome Tracking System (MOTS) f. LTPC Determination Forms *42 CFR §438.242(a)* *Contract: Exhibit J (1)*	Advanced Health is currently implementing the PLEXIS Quantum Choice (hereafter referred to as QC) platform to replace its existing system. QC will service as Advanced Health's primary Health Information System. Advanced Health has made significant progress towards its scheduled QC go-live and will be in a production state no later than January 1st, 2020 as evidenced by the following documents: • PLEXIS SOW.pdf o Page 6 – EDI/Integration • PLEXIS Project Plan.pdf • PLEXIS High Level Timeline.pdf Advanced Health has begun, and will continue to, develop procedures for the updating and maintenance of QC, related systems, and code sets (CPT, ICD10, etc.) throughout the remainder of the implementation. Advanced Health will comply with all of the required elements of 42 CFR §438.242(a) and Contract: Exhibit J (1), the specific items identified in Standard XIII, Question 1 (at left) are addressed below. QC will contain all enrollment/disenrollment data, authorization data, claims data, as well as payment and adjudication data that will be submitted to OHA as encounter data. PLEXIS has made enhancements	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	to QC to store and display the unique elements of OHA's 834 file as well as necessary enhancements to the inbound 837 specifications. QC will store all member characteristics provided by OHA in the 834 (such as race, ethnicity, preferred language, and termination reason when provided). See the attached enhancement requests as evidence: • PLEXIS 834 System Requirements.pdf o § 6.6 • PLEXIS 837I 837P System Enhancements.pdf Member records in QC are associated with provider records for the purpose of identifying the member's Primary Care Provider. PCP records will contain phone numbers as evidenced by the attached provider configuration procedure: • QC Provider Configuration Policy and Procedure.pdf o § 4.1 4,v,d (Page 9) QC has a feature called "Topics" which are user-defined data fields which will be used to store additional information such as Rights and Responsibilities attestations, which may also be scanned and attached to the member record as a digital document. Please see the attached screenshot as evidence: • PLEXIS Attached Document Screenshot.pdf	

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Similarly, LTPC Determination Forms can be stored electronically and linked to member records in QC. See the attached screenshot as evidence: • PLEXIS Attached Document Screenshot.pdf QC provides functionality suitable for tracking Grievance, Appeal, and Hearing data. Please see the following attached procedure as evidence of how Advanced Health will collect and store this data. • PLEXIS Grievance, Appeal and Hearing Procedure.pdf Advanced Health does not directly store MOTS data; however, Advanced Health will require, through its provider contracts, and Provider Handbook, that behavioral health providers maintain systems sufficient to accurately store and submit MOTS data to OHA. Advanced Health is currently developing policies and procedures for MOTS reporting. Please see the relevant section of the attached document as evidence: • Behavioral Health Policy and Procedure Status Report.pdf Page 7: Attachment 2- Behavioral Health Policies & Procedures	
HSAG Findings: Through its policies, procedures, information systems documentation, and remote demonstrations, the CCO provided evidence of its ability to capture, analyze, and report required Medicaid program elements except Measures and Outcome Tracking System (MOTS) information. While the CCO currently requires its behavioral health providers (via contracts and its provider manual) to collect, store, and report MOTS data, the CCO is not currently receiving this data. However, the CCO does work with its providers to ensure the information is accessible for healthcare		

