Oregon Health Authority

2023 Compliance Monitoring Review Report

for

AllCare CCO, Inc.

December 2023

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Overview

Background

According to federal requirements located within Title 42 of the Code of Federal Regulations (42 CFR) §438.358, the State, an agent that is not a coordinated care organization (CCO), or its external quality review organization (EQRO) must conduct a review within a three-year period to determine a Medicaid CCO's compliance with the standards set forth in 42 CFR §438—Managed Care Subpart D, the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and poststabilization services requirements described in §438.114, and the quality assessment and performance improvement requirements described in §438.330.

To comply with the federal requirements, the State of Oregon, Oregon Health Authority (OHA) contracted with Health Services Advisory Group, Inc. (HSAG) as its EQRO to:

- Conduct the calendar year (CY) 2023 compliance monitoring reviews (CMRs) of each of its contracted CCOs, across six standards for the review period of January 1, 2022–December 31, 2022.
- Prepare a report of findings with respect to each CCO's performance strengths and areas requiring corrective action or performance improvement.
- Conduct a follow-up reevaluation of any CCOs that require implementation of corrective actions in order to attain full compliance.

HSAG is an EQRO that meets the competency and independence requirements of 42 CFR §438.354(b) and (c). HSAG has extensive experience and expertise in conducting reviews to evaluate managed care organization, prepaid inpatient health plan, prepaid ambulatory health plan, and primary care case management entity compliance with the Medicaid managed care regulations and associated State contract requirements. HSAG uses the information and data it derives from the reviews to reach conclusions and make recommendations about the quality, timeliness, and accessibility of care and services the State's CCOs provide. Table 1-1 depicts the assignment of the standards reviewed in CY 2023 to the domains of care.

Table 1-1—Assignment of CMR Standards to the Quality, Timeliness, and Access Domains

CMR Standard	Quality	Timeliness	Access
Standard III—Coordination and Continuity of Care	✓	✓	✓
Standard IV—Coverage and Authorization of Services		✓	✓
Standard VII—Member Rights and Protections	✓		
Standard X—Grievance and Appeal Systems	✓	✓	✓
Standard XIV—Member Information		✓	✓
Standard XVI—Emergency and Poststabilization Services		✓	✓

In CY 2023, OHA contracted with 16 CCOs to provide Medicaid-covered primary and acute physical, behavioral, and oral health services to over 1.2 million Oregon Health Plan (OHP) members. The following sections describe how the review was conducted and summarize the findings from the CY 2023 CMR.

2. Review Methodology

Introduction

The CMRs assess CCO compliance with federal compliance review standards outlined in 42 CFR §438.358(b)(1)(iii) and related State contract requirements in accordance with the Centers for Medicare & Medicaid Services (CMS) External Quality Review (EQR) *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019 (EQR Protocol 3),[2-1] to create the process, tools, and interview questions used for the CY 2023 CMR.

Objectives

The objective of the CMRs is to provide meaningful information to OHA and the CCOs regarding:

- The CCOs' compliance with federal managed care regulations, Oregon Administrative Rules (OARs), and contract requirements with the standard areas reviewed.
- Strengths, opportunities for improvement, recommendations, or required actions to bring the CCOs into compliance with federal managed care regulations and State requirements with the standard areas reviewed.
- The quality, timeliness, and accessibility of care and services furnished by the CCOs, as addressed within the specific areas reviewed.
- Possible additional interventions recommended to improve the quality of the CCOs' care provided and services offered related to the areas reviewed.

To accomplish its objective and based on the results of collaborative planning with OHA, HSAG developed data collection tools to assess and document each CCO's compliance with certain federal Medicaid managed care regulations, State rules, and the associated OHA contractual requirements. Table 2-1 describes the requirements that address the performance areas included in this year's review (CY 2023).

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Mar 6, 2023.

Table 2-1—CMR Three-Year Cycle

CMR Standard	Federal Requirements Included	Year One (CY 2023)	Year Two (CY 2024)	Year Three (CY 2025)
Standard I—Availability of Services	42 CFR §438.206		✓	
Standard II—Assurances of Adequate Capacity and Services	42 CFR §438.207		✓	
Standard III—Coordination and Continuity of Care	42 CFR §438.208	✓		
Standard IV—Coverage and Authorization of Services	42 CFR §438.210	✓		
Standard V—Provider Selection	42 CFR §438.12; 42 CFR §438.214		✓	
Standard VI—Subcontractual Relationships and Delegation	42 CFR §438.230		✓	
Standard VII—Member Rights and Protections	42 CFR §438.100– 42 CFR §438.102	✓		
Standard VIII—Confidentiality	42 CFR §438.224			✓
Standard IX—Enrollment and Disenrollment	42 CFR §438.3 42 CFR §438.56			✓
Standard X—Grievance and Appeal Systems	42 CFR §438.228; 42 CFR §438.400– 42 CFR §438.424	✓		
Standard XI—Practice Guidelines	42 CFR §438.236		✓	
Standard XII—Quality Assessment and Performance Improvement	42 CFR §438.330			✓
Standard XIII—Health Information Systems, including Information Systems Capabilities Assessment (ISCA)	42 CFR §438.242			✓
Standard XIV—Member Information	42 CFR §438.10	✓		
Standard XVI—Emergency and Poststabilization Services	42 CFR §438.114	✓		

Table 2-2—CY 2023 CMR Standards and Descriptions

CMR Standard	Description
Standard III—Coordination and Continuity of Care *42 CFR §438.208*	Requires the CCO to have policies and procedures that ensure each member has an ongoing source of appropriate care that is coordinated among medical providers and other entities serving the member, and is compliant with applicable privacy requirements. The CCO must conduct health risk screenings and an assessment/reassessment of prioritized populations and members with special health care needs (SHCN) for intensive care coordination (ICC) services.
Standard IV—Coverage and Authorization of Services *42 CFR §438.210*	Requires the CCO to have an effective system to review, approve, or deny authorization requests while consistently applying the use of medical necessity criteria. The CCO must have policies and procedures related to coverage and authorization ensuring decision-makers have the appropriate level of expertise, and that notification of decisions are provided in a timely fashion.
Standard VII—Member Rights and Protections *42 CFR §438.100*	Requires the CCO to inform its members, subcontractors, and network providers of members' rights. The CCO must ensure that member rights are respected and allowed to be exercised freely without affecting the treatment of members. The CCO's policies, procedures, and member information must include the State and federal requirements for advance directives.
Standard X—Grievance and Appeal Systems *42 CFR §438.228*	Requires the CCO to maintain a system for grievances and appeals that includes required member information and communications. The CCO's policies and procedures address how grievances are filed and processed, the appeals process related to adverse benefit determinations, assistance with the grievance and appeal process, time frames for issuing acknowledgement notices and notices of adverse benefit determination (NOABDs), as well as an expedited appeal process.
Standard XIV—Member Information *42 CFR §438.10*	Requires the CCO to provide information to its members in a way that is easy to access and understand, including the provision of materials in alternative formats and languages. The CCO must have a mechanism to communicate significant changes in a timely manner. The CCO's policies and procedures address how the CCO ensures compliance with furnishing each member with required information within the state-established time frames.
Standard XVI—Emergency and Poststabilization Services *42 CFR §438.114*	Requires the CCO to ensure access to emergency and poststabilization services without prior authorization. The CCO's policies and procedures address coverage and payment for emergency and poststabilization services.

The information and findings that resulted from HSAG's review of standards and files were used by OHA and each CCO to:

- Evaluate the degree to which the CCO's operations comply with State contracts and federal Medicaid managed care requirements.
- Evaluate the CCO's organizational strengths and identify areas for improvement.
- Identify and monitor the CCO's implementation of interventions to improve the CCO's compliance with quality, timeliness, and accessibility of health care services provided to members.

Compliance Monitoring Review Activities and Technical Methods of Data Collection

Before beginning the CMR, HSAG developed data collection tools to document the review. The requirements in the tools were selected based on applicable federal and State regulations and requirements set forth in the contract between OHA and the CCOs as they relate to the scope of the review. HSAG conducted the following preliminary review (pre-site visit), site visit, and post-site visit activities:

Preliminary Review (Pre-Site Visit) Activities

Preliminary review activities included:

- Providing the CMR Protocol, CMR tools, and applicable guidance to the CCOs.
- Hosting a pre-review technical assistance session with the CCOs.
- Receiving CMR documentation submissions from the CCOs, including complete universes of cases for selected file reviews.
- Conducting a desk review of key documents and other information submitted to HSAG by the CCOs, and from OHA, as applicable. The desk review enables HSAG reviewers to increase their knowledge and understanding of the CCO's operations, identify areas needing clarification, and begin compiling information before the site visit.
- Scheduling the site visit, either in person or virtual.
- Distributing the site visit meeting agenda to the CCO to facilitate preparation for HSAG's site visit.
- Conducting a file review of key data elements to evaluate how each organization implemented a number of the requirements for certain managed care administrative functions by reviewing samples of:
  - Appeal records.
  - Grievance records.
  - Service authorization denials.
  - Care management and service coordination records.