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
operations through collaboration. The CCO indicated that it is currently in the process of updating its behavioral health policies (expected completion November 1, 2019) to incorporate reporting requirements for MOTS data.		
Required Actions: HSAG recommends that the CCO finalize, implement, and train its behavioral health providers on its updated policies regarding the collection, storage, and reporting of MOTS data to support CCO operations. The policies should include the mechanisms used by the CCO to access and/or request MOTS data from providers or Adult Mental Health Services.		
2. Contractor's claims processing and retrieval systems shall collect data elements necessary to enable the mechanized claims processing and information retrieval systems operated by the State. *42 CFR §438.242(b)(1)*	Advanced Health meets the requirements of 42 CFR § 438.242 through its use of the QC Platform and its adherence to its Claims Adjudication and Encounter Data policies and procedures. In addition to the evidence provided in the preceding question, please see the following attached policies and procedures in their entirety: • Claim Processing and Adjudication Policies and Procedures.pdf • Encounter Data Policies and Procedures.pdf As referenced in the policies and procedures submitted above, Advanced Health contracts with VisibilEDI to assist with the submission of encounter data. Please see the attached SoW as evidence of the services they provide to Advanced Health: • VisibilEDI SOW.pdf For a comprehensive overview of how the VisibilEDI system interfaces with QC, please see the attached ISCAT Medicaid Data Flow & System Infrastructure Narrative. ISCAT Data Flow Narrative.pdf	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
3. Contractor shall collect data at a minimum on: a. Member and provider characteristics as specified by OHA and in Exhibit G b. Member enrollment c. All services furnished to members through an encounter data system, pharmacy, or other methods as specified by OHA *42 CFR §438.242(b)(2)* *Contract: Exhibit J(2)*	Advanced Health meets the requirements of 42 CFR § 438.242(b)(2) and Contract: Exhibit J(2) through its use of the QC, and VisibilEDI Platforms, it's Pharmacy Benefits Manager, and its adherence to its Enrollment Data, Claims Adjudication, Encounter Data, and Provider Configuration policies and procedures. The specific items identified in Standard XIII, Question 3 (at left) are outlined below: Advanced Health collects member and provider characteristics suitable to complete the reports outlined in Exhibit G through its provider contracting, credentialing, and configuration activities in addition to the member characteristics provided by OHA or identified through claims, grievances, appeals, or other means. Many of these provider elements are stored directly within QC. Please see the attached document as evidence of how key elements such as • QC Provider Configuration Policy and Procedure.pdf o §4 - Procedure All member enrollment information is provided by OHA and stored indefinitely within the QC system. As evidenced in the preceding questions, QC stores all available fields contained within the 834. As further evidence, please see the attached HIMS Enrollment and Disenrollment policy and procedure in its entirety:	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• Enrollment and Disenrollment (HIMS) Policy and Procedure.pdf All non-pharmacy services furnished to members are tracked within either the QC or VisibilEDI as previously outlined. Pharmacy encounters are submitted bi-weekly to Advanced Health by its Pharmacy Benefits Manager (PBM), MedImpact. Much greater detail regarding how this data is stored and exchanged is provided in each entity's bulleted section contained within the attached ISCAT Data Flow Narrative • ISCAT Data Flow Narrative.pdf o § VisibilEDI o § MedImpact o § PLEXIS Quantum Choice A graphical overview of the flow of claim and encounter data is available in the attached diagram: • ISCAT Data Flow Diagram.pdf All encounters are collected and stored by Advanced Health and subsequently submitted to OHA in accordance with OHA requirements and Advanced Health's encounter data policy and procedure. Please see the attached document as evidence: Encounter Data Policies and Procedures.pdf	
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:	Advanced Health complies with 42 CFR §438.242(b)(3)(i-iii), Contract: Exhibit J(3), OAR 410-120-1280, and OAR 410-141-3420 through its rigorous evaluation of claims and encounter data in	☒ Complete ☐ Progress Sufficient to Start Operations

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
a. Verifying the accuracy and timeliness of data reported b. Screening the data for completeness, logic, and consistency c. Submitting the certification to verify current member eligibility for fully dual eligible members using the AVR system or MMIS Web Portal. d. Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts in accordance with OHA Electronic Data Transmission (EDT) procedures in OAR Chapter 943 Division 120. *42 CFR §438.242(b)(3)(i-iii)* *Contract: Exhibit J(3)*	accordance with Advanced Health's relevant policies and procedures. The specific items identified in Standard XIII, Question 4 (at left) are outlined below: Advanced Health assesses the accuracy of claims data received from providers through systematic and manual evaluation at the time of adjudication prior to payment. Pleases see the following indicated section from the attached claims adjudication policy procedure as evidence: • Claim Processing and Adjudication Policies and Procedures.pdf o §4.3 Data accuracy and completeness Advanced Health also performs various post-payment activities to assess the validity of claims data received from providers as described throughout our Post Payment Integrity and Fraud Waste and Abuse policy and procedures. In addition to monitoring utilization and coding levels, Advanced Health will perform the following activities as described below. Advanced Health has developed, and will fully implement by January 1st, 2020, an Encounter Data Validation procedure that describes a monthly process for randomly, or semi-randomly sampling claims data, requesting relevant medical records, and performing a chart audit by either a Certified	☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Professional Coder or Certified Professional Medical Auditor. • Post Payment Integrity Policy and Procedure.pdf o §4.5 Procedure #4: Encounter Data Validation Advanced Health also conducts a monthly member survey for randomly selected claims for the verification of services billed to Advanced Health. • Post-Payment Integrity Policy and Procedure o §4.6 Member Survey Letters Advanced Health evaluates the timeliness of claims data received from providers at the time of adjudication (whether systematically or manually). Contracted and non-contracted providers are held to their respective timely filing requirements in accordance with the CCO contract and relevant OAR's. Please see the following indicated sections from attached claims adjudication policy procedure as evidence: • Claim Processing and Adjudication Policies and Procedures.pdf o § 4.5.4 – Timely Filing o § 4.5.5 – Resubmissions and Corrections Advanced Health screens data received from providers for completeness, logic, and consistency at	

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	the time of adjudication (whether systematically or manually) using a number of different methods including, but not limited to, ensuring that ICD-10 codes are billed to the highest degree of specificity, NCCI & MUE edits, identifying manifestation diagnosis codes, validating that NDC codes are present and appropriate for the submitted HCPCS code, and evaluating CPT and ICD-10 codes against OHA's Prioritized List of Healthcare Services to ensure that they pair accordingly. In addition, claim processing staff have access to Optum's "Encoder Pro For Payers" website which provides reference material and guidelines for CPT/HCPCS and ICD-10 codes. Please see the following indicated sections from attached claims adjudication policy procedure as evidence: • Claim Processing and Adjudication Policies and Procedures.pdf o § 4.5 – Claim Adjudication ** In reference to Question 4.c (at left), please see the clarification provided by HSAG on 07/29/2019 at 1:13 PM, which is quoted as follows:* *"Exhibit J included several changes in the revised contract disseminated on 7/9/2019 and affected this element. Exhibit J(1)(b)(3) now states that CCOs, in part, must ensure the accuracy of data received from providers, in part, by "submitting the certification identified in Exhibit B, Part 8", which refers to the encounter data validation and certification form. This is what the term "certification" is referring to in this*	

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	element. As such, part of the CCO's processes are expected to address how certification of the data is incorporated. " Advanced Health submits the certification identified in Exhibit B, Part 8 weekly in accordance with its Encounter Data policies and procedures. As required by OHA, Advanced Health certifies that "based on best knowledge, information and belief that the data and information submitted to OHA are accurate, complete and truthful." As evidence, please see the relevant sections from the attached procedure cited below: • Encounter Data Policies and Procedures.pdf § 4.8 - Encounter Data Certification § 4.9 - Encounter Data Certification Discrepancies Advanced Health collects data from providers in standardized formats to the extent feasible and appropriate. Advanced Health only accepts electronic claims data that is submitted using standard HIPAA 5010 ASCX12 compliant 837 files. All file transfers are accomplished via Secure File Transport Protocol (SFTP).	
5. Contractor shall make all collected and reported data available to the State and upon request to OHA and CMS. *42 CFR §438.242(b)(4)* *Contract: Exhibit J(3)(g)*	Pursuant to 42 CFR §438.242(b)(4) and Contract: Exhibit J(3)(g), Advanced Health shall make all collected and reported data available to the State and upon request to OHA and CMS. Such data shall be produced in such a manner, format and timeframe as required by the State (or by OHA or CMS), and in	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	accordance with all applicable State and federal laws and regulations.	
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.		
9. Contractor shall develop IS contingency planning in accordance with 45 C.F.R. §164.308. Contingency plans shall include: a. Data Backup plans	45 CFR 164.308 is addressed throughout the entirety of the following documents. • *Data Backup Policy and Procedure.pdf*	☒ Complete ☐ Progress Sufficient to Start Operations

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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*	• *Business Continuity Plan.pdf* • *Disaster Recovery Plan.pdf* *Advanced Health Backup Solution – July 2019.pdf* explains more detail on backups specifically. *Advanced Health Backup Report – July 2019.pdf* is a report that Advanced Health receives from CORE with details on the backups that are scheduled for each of the servers. *Data Backup Retrieval Log Template.pdf* is the template of the log that is used to document when a file is retrieved by the IT department, whether it is a test or requested from an employee. *BCDR Implementation Schedule.pdf* addresses the steps that have been taken in regard to the Data Backups, Disaster Recovery, Business Continuity Plans.	☐ Incomplete ☐ NA
10. The CCO shall develop and maintain an OHA-approved HIT Roadmap inclusive of CCO's activities, milestones and timelines. The HIT Roadmap must describe where the CCO has implemented its own HIT and where it leverages collaborative HIT solutions, as well as describe how the CCO: a. Uses HIT to achieve its desired outcomes b. Supports EHR adoption for its contracted providers c. Supports access to health information exchanges to enable sharing patient information for care coordination for its contracted providers d. Ensures access to hospital event notifications for its contracted providers		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA

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

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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.		
Required Actions: None.		
13. The CCO shall participate in OHA's HIT Advisory Group (HITAG) at least once annually.		☐ Complete ☐ Progress Sufficient to Start Operations

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Contract: Exhibit J(2)(e)		☐ 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)*	Please see the attached narrative document in its entirety: • Standard XIII-Q.14 - Narrative.pdf	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
15. The CCO shall document and report to OHA, annually, on how HIT is used to support population health management, including: a. The ability to identify and report on member characteristics (e.g., past diagnoses and services) b. The capability of risk stratifying members c. The ability to provide risk stratification and member characteristics to contracted providers with VBP arrangements for the population(s) addressed in the arrangement(s).	Advanced Health will report to OHA, annually, on how HIT is used to support population health management. The reporting will be a component of Advanced Health's required HIT Roadmap progress reporting. Advanced Health's plan to support population health management includes the following: Advanced Health has already developed and implemented tools for identifying and reporting on	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Contract: Exhibit J (2)(k)(8)	member characteristics and member risk stratification, using Milliman PRM Analytics and custom reports. The Care Coordinator Report included in PRM analytics contains extensive filters for member demographic factors and past medical history. The Care Coordinator Report also includes several risk-stratification tools, including risk of readmission, risk of emergency department visit, risk of total cost, and avoidable costs. These risk stratification and member characteristic filtering tools will be available to contracted providers with VBP arrangements for populations addressed in the arrangements. Please see the attached documents as evidence: • surveyor_database.pdf • HRA Survey Example.pdf • hades_data_warehouse_spec.pdf • PRMAnalyticsDataDictionary.xlsx • Advanced Health HIT Roadmap.pdf	

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 AH's Provider Capacity Reports were good with minor errors identified in both the individual practitioner and facility and service provider files.