Site Visit Activities

Site visit activities included:

- Conducting an opening conference, with introductions and a review of the agenda and logistics for HSAG's site visit activities.
- Reviewing additional documents requested by HSAG and made available by the CCOs during the interview sessions.
- Reviewing applicable data systems that the CCOs uses in its operation to support standards under review, including but not limited to, utilization management (UM), care coordination, etc.
- Reviewing selected member clinical/nonclinical records in support of file reviews associated with regulatory standards.
- Conducting interviews with the CCOs' key administrative and program staff members.
- Conducting a closing conference where HSAG reviewers summarize their preliminary findings and next steps.

Post-Site Visit Activities

Post-site visit activities included:

- Collecting supplemental information identified during the site visit.
- Compiling data and information obtained from the desk review and site visit interviews.
- Analyzing and aggregating all review findings to produce final compliance determinations.
- Preparing and publishing draft and final compliance reports.

Description of Data Obtained

To assess the CCO's compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the CCOs, including, but not limited to:

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- Management/monitoring reports and audits.
- Staff training materials and documentation of training attendance.
- Narrative and/or data reports across a broad range of performance and content areas.
- CCO-maintained records for service authorization denials.
- Member handbooks, informational materials, the provider directory, and the provider manual.

- Applicable sample correspondence or template communications.
- Member-level clinical and nonclinical files (e.g., care management records).

HSAG obtained additional information for the CMR through interactions, discussions, and interviews with the CCO's key staff members.

Table 2-3 lists the major data sources HSAG used to determine the CCO's performance in complying with requirements and the time period to which the data applied.

Table 2-3—Description of the CCO's Data Sources

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during the site visit.	January 1, 2022–December 31, 2022*
Clinical and nonclinical member records submitted for HSAG's file review.	January 1, 2022–December 31, 2022*
Information obtained through interviews.	July 1, 2023–September 30, 2023

*Data obtained for the record reviews may exceed the time period specified depending on the resolution time frame.

Data Aggregation and Analysis

HSAG reviewers used ratings of *Met*, *Partially Met*, and *Not Met* to indicate the degree to which the CCO's performance complied with the requirements. This scoring methodology is in alignment with CMS' EQR Protocol 3. HSAG compiled all submitted documentation and conducted a final review, considering the intent of the regulations, and applied a rating for each element based on the following definitions:

Met indicates full compliance, defined as:

- All documentation listed under a regulatory provision, or component thereof, is present; and
- CCO staff provide responses to reviewers that are consistent with each other and with the documentation.

Partially Met indicates partial compliance, defined as:

- There is compliance with all documentation requirements, but CCO staff are unable to consistently articulate evidence of compliance during interviews; or
- CCO staff can describe and verify the existence of compliant practices during the interview, but documentation is found to be incomplete or inconsistent with practice.

Not Met indicates noncompliance, defined as:

- No documentation is present, and staff members have minimal or no knowledge of processes or issues addressed by the regulatory provisions; or
- No documentation is present and staff members have little or no knowledge of processes or issues that comply with key components (as defined by OHA) of a multi-component regulatory provision, regardless of compliance determinations for remaining, non-key components of a regulatory provision.

From the scores it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each of the six standards and an overall percentage-of-compliance score across the six standards. HSAG calculated the total score for each standard by totaling the number of *Met* (1 point) elements, the number of *Partially Met* (0.5 points) elements, and the number of *Not Met* (0 points) elements, then dividing the summed score by the total number of applicable elements for that standard.

HSAG determined the overall percentage-of-compliance score across the areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the total values of the scores and dividing the result by the total number of applicable elements).

How Data Were Aggregated and Analyzed

To draw conclusions about the quality, timeliness, and accessibility of care and services the CCOs provided to members, HSAG aggregated and analyzed the data resulting from its pre-site visit and site visit review activities. The data that HSAG aggregated and analyzed included the following:

- Documented findings describing the CCO's progress in achieving compliance with State and federal requirements.
- Scores assigned to the CCO's performance for each element.
- The total percentage-of-compliance score calculated for each of the standards.
- The overall percentage-of-compliance score calculated across the standards.
- Documentation of the actions required to bring performance into compliance with the requirements that HSAG assigned a score of *Partially Met* and *Not Met*.

Based on the results of the data aggregation and analysis, HSAG prepared and forwarded preliminary findings to the CCOs and draft reports to OHA for their review and comment prior to issuing final reports.

3. Summary of Results

Compliance With Review Standards

HSAG's findings for the CY 2023 CMR were determined from its:

- Desk review of the documents AllCare CCO, Inc. (AllCare) submitted to HSAG prior to the site visit portion of the review.
- Service authorization denials, care/service coordination, member grievances, and member appeal file reviews conducted prior to the site visit portion of the review.
- Site visit activities that included reviewing additional documents and records, interviewing key AllCare administrative and program staff members, and system demonstrations.

For each of the individual elements (i.e., requirements) within each standard, HSAG assigned a score of *Met*, *Partially Met*, or *Not Met* based on the results of its findings. HSAG then calculated a total percentage-of-compliance score for each of the six standards and an overall percentage-of-compliance score across the six standards.

The following methodology was used to indicate the confidence level assigned following HSAG's assessment of AllCare's operational structure and implementation of documented processes to determine the degree to which the CCO achieved compliance with the standards reviewed in CY 2023.

- ***High Confidence*** = Compliance Score ≥ 95 percent.
- ***Moderate Confidence*** = Compliance Score ≥ 85 percent and < 95 percent.
- ***Low Confidence*** = Compliance Score ≥ 75 percent and < 85 percent.
- ***No Confidence*** = Compliance Score < 75 percent.

Table 3-1 presents a summary of AllCare's performance results, including a comparison to the CCO's previous performance in the standards reviewed (CY 2020) and the statewide CCO compliance score. Details of the scoring methodology are described in *Section 2. Review Methodology*. Due to the small number of elements associated with individual standards, a single *Partially Met* or *Not Met* rating may lead to substantive changes in the confidence level. As such, results at the standard level should be viewed as informational in support of the CCO's overall compliance score and confidence level.

Table 3-1—Standards and Compliance Scores for AllCare

Standard	Total # of Elements	# Met	# Partially Met	# Not Met	CY 2023 Compliance Score	CY 2023 Confidence Levels	CY 2020 Compliance Score	Statewide CY 2023 CCO Compliance Score
Standard III—Coordination and Continuity of Care	9	7	2	0	88.9%	*Moderate Confidence*	90.0%	85.1%
Standard IV—Coverage and Authorization of Services	18	9	9	0	75.0%	*Low Confidence*	100%	70.1%
Standard VII—Member Rights and Protections	5	1	4	0	60.0%	*No Confidence*	78.0%	69.4%
Standard X—Grievance and Appeal Systems	27	19	8	0	85.2%	*Moderate Confidence*	95.0%	85.2%
Standard XIV—Member Information	22	11	9	2	70.5%	*No Confidence*	100%	80.0%
Standard XVI—Emergency and Poststabilization Services	12	9	3	0	87.5%	*Moderate Confidence*	--	85.4%
Overall Compliance Score	**93**	**56**	**35**	**2**	**79.0%**	***Low Confidence***	**94.0%**	**80.2%**

***Total # of Elements*:** The total number of elements in each standard.

***Overall Compliance Score*:** The percentages obtained by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

The findings from the CMR show how well the CCO interpreted State and federal regulations and the CCO contract requirements and developed the necessary policies, procedures, and plans to carry out the required functions of the CCO. HSAG assigned a *Low Confidence* level to AllCare's compliance with all regulatory requirements reviewed based on the overall compliance score of 79.0 percent. HSAG also assigned a confidence level to each standard reviewed for AllCare in CY 2023. HSAG assigned the CCO a *Moderate Confidence* level for *Coordination and Continuity of Care*, *Grievance and Appeal Systems*, and *Emergency and Poststabilization Services*; a *Low Confidence* level for *Coverage and Authorization of Services*; and a *No Confidence* level for *Member Rights and Protections* and *Member Information*. None of the standards reviewed were assigned a *High Confidence* level. Of the 93 elements, AllCare received *Met* scores for 56 elements, *Partially Met* scores for 35 elements, and *Not Met* scores for two elements.

The overall CY 2023 compliance score of 79.0 percent declined by 15 percentage points compared to the overall score of 94.0 percent from the CY 2020 CMR. Additionally, AllCare's scores declined in all standards compared to the previous review conducted in CY 2020. AllCare performed below the overall statewide CCO average by 1.2 percentage points for the CY 2023 CMR. Of note, AllCare scored /lower than the statewide CCO average compliance score for *Member Rights and Protections and Member Information*.

The areas with opportunities for improvement from the CY 2023 CMR were related to *Coordination and Continuity of Care*, *Coverage and Authorization of Services*, *Member Rights and Protections*, *Grievance and Appeal Systems*, *Member Information*, and *Emergency and Poststabilization Services*, as these areas received performance scores of less than 100 percent. These findings suggest that AllCare did not consistently establish and implement the necessary policies, procedures, and plans to operationalize the required elements of its contract and regulatory provisions, and did not consistently demonstrate compliance with the expectations of the contract. Further, AllCare staff interviews showed that staff members were not consistently knowledgeable about the requirements of the contract, and the policies and procedures that the CCO employed to meet contractual and regulatory requirements.