Table B-1—AH 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	15.0	100.0	
City	100.0		
Status of Medicaid Contract	100.0	100.0	
County	100.0		
Credentialing Date	91.5	100.0	100.0

DSN Data Field	DSN Quality Metrics		
	% Present	% Valid Format	% Valid Values
DMAP (Medicaid ID)	98.4	100.0	
Provider First Name	100.0		
Group/Clinic Name	100.0		
Non-English Language 1	4.2		
Non-English Language 2			
Non-English Language 3			
Provider Last Name	100.0		
Provider Network Status	100.0	100.0	
Provider NPI	98.9	100.0	100.0
Number of Members Assigned to PCPs	15.0	100.0	
PCP Indicator	100.0	100.0	
PCPCH Tier	18.7	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	0.0	
Provider Taxonomy	98.9	100.0	99.5
Zip Code	100.0		

In general, all key DSN data fields in the individual practitioner capacity report were populated except for Credentialing Date for which 91.5 percent of the records contained a value. However, of the records with a credentialing date, 100 percent of the records contained valid formats and values (i.e., date within three years). Conversely, while 100 percent of the records listed a Provider TIN, zero percent were correctly formatted. Of note, only 4.2 percent of providers were associated with a non-English language.

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

DSN Data Field	DSN Quality Metrics		
	% Present	%Valid Format	% Valid Values
Address #1	100.0		
Facility or Business Name	100.0		
City	100.0		
Status of Medicaid Contract	100.0	100.0	
County	100.0		

DSN Data Field	DSN Quality Metrics		
	% Present	%Valid Format	% Valid Values
DMAP (Medicaid ID)	95.2	99.0	
Facility NPI	95.2	100.0	100.0
Phone Number	100.0		
Provider Category	100.0	100.0	100.0
Provider Service Category	100.0	100.0	93.3
Facility TIN	100.0	18.3	
Facility or Business Taxonomy	100.0	100.0	99.0
Zip Code	100.0		

Overall, key DSN data fields in the facility and service provider capacity report were present and populated with valid values with the exception of two data fields—i.e., DMAP ID (95.2 percent) and Facility NPI (95.2 percent). Overall, the average completeness across all data fields was 99.3 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 with the exception 6 ambulance and emergency medical transportation providers.

Table B-3—AH 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	90	18.6	90	100.0	0	0.0
Specialty Provider	115	23.7	115	100.0	0	0.0
Dental Service Provider	42	8.7	42	100.0	0	0.0
Mental Health Provider	144	29.7	144	100.0	0	0.0
SUD Provider	44	9.1	44	100.0	0	0.0
Certified or Qualified Health Care Interpreters	1	0.2	1	100.0	0	0.0
Traditional Health Workers	12	2.5	12	100.0	0	0.0
Alcohol/Drug	0	0.0	0	0.0	0	0.0

Provider Specialty Category	Total		Contract Status = Yes		Contract Status = PEND	
	Number	Percent	Number	Percent	Number	Percent
Health Education, Health Promotion, Health Literacy	35	7.2	35	100.0	0	0.0
Palliative Care	2	0.4	2	100.0	0	0.0
Facility/Service Practitioners						
Hospital, Acute Psychiatric Care	1	1.8	1	100.0	0	0.0
Ambulance and Emergency Medical Transportation	7	12.7	0	0.0	1	14.3
Federally Qualified Health Centers	2	3.6	2	100.0	0	0.0
Home Health	2	3.6	2	100.0	0	0.0
Hospice	0	0.0	0	0.0	0	0.0
Hospital	7	12.7	7	100.0	0	0.0
Imaging	0	0.0	0	0.0	0	0.0
Indian Health Service and Tribal Health Services	1	1.8	1	100.0	0	0.0
Mental Health Crisis Services	2	3.6	2	100.0	0	0.0
Community Prevention Services	2	3.6	2	100.0	0	0.0
Non-Emergent Medical Transportation	1	1.8	1	100.0	0	0.0
Pharmacies	17	30.9	17	100.0	0	0.0
Durable Medical Providers	4	7.3	4	100.0	0	0.0
Post-Hospital Skilled Nursing Facility	6	10.9	6	100.0	0	0.0
Rural Health Centers	2	3.6	2	100.0	0	0.0
School-Based Health Centers	1	1.8	1	100.0	0	0.0
Urgent Care Center	0	0.0	0	0.0	0	0.0

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

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

In general, AH's individual provider capacity demonstrated network coverage of required physical health (primary and specialty), oral health, and mental health and substance use disorder providers. Further, within the individual practitioner data only one specialty category was not represented—i.e., alcohol/drug providers. Of the 17 required facilities and services, three provider service categories had a count of zero—i.e., hospice, imaging services, and urgent care centers.

Provider Accessibility

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

Table B-4—AH 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	90	90	100.0	8	8.9
Specialty Provider	115	115	100.0	3	2.6
Dental Service Provider	42	42	100.0	4	9.5
Mental Health Provider	144	144	100.0	4	2.8
SUD Provider	44	44	100.0	0	0.0
Certified or Qualified Health Care Interpreters	1	1	100.0	1	100.0
Traditional Health Workers	12	12	100.0	1	8.3
Alcohol/Drug	0	0	0.0	0	0.0
Health Education, Health Promotion, Health Literacy	35	35	100.0	1	2.9
Palliative Care	2	2	100.0	0	0.0
TOTAL	**485**	**485**	**100.0**	**22**	**4.5**

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.