Detailed findings for each element within each standard reviewed, including program enhancements and required actions, are documented in *Appendix A. Evaluation Tool*.

Summary of Overall Strengths and Areas Requiring Improvement

Standard III—Coordination and Continuity of Care

Performance Strengths	**Strength:** No strengths were identified for the *Coordination and Continuity of Care* standard.
Area(s) Requiring Improvement	**Area(s) requiring improvement:** The CCO received a score of 88.9 percent in the *Coordination and Continuity of Care* standard due to a lack of operational structure and failure to appropriately assess/reassess members of prioritized populations and members with SHCN for intensive care coordination services. **[Quality, Timeliness, and Access]** **Rationale:** The CCO's policies and procedures did not align with State requirements. Additionally, the CCO failed to demonstrate a streamlined method of assessing and reassessing members and updating the member's care plan within the appropriate time frame for members enrolled in intensive care coordination. **Required action(s):** The CCO must revise its policies and procedures to align with State requirements. The CCO must also demonstrate implementation of appropriate assessments, reassessments, and revision of treatment plans according to federal and State requirements.

Standard IV—Coverage and Authorization of Services

Performance Strengths

Strength: No strengths were identified for the *Coverage and Authorization of Services* standard.

Area(s) Requiring Improvement

Area(s) requiring improvement: The CCO received a score of 75.0 percent in the *Coverage and Authorization of Services* standard due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting the CCO's ability to ensure it offers the appropriate services, appropriate and consistent coverage determinations, and proper and timely notification of adverse benefit determinations to members. **[Quality, Timeliness, and Access]**
Rationale: The CCO's policies and procedures did not align with federal and State requirements. Additionally, the CCO failed to demonstrate mechanisms for ensuring the services offered by the CCO were appropriate, and consistent application of medical necessity criteria. The CCO also failed to adhere to requirements for the appropriate decision-makers and time frames for notification of adverse benefit determinations.
Required action(s): The CCO must revise its policies and procedures to align with federal and State requirements. The CCO must also demonstrate implementation of appropriate service offerings and consistent application of medical necessity criteria according to federal and State requirements. The CCO must also demonstrate adherence to federal and State required time frames for notification of adverse benefit determinations.

Standard VII—Member Rights and Protections

Performance Strengths

Strength: No strengths were identified for the *Member Rights and Protections* standard.

Area(s) Requiring Improvement

Area(s) requiring improvement: The CCO received a score of 60.0 percent in the *Member Rights and Protections* standard due to a lack of operational structure and failure to demonstrate implementation of an established process, impacting the CCO's ability to ensure that member rights are respected and allowed to be exercised freely without affecting the treatment of members, advance directive requirements are met, and members are notified of their rights as required by federal and State requirements. **[Quality and Access]**
Rationale: The CCO's policies and procedures and member- and provider-facing materials did not align with federal and State requirements.
Required action(s): The CCO must revise its policies and procedures and member- and provider-facing materials to align with federal and State requirements.

Standard X—Grievance and Appeal Systems

Performance Strengths

Strength: No strengths were identified for the *Grievance and Appeal Systems* standard.

Area(s) Requiring Improvement

Area(s) requiring improvement: The CCO received a score of 85.2 percent in the *Grievance and Appeal Systems* standard due to a lack of operational structure and failure to demonstrate appropriate implementation, impacting the CCO's ability to ensure member grievances and appeals are addressed and responded to appropriately. **[Quality, Timeliness, and Access]**
Rationale: The CCO's policies and procedures did not align with federal and State requirements. Additionally, the CCO failed to use the appropriate staff messaging. The CCO also failed to adhere to requirements for the appropriate decision-makers on clinically-related grievances, time frames for acknowledging receipt of grievances, and readability of notices. The CCO also failed to communicate grievance and/or appeal requirements to members, providers, and subcontractors.
Required action(s): The CCO must revise its policies and procedures to align with federal and State requirements. The CCO must also demonstrate implementation of federal and State requirements within staff messaging. The CCO must also demonstrate adherence to federal and State requirements for decision-makers on clinically-related grievances, time frames for acknowledging receipt of grievances, and readability of notices. The CCO must also demonstrate implementation of federal and State requirements within communications to members, providers, and subcontractors.

Standard XIV—Member Information

Performance Strengths

Strength: No strengths were identified for the *Member Information* standard.

Area(s) Requiring Improvement

Area(s) requiring improvement: The CCO received a score of 70.5 percent in the *Member Information* standard due to a lack of operational structure and failure to demonstrate implementation of an established process, impacting the CCO's ability to ensure timely and proper member communication. **[Quality, Timeliness, and Access]**
Rationale: The CCO's policies and procedures and member-facing materials, including the member handbook, member notices, CCO formulary, and provider directory, did not align with federal and State requirements. Additionally, the CCO did not provide proper notification to members of the availability of member information. The CCO also failed to demonstrate monitoring for timeliness of providing notification to members of significant information changes.
Required action(s): The CCO must revise its policies, procedures, and member-facing materials to align with federal and State requirements. The CCO must also demonstrate

monitoring of timeliness of notification to members of significant information changes and provide proper notification to members of the availability of member information.

Standard XVI—Emergency and Poststabilization Services

Performance Strengths

Strength: No strengths were identified for the *Emergency and Poststabilization Services* standard.

Area(s) Requiring Improvement

Area(s) requiring improvement: The CCO received a score of 87.5 percent in the *Emergency and Poststabilization* Services standard due to failure to demonstrate implementation of appropriate processes and workflows, impacting the CCO's ability to ensure emergency and poststabilization services are covered appropriately. **[Timeliness and Access]**
Rationale: The CCO failed to demonstrate evidence of processes to ensure payment of emergency and poststabilization services.
Required action(s): The CCO must demonstrate evidence of processes to ensure payment of emergency and poststabilization services.

CY 2022 Improvement Plan Review

AllCare was required to implement an Improvement Plan (IP) for all elements scored *Partially Met* or *Not Met* during the CY 2022 CMR and continue to address unresolved findings from previous CMRs. The CCO was expected to fully resolve all findings and demonstrate compliance with regulatory requirements prior to the CY 2023 CMR. To ensure the CCO had implemented plans of action to remediate the CMR findings, HSAG conducted follow-up reviews to evaluate the CCO's compliance with requirements.

HSAG used the following criteria to evaluate the sufficiency of the required actions and determine if the IP elements were resolved:

- The completeness of the IP document in addressing each required action and assigning a responsible individual, a timeline/completion date, and specific actions/interventions that the organization will implement to bring the element into compliance.
- The extent to which the planned activities/interventions bring the organization into compliance with the requirement.
- The timeliness of the CCO's efforts to correct the deficiency.

Table 3-2 presents AllCare's summary of findings for the CY 2022 IP review. HSAG's evaluation of AllCare's approach to addressing the 14 IP findings issued during CY 2022 and unresolved findings from CY 2021 revealed five findings remain unresolved, indicating continued noncompliance with State and federal regulatory requirements.

Table 3-2—Summary of Findings for AllCare's CY 2022 IP Review

Standard	Total # of Findings	Total # of Resolved Findings	Total # of Unresolved Findings	Total % of Unresolved Findings
Standard I—Availability of Services***	4	1	3	75.0%
Standard II—Assurances of Adequate Capacity and Services***	N/A	N/A	N/A	N/A
Standard III—Coordination and Continuity of Care*	N/A	N/A	N/A	N/A
Standard IV—Coverage and Authorization of Services*	N/A	N/A	N/A	N/A
Standard V—Provider Selection***	N/A	N/A	N/A	N/A
Standard VI—Subcontractual Relationships and Delegation***	N/A	N/A	N/A	N/A
Standard VII—Member Rights and Protections*	N/A	N/A	N/A	N/A
Standard VIII—Confidentiality	N/A	N/A	N/A	N/A
Standard IX—Enrollment and Disenrollment	4	4	0	---
Standard X—Grievance and Appeal Systems*	N/A	N/A	N/A	N/A
Standard XI—Practice Guidelines***	N/A	N/A	N/A	N/A
Standard XII—Quality Assessment and Performance Improvement	4	2	2	50.0%
Standard XIII—Health Information Systems, including ISCA	2	2	0	---
Standard XIV—Member Information*	N/A	N/A	N/A	N/A
Standard XVI—Emergency and Poststabilization Services**	N/A	N/A	N/A	N/A
Total	**14**	**9**	**5**	**35.7%**

* Standards assessed during the CY 2020 CMR and reassessed in CY 2023. Gray shading indicates the CY 2023 IP may include additional findings for these standards identified during this year's CMR. Unresolved findings represented for these standards indicate the CCO has remained out of compliance since the CY 2020 CMR.

** Standard initially assessed under Standard IV—Coverage and Authorization of Services during the CY 2020 CMR and reassessed in CY 2023. Gray shading indicates the CY 2023 IP may include additional findings for these standards identified during this year's review. Unresolved findings represented for this standard indicate the CCO has remained out of compliance since the CY 2020 CMR.

***Standards assessed during the CY 2021 CMR. Unresolved findings represented for these standards indicate the CCO has remained out of compliance since the CY 2021 CMR.

4. Improvement Plan Process

AllCare is required to submit an IP addressing all elements scored *Partially Met* or *Not Met* during the CY 2023 CMR. For each element that requires corrective action, the CCO should use the CCO-specific prepopulated CY 2023 IP tool to identify the actions(s) taken to achieve compliance with the requirement, the individual(s) responsible, and the timelines for completing the planned activities. Implementation of interventions identified in the IP should begin immediately to resolve findings and bring the organization into compliance with federal and State requirements. The completed IP and evidence of implementation must be submitted with the CY 2024 CMR pre-site visit documentation.

HSAG will review the CCO's IP, evidence of implementation for resolution of the CY 2023 findings, and any unresolved findings from previous reviews. Results of HSAG's assessment will be included in the CY 2024 CMR report. The CCO is encouraged to contact HSAG to schedule a technical assistance call to review findings and ensure proposed interventions will successfully resolve areas of noncompliance.

Appendix A. Evaluation Tool

Following this page is the completed compliance review tools HSAG used to evaluate AllCare's performance for each requirement.

Standard III—Coordination and Continuity of Care

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. The CCO implements procedures to deliver care and coordinate services for all members, which include ensuring 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. *42 CFR § 438.208(b)(1)* *Contract: Exhibit B Part 4 (2)(l)* *OAR 410-141-3860 (6)(b)*	**Suggested Documents:** • Care Coordination and/or Care Management Program Descriptions • Care Coordination and/or Care Management policies and procedures • Member Welcome Letter or other outreach letter • Member Handbook **Documents Submitted for Desk Review:** • 1.01 New Member Welcome Letter 2022-PQ- **Page 1** • 1.02 Member Handbook 2022- **Page 3, 9, 24, 61, 62-67, 97-99, 116, 120, 132** • 1.03 Health Risk Survey 2022- **Page 2** • 1.05 PCP-Dental Selection Form- **Page 1** • 1.06 Dental Brochure 2022 **Page 2** • 1.07 Mental Health Provider Card-English- **Page 1** • 1.08 Behavioral Health Handbook 2022- **Page 4, 5, 9, 21-22, 33** • 1.09 ICC Letter Revised 2022 –**Page 1** • 1.12 2022ACHHC CUSTCAR 012 Providing Member Materials Policy – **Page 3** • 1.13 Care Coordination Decline letter 2022 example **Page 1** • 1.14 Care Coordination Unable to Reach Letter 2022 example **Page 1**	☒ Met ☐ Partially Met ☐ Not Met

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• 1.15 Care Coordination Welcome Letter 2022 example **Page 1** • 1.16 Member Services Online Portal Completed HRA Forms v1- **Page 1** • 1.17 Care Coordination Program Summary 2022 - **pages 3, 5, 8 & 9** • 1.19 POP CCO 003 Member Rights and Responsibilities - **page 2** • 1.20 POP CCO 004 Cultural Considerations - **page 2 & 3** • 1.21 POP CCO 005 Nurse Helpline - **page 2** • 1.22 POP CCO 007 Special Health Care Needs - **page 2 & 3** • 1.23 POP-CCO 008 Care Coordination - **pages 2-9** • 1.24 POP CCO 009 Care Coordination Scope of Practice - **page 2 & 3** • 1.25 POP CCO 010 Intensive Care Coordination - **pages 3-8, 11, 12** • 1.26 POP CCO 011 Health Risk Assessment - **page 2** • 1.27 POP CCO 206 Health Risk Assessment Desk Procedure - **page 1-3** • 1.28 POP CCO 015 Continuity of Care - **page 2 & 3** • 1.29 POP CCO 021 Transition of Care - **page 2-8** • 1.30 POP CCO 012 Individualized Care Planning - **page 2** • 1.31 POP CCO 013 Interdisciplinary Care Team - **page 2 & 3** • 1.32 BMPS CCO 132.pdf **Page 1**	

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
2. The CCO implements procedures to coordinate services the CCO furnishes 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 MCE; 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)* *Contract: Exhibit M (11)(b)* *OAR 410-141-3860 (3)*	**Suggested Documents:** • Policies and procedures that address care coordination and/or continuity of care for services outlined in the requirement • Processes or workflows for coordinating with other entities (outlined in the requirement) and identification of responsibilities • One example showing the CCO coordinating care with each of the following entities listed in letters (a) through (d) of the requirement **Documents Submitted for Desk Review:** • 1.17 Care Coordination Program Summary 2022 - **page 1, 2, 5 & 6** • 1.18 Care Coordination Referral Pathways Visio 2022 - **page 2-4** • 1.19 POP CCO 003 Member Rights and Responsibilities - **page 2** • 1.20 POP CCO 004 Cultural Considerations - **page 2 & 3** • 1.22 POP CCO 007 Special Health Care Needs - **page 2 & 3** • 1.23 POP-CCO-008 Care Coordination - **page 2-7, 9** • 1.24 POP CCO 009 Care Coordination Scope of Practice - **page 2 & 3**	☒ Met ☐ Partially Met ☐ Not Met

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• 1.25 POP-CCO-010 Intensive Care Coordination - **page 3-8, 11 & 12** • 1.28 POP CCO 015 Continuity of Care - **page 2 & 3** • 1.29 POP CCO 021 Transition of Care - **page 1-8** • 1.30 POP CCO 012 Individualized Care Planning - **page 2** • 1.31 POP CCO 013 Interdisciplinary Care Team - **page 2 & 3** • 1.32 BMPS CCO 132 - **page 1 & 3** • 1.40 POP-CCO-101 Transition of Care Program Summary - **page 2 & 3** • 1.41 POP CCO 031 Integration with Insurers and Vendors - **page 1 & 2** • 1.42 POP CCO 032 Partnerships with Other Organizations and CBOs - **page 1-3** • 1.73 POP CCO 025 Maternal Child Health - **page 3** • 1.74 POP CCO 102 Maternal Child Health Program Summary - **page 1 & 2** • 1.43 Requirement example 2a • 1.44 Requirement 2 Evidence b c d • 1.46 Requirement 2 a	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
3. The CCO implements procedures to make a best effort to conduct an initial health risk screening, which shall include a screening for behavioral health issues, of each new member's needs:	**Suggested Documents:** • Initial health risk screening policies and procedures • Description of need stratification mechanism used to identify members receiving LTSS or members of	☒ Met ☐ Partially Met ☐ Not Met

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
a. Within 90 days of the effective date enrollment; or b. Within 30 days after the effective date of enrollment when the member is referred, receiving Medicaid-funded long-term care, services and supports (LTSS), or is a member of a priority population for intensive care coordination (ICC) as described in OAR 410-141-3870; or c. Sooner than the timeframes required if required by the member's health condition. ***The CCO shall maintain documentation on the health risk screening process, including subsequent attempts if the initial attempt to contact the member is unsuccessful.* *42 CFR § 438.208(b)(3)* *CCO Contract: Exhibit B Part 4 (1)* *OAR 410-141-3865 (3)(b)(A-C)*	a priority population (as defined in OAR 410-141-3870 (2)) • Sample of the initial health risk screening form/template • Samples of completed health risk screenings (one each) for the following: – Member not meeting criteria for screening in less than 90 days; – Member of prioritized population; – Member with special health care needs (SHCN); and – Member receiving LTSS. – **Additional examples may be requested during the onsite.* • Timeliness tracking of outreach and health risk screening completions **Documents Submitted for Desk Review:** • 1.03 Health Risk Survey 2022 - **page 1** • 1.17 Care Coordination Program Summary 2022 - **page 5, 8 & 10** • 1.18 Care Coordination Referral Pathways Visio 2022 - **page 1, 3 & 4** • 1.20 POP CCO 004 Cultural Considerations - **page 2** • 1.22 POP CCO 007 Special Health Care Needs - **page 2** • 1.23 POP-CCO-008 Care Coordination - **page 4-6, 8 & 9**	