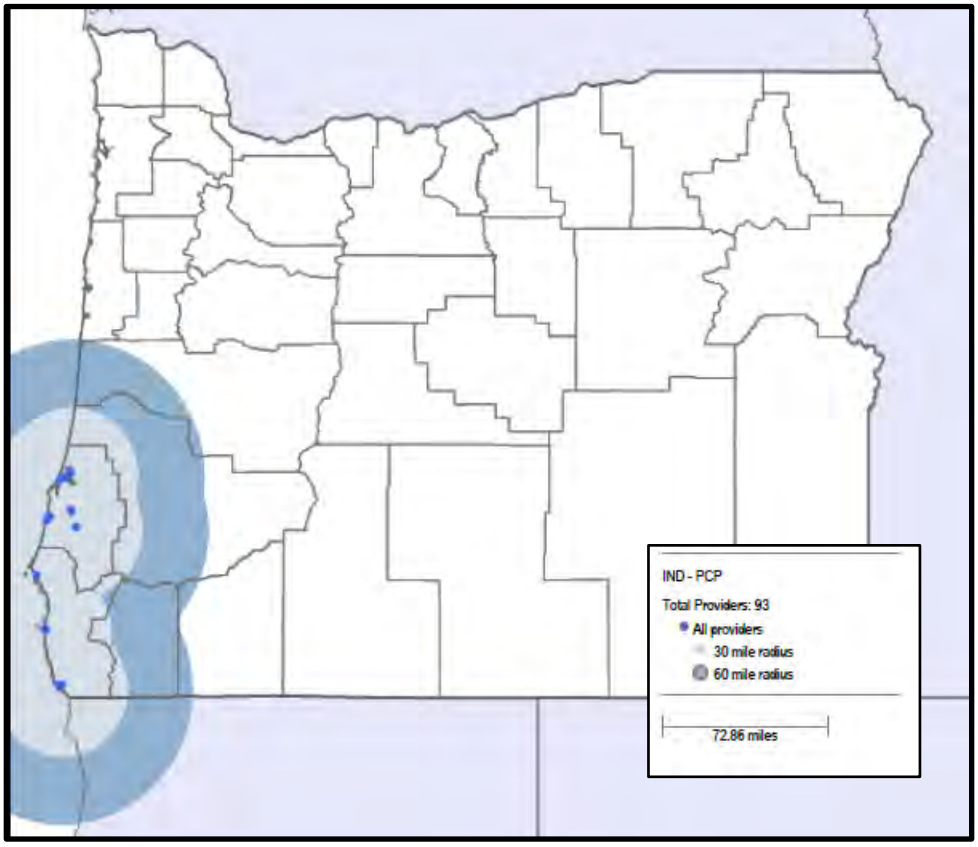
Overall, 100 percent of AH's provider network was accepting new patients. Of its individual practitioners, AH identified 4.5 percent who spoke a language other than English. Overall, 8.9 percent of PCPs were associated with non-English language.

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

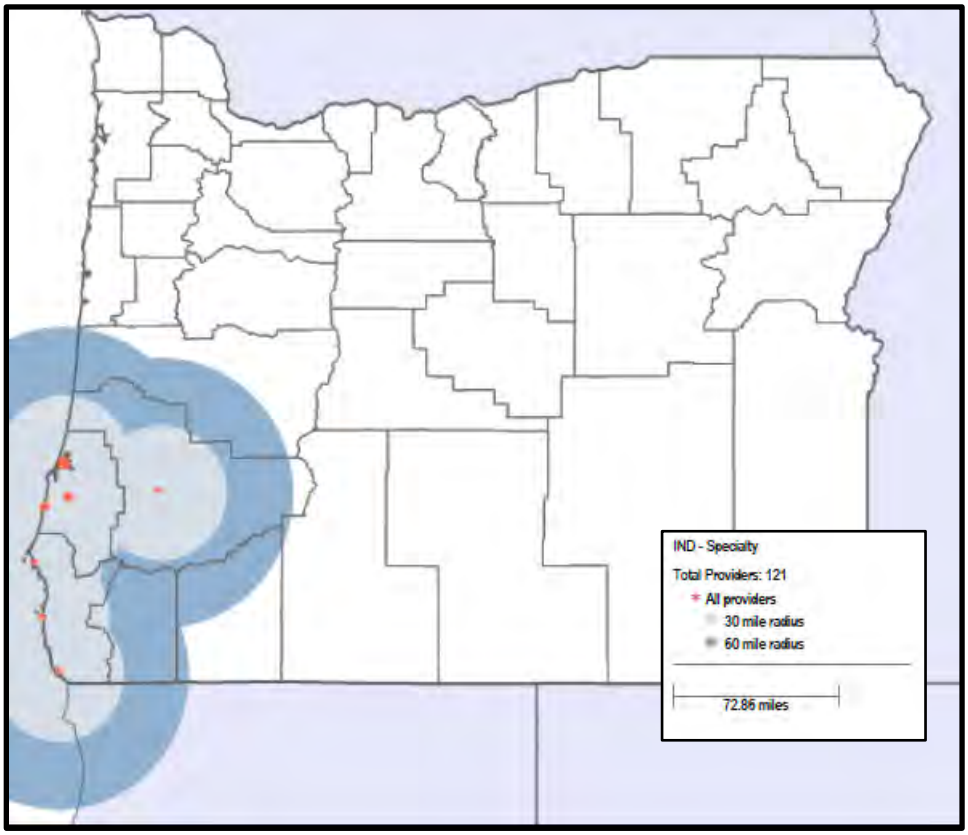
individual and facility providers. All of the zip codes within AH's service area (i.e., Coos County and Curry County), are classified as rural.