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• 1.25 POP-CCO-010 Intensive Care Coordination - **page 3-5, 9 & 10** • 1.26 POP-CCO-011 Health Risk Assessment - **page 2** • 1.27 POP CCO 206 Health Risk Assessment Desk Procedure - **page 1 & 2** • 1.28 POP CCO 015 Continuity of Care - **page 2** • 1.29 POP CCO 021 Transition of Care - **page 3 & 7** • 1.60 ACHHC-Online Member Portal HRA **Page 1, 2** • 1.61 Completed Member Services Online Portal HRA Form v1 **Page 1** • 1.62 Health Risk Survey Listing Weekly Report example • 1.63 HRA Evidence 3a Mailed in Completed AS HRS 7.6.22. • 1.64 Medical Management 8133 LTSS Monitoring Report Coordination and Continuity of Care example • 1.65 Collective Medical Notification TAGS and HEN SNF follow up in EHR • 1.66 requirement 3 HRA LTSS SHCN PEDIATRIC evidence • 1.67 Collective Medical Cohorts and tags • 1.94 Requirement 7 Evidence a and b • 2.27 IV-Special Health Care Needs Members 2022.08 **Page 2**	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
4. The CCO implements procedures to share with participating medical providers, the State, CCOs, or other entities serving the member the results of its 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)(g)(3)* *OAR 410-141-3865(4)(c)*	**Suggested Documents:** • Care Coordination and/or Care Management policies and procedures • Sample documentation showing sharing of assessments with relevant entities involved in the member's care *HSAG will also use the results of the care coordination file review **Documents Submitted for Desk Review:** • 1.17 POP CCO Care Coordination Program Summary - **page 2, 5 & 8** • 1.22 POP CCO 007 Special Health Care Needs - **page 2 & 3** • 1.23 POP-CCO 008 Care Coordination - **page 4-7 & 9** • 1.24 POP CCO 009 Care Coordination Scope of Practice - **page 2 & 3** • 1.25 POP CCO 010 Intensive Care Coordination - **page 4-7, 11 & 12** • 1.27 POP CCO 206 Health Risk Survey Desk Procedure - **page 3** • 1.28 POP CCO 015 Continuity of Care - **page 2 & 3** • 1.29 POP CCO 021 Transition of Care - **page 3-5 & 7** • 1.30 POP CCO 012 Individualized Care Planning - **page 2**	☒ Met ☐ Partially Met ☐ Not Met

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• 1.31 POP CCO 013 Interdisciplinary Care Team - **page 2 & 3** • 1.40 POP-CCO-101 TOC Program Summary - **page 2** • 1.41 POP CCO 031 Integration with Insurers and Vendors - **page 1 & 2** • 1.42 POP CCO 032 Partnerships with Other Organizations and CBOS - **page 2** • 1.70 Adapt Care Coord Policy revised 03032022 **Page 2** • 1.71 Option II.I Care Coordination and Transitions of Care **Page 1** • 1.73 POP CCO 025 Maternal Child Health- **Page 2** • 1.74 POP CCO 102 Maternal Child Health Program Summary - **page 1** • 1.75 Shared Member Data to PCP Example • 1.76 Shared member Data to APD Community Partner Example • 1.77 Evidence Share member information IDT • 1.78 Shared Member HRA to PCP • 2.13 2022 Advantage Dental Services Member Handbook **Page 19-20** • 2.14 2022 Privacy Computer Information Security Training 220330 AD **Page 6** • 2.20 Care Coordination SOPs 2022 AD **Page 2-4** • 2.18 PLANCG-07 Care Coordination AD **Page 2, 4** • 2.17 SAMPLE OHP Provider Agreement AD **Page 6**	

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• 2.22 III-Care Coordination and Case Management 2022.08 **Page 1, 2, 4** • 2.28 IV-Special Needs Referral Policy 2022.06 **Page 1-3**	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
5. The CCO implements procedures to ensure 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)*	**Suggested Documents:** • Care Coordination and/or Care Management policies and procedures • Policies guiding health record disclosure for care coordination • Health/dental record documentation requirements or policies • Provider Manual, Provider Agreement, or other provider messaging regarding documentation requirements • Sample provider chart reviews/audits • Committee meeting minutes demonstrating monitoring of member health records **Documents Submitted for Desk Review:** • 1.04 Notice of Privacy Form -**Page 1** • 1.17 Care Coordination Program Summary 2022 - **page 2** • 1.23 POP CCO 008 Care Coordination - **page 4-6** • 1.29 POP CCO 021 Transition of Care - **page 3 & 4**	☒ Met ☐ Partially Met ☐ Not Met

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• 1.30 POP CCO 012 Individualized Care Planning - **page 2** • 1.31 POP CCO 013 Interdisciplinary Care Team - page **2 & 3** • 1.41 POP CCO 031 Integration with Insurers and Vendors - **page 2** • 1.70 Adapt Care Coord Policy revised 03032022 **Page 2** • 1.71 Option II.I Care Coordination and Transitions of Care **Page 1** • 1.72 POP CCO 006 Medical Record Documentation - **page 2** • 1.80 Sample audit list of documents_MH Crisis Provider -**Page 1, 2** • 1.81 Sample Audit List of documents_SUD provider- **Page 1** • 1.82 POP CCO 001 Protected Health Information- **Page 5** • 1.83 CCO Provider Manual - **page 11, 13, 17, 19, 20 & 26** • 1.84 AllCare CCO Direct Provider Agreement 2020 5876.1.0.docx **Page 4, 14,15, 19, 23-24, 32** • 2.13 2022 Advantage Dental Services Member Handbook **Page 19-20** • 2.14 2022 Privacy Computer Information Security Training 220330 AD **Page 3, 5** • 2.15 COMCG-02 Privacy Policy AD **Page 1** • 2.18 PLANCG-07 Care Coordination AD **Page 2, 4**	

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• 2.19 PLANCG-09 Chart Audits AD Page 1 • 2.22 III-Care Coordination and Case Management 2022.08 **Page 1** • 2.23 III-Dental Records 2022.06 **Page 2** • 2.24 III-HIPAA Privacy Policy & Procedures 5.1.19.rev 1.2023.final **Page 34** • 2.26 III-Provider-Manual-CDC 2022 **Page 2, 5, 15,**	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
6. The CCO implements procedures to ensure 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 (Health Insurance Portability and Accountability Act of 1996 [HIPAA]), to the extent that they are applicable. *42 CFR § 438.208(b)(6)* *CCO Contract: Exhibit B Part 4 (1)(a)*	**Suggested Documents:** • Care Coordination and/or Care Management policies and procedures • Privacy/HIPAA policies and procedures *HSAG will also use the results of the care coordination file review **Documents Submitted for Desk Review:** • 1.04 Notice of Privacy Form -**Page 1** • 1.19 POP CCO 003 Member Rights and Responsibilities page - **3 & 4** • 1.22 POP CCO 007 Special Health Care Needs - **page 3** • 1.23 POP CCO 008 Care Coordination - **page 2, 6 & 9** • 1.25 POP CCO 010 Intensive Care Coordination - **page 3 & 6** • 1.27 POP CCO 206 Health Risk Survey Desk Procedure - **page 2**	☒ Met ☐ Partially Met ☐ Not Met

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• 1.29 POP CCO 021 Transition of Care - **page 2, 4 & 6** • 1.31 POP CCO 013 Interdisciplinary Care Team - **page 2** • 1.73 POP CCO 025 Maternal Child Health - **page 2** • 1.70 Adapt Care Coord Policy revised 03032022 **Page 2** • 1.80 Sample audit list of documents MH Crisis Provider - **page 1, 2** • 1.81 Sample Audit List of documents SUD provider - **page 1** • 1.82 POP CCO 001 Protected Health Information - **page 2-7** • 1.83 CCO Provider Manual- **Page 13** • 1.84 AllCare CCO Direct Provider Agreement 2020 5876.1.0.docx **Page 4, 8, 10, 14, 15, 19-20, 23-24, 32, 35** • 1.85 For CAP Service Plan Report Template Options **Page 1** • 1.86 For CAP Service Plan Report Template SUD **Page 1** • 5.0 Options of Southern Oregon Audit Results- **Page 3, 5** • 1.87 Policy QIP Authorization to discuss PHI- **Page 1-3** • 1.88 Authorization to Discuss PHI phone script- **Page 1** • 1.89 Encrypted Email Policy –**Page 1-2**	

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• 2.11 (ePHI) Access Controls AD **Page 1** • 2.12 (ePHI) Access Establishment, Modification and Termination **Page 1** • 2.13 2022 Advantage Dental Services Member Handbook **Page 16** • 2.14 2022 Privacy Computer Information Security Training 220330 AD **Page 3, 5** • 2.15 COMCG-02 Privacy Policy AD **Page 1** • 2.16 PLANCG-13 Confidentiality AD **Page 1, 7-11** • 2.17 SAMPLE OHP Provider Agreement AD **Page 17, 26, 27** • 2.21 III-2021 CDC Provider Agreement rev 08.30.2021.rev **Page 10, 17** • 2.22 III-Care Coordination and Case Management 2022.08 **Page 1** • 2.24 III-HIPAA Privacy Policy & Procedures 5.1.19.rev 1.2023.final **Page 5, 9, 12** • 2.25 III-Provider Communications 2022.02 **Page 2, 4,** • 2.26 III-Provider-Manual-CDC 2022 **Page 23**	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
7. The CCO implements mechanisms to comprehensively assess each member identified by the State as needing LTSS or having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. The assessment mechanisms	**Suggested Documents:** • Member onboarding policies and procedures • Care Coordination and/or Care Management policies and procedures addressing ICC assessment processes	☐ Met ☒ Partially Met ☐ Not Met