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



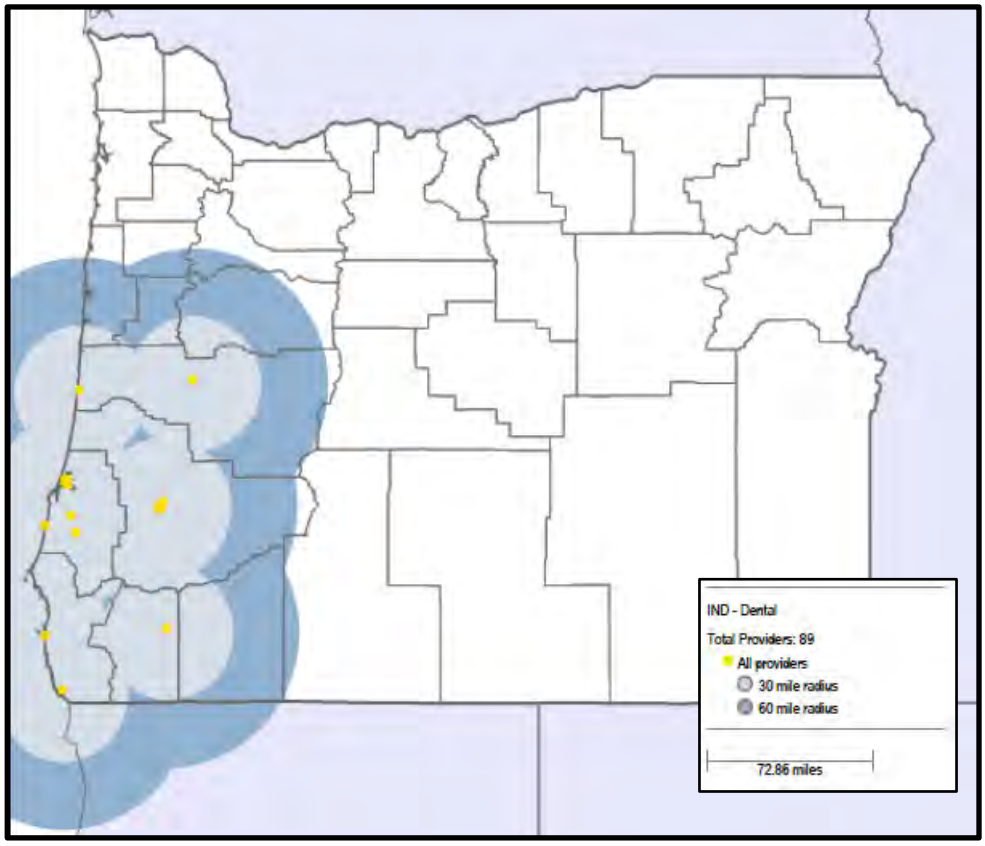
As shown in Figure B-1, the distribution of AH's network of PCPs is sufficient to cover the CCO's service area. Most of the regions in the CCO's service area are within 30 miles of a primary care provider and all areas are within 60 miles.

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



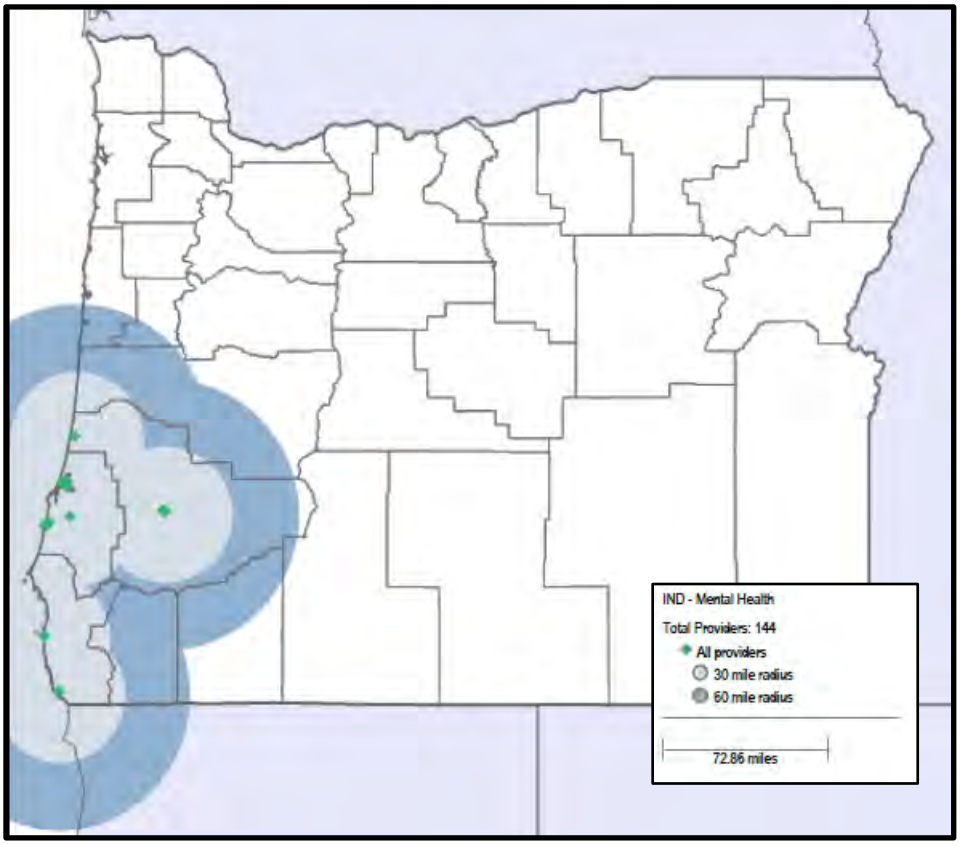
As shown in Figure B-2, the distribution of AH's specialty providers is sufficient to cover the CCO's service area. Most of the regions in the CCO's service area are within 30 miles of a specialty provider and all areas are within 60 miles.