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
must use appropriate providers or individuals meeting LTSS service coordination requirements of the State or CCO, as appropriate. The CCO must conduct the ICC assessment: a. Within 10 days of completion of the health risk screening, or sooner if required by their health condition for prioritized populations. b. Within 30 days of referral or completion of an initial health risk screening for members with special health care needs (SHCN), members receiving LTSS, members with needs or conditions that may indicate a need for ICC services, and those self-referred or referred by the member's representative or provider. *42 CFR §438.208(c)(2)* *CCO Contract: Exhibit B Part 4(2)(g)* *CCO Contract: Exhibit B Part 4 (9)(a* *OAR 410-141-3865 (3)(d)* *OAR 410-141-3870 (2),(5)*	• Protocols used to determine needs of the member and how the health plan will meet those needs • Sample ICC assessment form/template • Sample completed ICC assessment (one each) for the following: – Member of prioritized population; – Member with SHCN; – Member receiving LTSS; – Member identified during the health risk screening with needs or conditions that may indicate a need for ICC services; and – Member referred by self, representative or provider. **Additional examples may be requested during the onsite.* • Sample screenshots, dashboards, or spreadsheets to show tracking to ensure the assessments are completed within the appropriate time frame **Documents Submitted for Desk Review:** • 1.22 POP CCO 007 Special Health Care Needs - **page 2 & 3** • 1.23 POP-CCO 008 Care Coordination - **page 3 & 4** • 1.25 POP CCO 010 Intensive Care Coordination - **page 2-5 & 7** • 1.26 POP CCO 011 Health Risk Assessment - **page 2** • 1.27 POP CCO 206 Health Risk Assessment Desk Procedure - **page 1**	

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• 1.28 POP CCO 015 Continuity of Care - **page 2** • 1.29 POP CCO 021 Transition of Care - **page 3, 4 & 7** • 1.73 POP CCO 025 Maternal Child Health - **page 3 & 4** • 1.90 EHR examples of SHCN and LTSS FLAG **Page 1** • 1.91 LTSS MOU Staff Training Document **(page 1, 4)** • 1.92 Blank ICC Assessment example • 1.93 Requirement 7 Evidence a and b • 1.95 Requirement 7 a and b • 1.96 Requirement 7b • 1.64 Medical Management 8133 LTSS Monitoring Report Coordination and Continuity of Care example • 1.65 Collective Medical Notification TAGS and HEN SNF follow up in EHR	

HSAG Findings: The CCO's *Intensive Care Coordination* policy stated that an ICC assessment is to be completed within 30 days after receipt of an ICC referral or upon an initial HRA completion, identifying that the ICC level of services was indicated. It also stated that an ICC assessment is to be conducted, including for children ages 18 and under, when a health risk screening is conducted in accordance with OAR 410-141-3865 indicating any of the following:

- A member has SHCN or other needs or conditions that indicate a need for ICC services.
- Member self-referral.
- A member's representative or provider, including a home and community-based services provider, referred the member.
- Upon referral of any medical personnel serving as a member's LTSS care manager.

The CCO's policies and procedures did not include the requirement that the CCO is to conduct the ICC assessment within 10 days of the health risk screening completion or sooner if required by the member's health condition for prioritized populations. During the site visit, the CCO

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
asserted that its policy is to conduct the ICC assessment within 10 days for each member and that the *Intensive Care Coordination* policy included the requirement. After the site visit, the reviewer confirmed that the language was omitted from the policy. This requirement was *Partially Met*.		
Required Actions: The CCO must ensure its policies and processes align with federal requirements and the upcoming changes to the OARs, effective February 2024, and it must demonstrate implementation.		
8. The CCO shall implement processes for documenting all of the ICC services provided and attempted to be provided to members and for creating and implementing ICC plans for members requiring ICC services. The CCO must produce a treatment or service plan meeting federal and State criteria (a) through (e) for members who require LTSS and produce a treatment or service plan meeting criteria (c) through (e) for members with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. The ICC plan or treatment plan must be: a. Developed by an individual meeting LTSS service coordination requirements with member participation, and in consultation with any providers caring for the member. b. Developed by a person trained in person-centered planning using a person-centered process and plan (as defined in 441.301(c) (1) and (2) for LTSS treatment or service plans). c. Approved by the CCO in a timely manner (if such approval is required by the CCO).	**Suggested Documents:** • Member onboarding policies and procedures • Care Coordination and/or Care Management policies and procedures • Sample care plans (one each) for the following: – Member receiving LTSS with care plan **developed** during the CY 2022 review period; – Member receiving LTSS with care plan **reviewed/revised** during the CY 2022 review period; – Member receiving ICC services with care plan **developed** during the CY 2022 review period; and – Member receiving ICC services with care plan **reviewed/revised** during the CY 2022 review period. **Additional examples may be requested during the onsite.* • Sample screenshots, dashboards, or spreadsheets to show tracking to ensure the reassessments are completed within the time frame *HSAG will also use the results of the care coordination file review	☐ Met ☒ Partially Met ☐ Not Met

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
d. Be developed in accordance with OHA quality assessment and performance improvement utilization review standards. e. Reviewed and revised upon reassessment of functional need, at least **every three months** for member's receiving ICC services and **every 12 months** for other members or when the member's circumstances or needs change significantly, or at the request of the member. *42 CFR §438.208(c)(3)* *Contract: Exhibit B Part 4 (2)(g)(1)* *OAR 410-141-3870 (15)*	**Documents Submitted for Desk Review:** • 1.22 POP CCO 007 Special Health Care Needs - **page 3** • 1.23 POP-CCO 008 Care Coordination - **page 1, 3-6 & 9** • 1.24 POP CCO 009 Care Coordination Scope of Practice - **page 2** • 1.25 POP CCO 010 Intensive Care Coordination - **page 3-7, 9, 11 & 12** • 1.26 POP CCO 011 Health Risk Assessment - **page 2** • 1.28 POP CCO 015 Continuity of Care - **page 2** • 1.29 POP CCO 021 Transition of Care - **page 2-5 & 7** • 1.30 POP CCO 012 Individualized Care Planning - **page 1-3** • 1.31 POP CCO 013 Interdisciplinary Care Team - **page 2** • 1.41 POP CCO 031 Integration with Insurers and Vendors - **page 2** • 1.64 Medical Management 8133 LTSS Monitoring Report Coordination and Continuity of Care example • 1.65 Collective Medical Notification TAGS and HEN SNF follow up in EHR • 1.67 Collective Medical Cohorts and Tags • 2.01 Community Partner LTSS APD referral form used by Care Coordination • 2.02 AllCare IDT_Form	

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• 2.03 IDT APD Meeting agenda 04062022 • 2.04 Evidence HRA ICC Triggering Event	

HSAG Findings: The CCO's *Care Coordination Scope of Practice* policy described the intensive care coordinator/advocate qualification as an expert in care coordination with at least two years of experience working in the community, working with members, and understanding local resources. The policy also included licensed care managers' qualifications as individuals with a high level of clinical practice and expertise navigating the healthcare system. The care coordinator position requirements stated that the individual was a registered nurse, licensed practical nurse, licensed clinical social worker, or respiratory therapist. The individual also was required to apply to receive his/her Certified Case Manager Certification after two years as a care coordinator. The *Transitions of Care* policy also stated that the treatment or service plan is to be developed by an individual meeting LTSS service coordination requirements with member participation and in consultation with any providers caring for the member, and developed by a person trained in person-centered planning using a person-centered process and plan as defined in 441.301(c)(1) and (2) for LTSS treatment or service plans. While the CCO coordinates services for LTSS members, it does not develop LTSS-specific care plans. Rather, such care plans are developed by Area Agencies on Aging/Aging and People with Disabilities (APD) through a memorandum of understanding (MOU) with the CCO. Therefore, components (a) and (b) of this element are not applicable.

The *Individualized Care Planning* policy stated that the CCO's care coordination team is to use the individualized care plan (ICP) to communicate and formalize a member's needs and goals and guide the member's overall care coordination plan. The ICP was developed in collaboration with the member, the member's authorized representative, and any other interdisciplinary care team members. The ICP contained information from treatment plans from providers involved in the member's care and, if appropriate and with the member's consent, community partner-provided information. The policy stated that treatment plans are to be developed by the member's designated primary care provider (PCP) or other practitioners with the member's participation, included consultation with any specialist caring for the member, and comply with any applicable State quality assurance and utilization review standards. The policy stated that ICPs were updated every 90 days or as needed, whichever came first based on a member's medical circumstances or significant changes.

File reviews for the CCO demonstrated that care plans were present. However, the CCO could not describe nor demonstrate a streamlined method of assessing and reassessing members and updating the care plan based on the reassessment in the appropriate time frame for ICC-enrolled members. Documentation demonstrated during the site visit included case notes that demonstrate discussion of progress with meeting care plan goals and care coordination, including discussions with the interdisciplinary team (IDT). However, notes did not confirm a comprehensive assessment or reassessment occurred. Case managers were identified in the record, and documentation showed member involvement in the care plan, where applicable. This requirement was *Partially Met*.

Required Actions: The CCO must ensure its policies and processes align with federal requirements and the upcoming changes to the OARs, effective February 2024, and it must demonstrate implementation.

Standard III—Coordination and Continuity of Care (42 CFR §438.208)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
9. For members with special health care needs determined through an assessment by appropriate health care professionals to need a course of treatment or regular care monitoring, the CCO must have a mechanism 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)(g)(2)* *OAR 410-141-3870 (19)*	**Suggested Documents:** • Policies and procedures on direct access for SHCN members • Materials informing SHCN members about direct access to specialists and the approval process • Samples documentation showing members being granted direct access **Documents Submitted for Desk Review:** • 2.10 UM CCO 03 Decision Making Scope- **Page 1, 3-4** • 1.22 POP CCO 007 Special Health Care Needs **Page 3** • 1.02 Member Handbook 2022- **Page 84** • 2.18 PLANCG-07 Care Coordination AD **Page 5**	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		

Results for Standard III—Coordination and Continuity of Care							
Total	Met	=	7	X	1.0	=	7.0
	Partially Met	=	2	X	0.5	=	1.0
	Not Met	=	0	X	0.0	=	0.0
Total Applicable		=	9	**Total Score**		=	8.0

Total Score ÷ Total Applicable	=	**88.9%**

Standard IV—Coverage and Authorization of Services

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. The CCO must: a. Specify the amount, duration, and scope of each service that the CCO is required to offer. b. Ensure that the services defined in the contract are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. i. Services may not be less than the amount, duration, and scope for the same services delivered to FFS Medicaid members. ii. Services for members under 21 must meet requirements set forth in subpart B of part 42 CFR §440.40(b) and subpart b of 42 CFR §441 (EPSDT services). *42 CFR § 438.210(a)(2);(3)(i)* *Contract: Exhibit B Part 2(2)(b)* *OAR 410-141-3835(6)*	**Suggested Documents:** • Coverage and authorization policies and procedures • Utilization management (UM) plan/utilization review (UR) policies and procedures • Service Authorization Handbook • Plan documents outlining the services defined in the contract • Member materials, such as the member handbook and benefits grid **Documents Submitted for Desk Review:** • **CAS Member Handbook 2022**, Page 50-56, and page 113-115 for EPSDT • **CAS Service Auth Handbook:** Page 24 -40 for the 2022 PA Grid • CAS UM CCO 03 PH Decision Making Scope: Pages 2-12 • **CAS UM CCO 134 OHP Benefit**: pages 4 (2c, i), Page 5 (2c, iv)	☐ Met ☒ Partially Met ☐ Not Met
HSAG Findings: The *OHP Benefit* policy and procedure stated that the CCO is to cover the medically necessary health services and items described in OHA's administrative rules and the Prioritized List of Health Services above the funding line set by the legislature. The policy stated that the CCO is to comply with the requirements listed in this element. The amount, duration, and scope of services were presented in the covered services section of the member handbook. The Service Authorization handbook included a service authorization grid that identified the services covered and the appropriate codes for coverage, along with stipulations considered and whether a prior authorization is required. During the site visit, the CCO discussed that it uses subcontractors to manage dental and behavioral health services. However, prior to the site		

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
visit, the CCO did not provide data demonstrating that a subcontractor managed behavioral health services. The CCO provided data for its subcontracted dental care entities, Capitol Dental Care (CDC) and Advantage Dental Services (ADS). During the site visit, the CCO discussed its process for ensuring services identified in the contract were sufficient and the same services offered by fee-for-service (FFS).These services include monitoring for contract and OAR changes, participating in state meetings, subscription to email groups, monitoring for OHA's notification of changes, clinical groups, and use of the prioritized list. However, the CCO did not provide evidence or a defined process for completing this. At the site visit, the CCO discussed that all Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services are reviewed for medical necessity. The CCO also reported that denied claims are flagged for review to ensure that EPSDT claims are not denied inappropriately. This requirement was *Partially Met*.		
Required Actions: The CCO must demonstrate its mechanism for ensuring that the services defined in the contract are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. Specifically, the CCO must ensure that the services offered by the CCO are not less than the amount, duration, and scope for the same services delivered to FFS Medicaid members.		
2. The CCO does 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 member. *42 CFR § 438.210(a)(3)(ii)* *Contract: Exhibit B Part 2(2)(a-b)* *OAR 410-141-3835(7)*	**Suggested Documents:** • Coverage and authorization policies and procedures • Service Authorization Handbook • UM plan/UR policies and procedures • Plan documents outlining process for determining service denials • Coverage guidelines/criteria **Documents Submitted for Desk Review:** • CAS UM CCO 111 Standard Service Determinations, page 3, item 11. • CAS UM CCO 110 Expedited Service Determination, page 3, item 10. • CAS UM CCO 108 Decision Making scope, page 1, "Purpose". • CAS UM CCO 134 OHP Benefit Page 4, 2a	☒ Met ☐ Partially Met ☐ Not Met

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
3. The CCO may place appropriate limits on services-- a. On the basis of criteria applied under the State plan (such as medical necessity). b. For the purpose of utilization control, provided that: i. The services furnished can reasonably achieve their purpose. 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. iii. Family planning services are provided in a manner that enables the member to choose the method of family planning. *42 CFR § 438.210(a)(4)* *Contract: Exhibit B Part 2(3)(b)(3)* *OAR 410-141-3835(9)*	**Suggested Documents:** • Coverage and authorization policies and procedures • Service Authorization Handbook • UM plan/UR policies and procedures • Plan documents outlining processes for determining quantitative and non-quantitative service limits • Coverage guidelines/criteria, including pharmacy • Member materials, such as member handbook **Documents Submitted for Desk Review:** • CAS UM CCO 108 Decision Making, page 2, #4.	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: The *Decision Making Process for Service Requests* policy and procedure outlined the requirements in this element. The CCO identified if there were limits on covered services in the covered services section of the member handbook. The member handbook addressed family planning services and stated that members do not need a referral to access the services. Additionally, the Family Planning section of the member handbook stated that if members have SHCN or receive LTSS, they can get direct access to specialty care, which appeared to be out of place in this handbook section. During the site visit, the CCO discussed that members receiving LTSS are flagged in their EZ-Cap system to identify their special needs and to ensure that those needs are considered during service requests. This requirement was *Met*.		
Required Actions: None.		

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Recommendations: The CCO should revise the member handbook to move the statement that if members have SHCN or receive LTSS, they can get direct access to specialty care from the Family Planning section into a more appropriate handbook section.		
4. The CCO specifies what constitutes medically necessary covered services and administers the services in a manner that: a. Is no more restrictive than that used in the State Medicaid program, including quantitative and non-quantitative limits (as indicated in other State policies, procedures and administrative rules). b. Takes into account and addresses the following: 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. iv. The opportunity for a member receiving long-term services and supports to have access to the benefits of community living, to achieve person centered goals, and live and work in the setting of their choice. *42 CFR § 438.210(a)(5)* *Contract: Exhibit B Part 2(2)(b)*	**Suggested Documents:** • Coverage and authorization policies and procedures • Service Authorization Handbook • UM plan/UR policies and procedures • Medical necessity criteria utilized (e.g., InterQual, MCG) **Documents Submitted for Desk Review:** • CAS UM CCO 108 Decision Making, page 2, #2 and #3. • **CAS UM CCO 134 OHP Benefit,** Page 2, #1, Page 3, #4, and Page 4, (1f)	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
5. The CCO and its subcontractors have in place and follow written policies and procedures that address the processing of requests for initial and continuing authorization of services. a. The CCO/subcontractor's policies and procedures must also comply with prior authorization requirements outlined in Contract: Exhibit B Part 2(3)(b). *42 CFR § 438.210(b)(1)* *Contract: Exhibit B Part 2(3)(a)* *OAR 410-141-3835(10)(f)(C)*	**Suggested Documents:** • UM plan/UR policies and procedures outlining procedures Coverage and authorization policies and procedures • Service and Authorization Handbook • Audit results from delegation oversight of policies and procedures **CCO should be prepared to provide copies of delegated entities' policies and procedures upon request* **Documents Submitted for Desk Review:** • **CAS Service Auth Handbook**, Page 6-12, "Appendix A" • CAS UM CCO Analyst Auth Process DP, (All) • CAS UM CCO 134 OHP Benefit, Page 1 "purpose" • CAS UM CCO 108 Decision Making, Page 2, #5	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
6. The CCO has and follows written policies and procedures that include mechanisms to ensure consistent application of review criteria for authorization decisions. *42 CFR §438.210(b)(2)(i)* *Contract: Exhibit B Part 2(3)(b)(1)* *OAR 410-141-3835(10)(f)*	**Suggested Documents:** • UM plan/UR policies and procedures • Coverage and authorization policies and procedures • Coverage guidelines/criteria • Service authorization handbook	☐ Met ☒ Partially Met ☐ Not Met