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



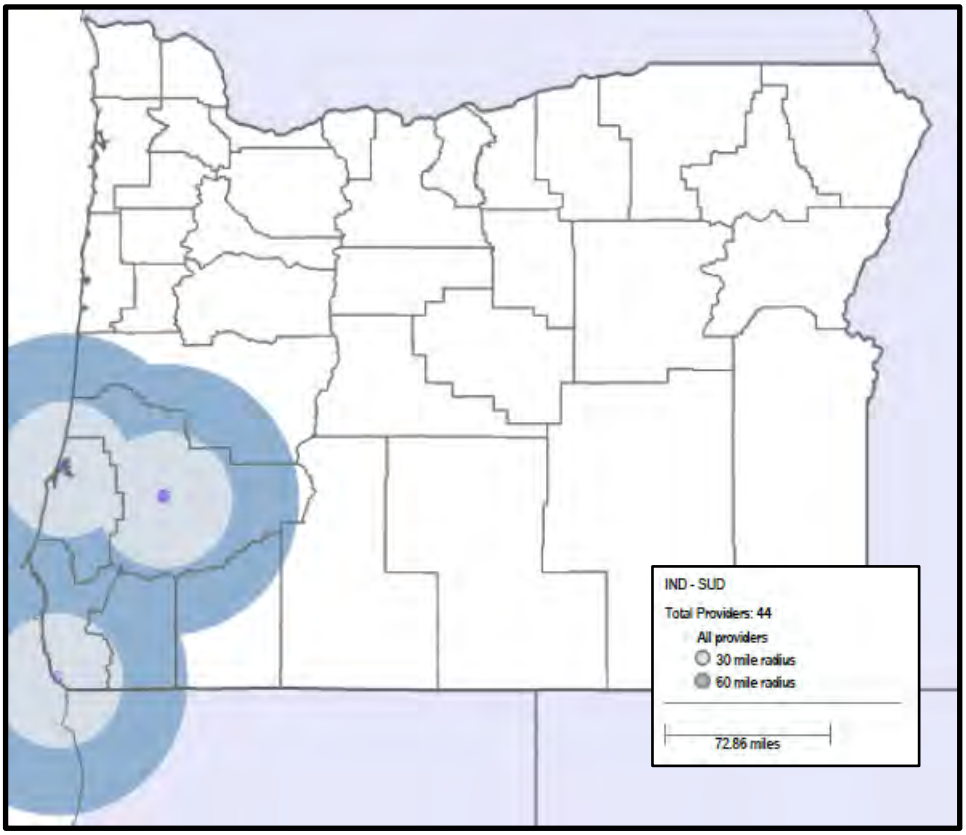
As shown in Figure B-3, the distribution of AH's dental service providers is sufficient to cover the CCO's service area. Most of the regions in the CCO's service area are within 30 miles of a dental service provider with the exception of small portion of northeastern Curry Count which is still within 60 miles of the nearest dental provider.

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



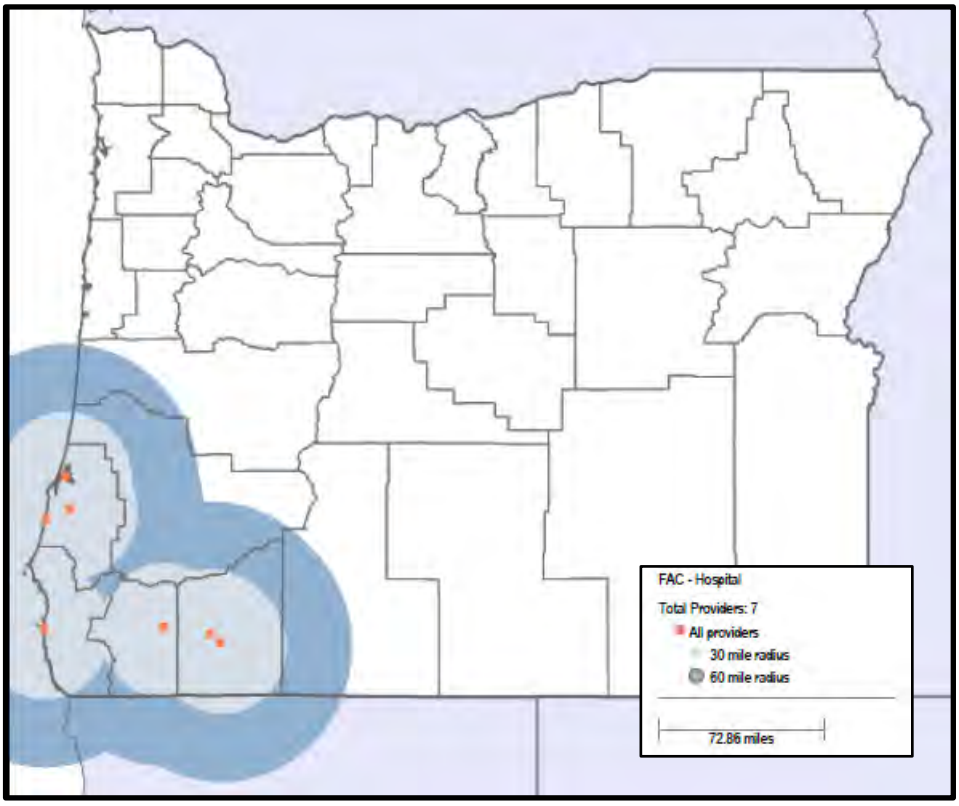
As shown in Figure B-4, the distribution of AH's mental health providers is sufficient to cover the CCO's service area. Most of the regions in the CCO's service area are within 30 miles of a mental health provider and all areas are within 60 miles.

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



As shown in Figure B-5, the distribution of AH's SUD providers is sufficient to cover the CCO's service area except. In general, most regions of the service area are within 30 miles of a SUD provider except for southern Coos County and northern Curry County which are within 60 miles of the nearest SUD provider.

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



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

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

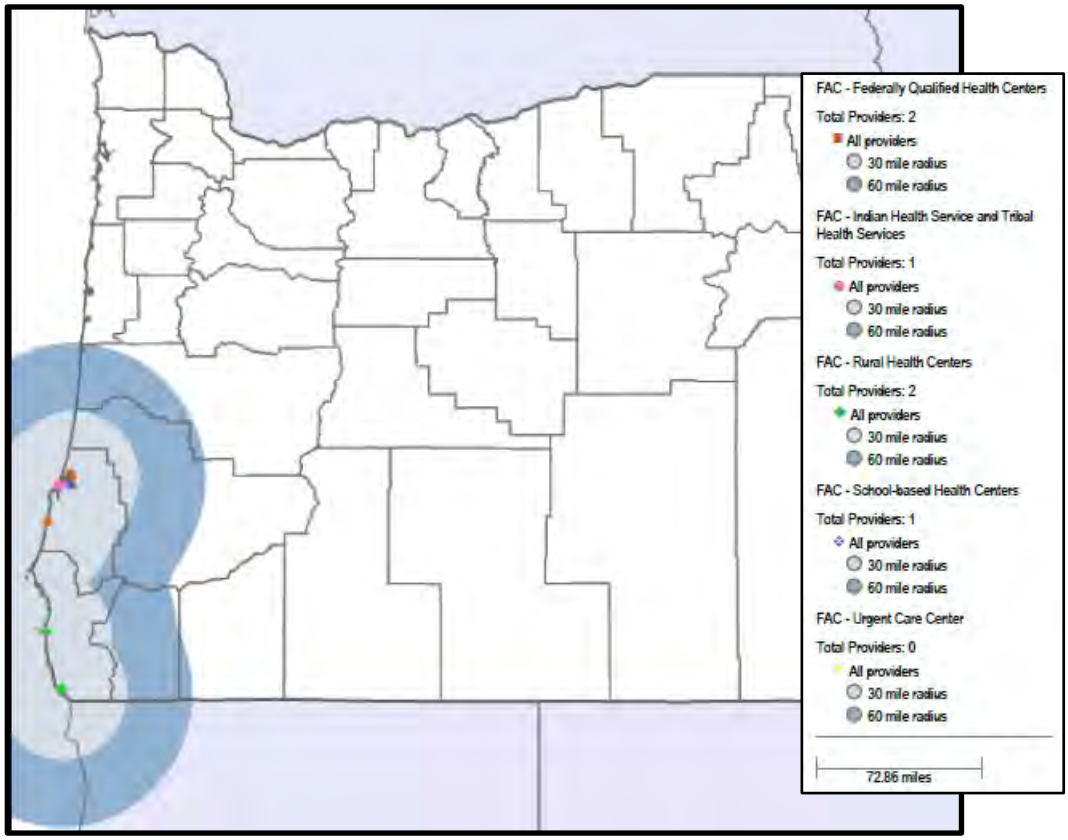


Figure B-7 displays the distribution of several clinic-based facilities within AH's service areas, including FQHCs, Indian Health Services and Tribal Health Services, Rural Health Centers, School-Based Health Centers, and Urgent Care Centers. The map shows that the distribution of clinic-based facilities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

Appendix C. Phase 2 Evaluation Tool

[Pending completion of the Phase 2 RR]