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• Results of inter-rater reliability (IRR) activities • Committee meeting minutes where IRR results are reviewed **Documents Submitted for Desk Review:** • CAS Inter Rater Relresults IRR • CAS IRR Summary 2022 • CAS UM CCO 136 Inter-Rater Reliability, All • CAS QI 12-7-22 minutes • CAS UMCPGURC minutes 12/13/2022 • CAS UMCPGURC agenda 12/13/2022 • CAS UMCPGURC minutes 11/22/2023 • CAS UMCPGURC agenda 11/22/2023 • CAS UM CCO 108 Decision Making, All • CAS UM CCO 133 UMCPGURC, Page 1, "Purpose" • CAS IRR QI 12-7-22	
HSAG Findings: The *Inter-rater Reliability* policy and procedure described the CCO's process for ensuring consistent application of review criteria for authorization decisions through IRR testing. The policy stated that all staff involved in the utilization review process are to be tested. The policy stated that there are two levels of review: clinical and non-clinical. The policy stated that staff are to be tested annually and as needed. The policy identified these areas of testing: referrals, prior authorizations, hospital inpatient, skilled nursing facilities, inpatient rehabilitation, home health, and hospice admissions. The policy reports that inter-rater reliability (IRR) testing is also conducted for dental and behavioral health decisions. However, the results provided for 2022 did not demonstrate a review of the consistency of dental service decisions. Additionally, the policy did not include the minimum threshold. However, the policy included the methodology for testing and stated that if staff are not compliant, staff are required to undergo retraining and retesting. The CCO provided evidence of the IRR testing from December 2022 which demonstrated the CCO had 95.7 percent consistency in reviewer results and provided a summary consistent with the CCO's methodology, identified discrepancies, and opportunities for improvement. The CCO provided evidence of reviewing IRR results at the		

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
November and December Utilization Management Clinical Practice Guideline and Utilization Review Committee meetings. This requirement was *Partially Met*.		
Required Actions: The CCO must ensure consistent application of review criteria for authorization decisions of all service decisions, including dental services. Also, to ensure consistent application of review criteria for authorization decisions, the CCO must identify a parameter for corrective action.		
7. The CCO has and follows written policies and procedures to consult with the requesting provider for medical services when appropriate. *42 CFR §438.210(b)(2)(ii)* *Contract: Exhibit B Part 2(3)(a)* *OAR 410-141-3835(10)(f)(A)*	**Suggested Documents:** • UM plan/UR policies and procedures Coverage and authorization policies and procedures • Service Authorization Handbook • Three examples of peer-to-peer consults **Documents Submitted for Desk Review:** • CAS Peer to Peer Example • CAS UM ACH 104 Peer to Peer Consults, All • CAS UM CCO 111 Standard Service Determination, Page 2, #8	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
8. The CCO ensures 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 treating the member's medical, behavioral health, oral health, or long-term services and supports needs. *42 CFR §438.210(b)(3)* *Contract: Exhibit B Part 2(3)(b)(2)*	**Suggested Documents:** • Coverage and authorization policies and procedures • Service Authorization Handbook • UM plan/UR policies and procedures • Policies and procedures outlining service authorization denials	☐ Met ☒ Partially Met ☐ Not Met

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• Job descriptions/minimum qualifications for UM decision makers *HSAG will also use the results of the service authorization denial file review **Documents Submitted for Desk Review:** • CAS UM CCO 03 PH Decision Making Scope, All • CAS UM CCO RX 101 Decision Making, All • CAS UM CCO 108 Decision Making, page 1, "Purpose" • CAS UM Analyst III Job Desc • CAS UM Analyst Supervisor Job Desc • CAS UM RN Supervisor Job Desc • CAS UM RN Job Desc • CAS Director of Behavioral Health • CAS Medical Director • CAS Clinical Pharmacist • CAS Director of Oral Health Services • CAS UM Analyst II	
HSAG Findings: The *Decision Making Process for Service Requests* policy and procedure stated the requirements of this element. The CCO provided job descriptions that identified staff member responsibilities. The policy communicated compliance. However, interviews conducted with the CCO and its subcontractor, ADS, during the site visit and file reviews revealed "system" denials occurred when information was requested from the provider by an analyst and/or registered nurse and was not received. Further, registered nurses and licensed social workers performed administrative denials when the services requested were considered exclusions or below the funded line, and no other conditions were noted in the medical record. However, the "Comorbidity Rule"		

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
outlined in OAR 410-141-3820 (10) requires the CCO to make coverage decisions for services for unfunded conditions based on the effect on funded comorbid conditions. The OAR specifically states: *(a) The OHP Benefit Package includes coverage in addition to that available under subsection (1). Specifically, it includes coverage of certain medically necessary and appropriate services for conditions which appear below the funding line in the Prioritized List of Health Services if it can be shown that:* *(A) The member has a funded condition for which documented clinical evidence shows that the funded treatments are not working or are contraindicated; and* *(B) The member concurrently has a medically related unfunded condition that is causing or exacerbating the funded condition; and* *(C) Treating the unfunded medically related condition would significantly improve the outcome of treating the funded condition.* Therefore, the CCO may not permit registered nurses to administratively deny requests for services that are placed below the funded line or do not meet the diagnosis and treatment code pairing requirements on the Prioritized List or guideline notes. Before a denial decision is issued, the request for unfunded conditions services also must be reviewed as described in the CCO contract, Exhibit B Part 2(3)(b)(2). This provision states that "any and all decisions 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 a Health Care Professional who has appropriate clinical expertise." This provision specifies that appropriate clinical expertise must be used "in treating the Member's physical, mental, Oral Health condition or disease, as applicable." In addition, the CCO may not permit "system" denials for requested information not being received prior to a review by an individual with appropriate expertise in treating the members' conditions. This requirement was *Partially Met.*		
Required Actions: The CCO must ensure individuals making decisions to deny or reduce services have appropriate expertise in treating the members' medical, behavioral health, oral health, or LTSS needs.		
Recommendations: HSAG recommends that the CCO implement processes to regularly monitor the credentials of individuals making decisions to deny or reduce services to ensure appropriate expertise, including decisions made by subcontracted entities.		
9. The CCO has and follows written policies and procedures that include the following time frames for making standard and expedited authorization decisions: a. For standard authorization decisions—as expeditiously as the member's physical health, oral, or behavioral health condition requires, but no later than **14 calendar days** from the receipt of the request for service authorization.**The CCO makes three attempts using two*	**Suggested Documents:** • Coverage and authorization policies and procedures • UM plan/UR policies and procedures • Service Authorization Handbook • Service authorization turn-around-time tracking	☐ Met ☒ Partially Met ☐ Not Met

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
methods to obtain the necessary information during the 14-day period. b. If the provider indicates, or the CCO determines, that following the standard time frames could seriously jeopardize the member's life or health, or ability to attain, maintain, or regain maximum function, the CCO makes an expedited authorization determination and provides notice as expeditiously as the member's condition requires and no later than **72 hours** after receipt of the request for service. c. The time frame for making standard or expedited authorization decisions may be extended by up to **14 additional calendar days** if: i. The member or the provider requests an extension, or ii. The CCO justifies (to the State upon request) a need for additional information and how the extension is in the member's interest. iii. If the CCO extends the time frame for standard or expedited authorization decisions, it must: – Give the member written notice of the reason for the extension (no later than the date the authorization time frame expires). – Inform the member of the right to file a grievance if he or she disagrees with that decision. – Issue and carry out its determination as expeditiously as the member's health condition	• Extension notice template • Three examples of an extensions notice and corresponding determination notice *HSAG will also use the results of the service authorization file review **Documents Submitted for Desk Review:** • **CAS UM CCO 110 Expedited Service Determinations**, Page 2-3 "Policy" • **CAS UM CCO 111 Standard Service Determinations**, Page 2-3 "Policy" and Page 5 "Procedure #11" • **CAS 2021ACHHC-TimelinesGuideline** • **CAS DailyInloadedMedList-11am-** Monitoring Report • **CAS 7_3 Report Daily8amRxStat-** Monitoring Report • **CAS DailyAuthLettersReportChanges-** (Monitoring report with note as to what it is) • **CAS UM CCO 114 NOABD** -Page 3 #4 • **CAS UM CCO 149 Extension letter policy,** Page 1-2, "Procedure" • **CAS Element 9 CCO EXT 20220810749999900161-1** • **CAS Element 9 CCO EXT 20221209749999900200**	

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
requires and no later than the date the extension expires. *42 CFR §438.210(d)(1-2)* *42 CFR §438.404(c)(4)* *Contract: Exhibit B Part 2(3)(b)(11);(12)* *OAR 410-141-3835(10)(a)(A)* *OAR 410-141-3835(10)(a)(B)(i)* *OAR 410-141-3835(10)(g)(A)*		
HSAG Findings: The *Standard Service Determination*, *Expedited Service Determination*, and *Notice of Action-Benefit Determination – (NOABD)* policies and procedures outlined the requirements of this element and addressed the appropriate time frame for extension of the standard, expedited requests, and components to substantiate an extension. The *Extension Letter* policy and procedure outlined the CCO's process for sending out extension letters. The CCO also provided the Timeliness Guideline, a one-pager outlining the standard and expedited timeliness requirement. Additionally, the CCO provided evidence of reports that included daily tracking of outstanding authorization requests to ensure timeliness. The sample extension letter provided by the CCO explained the reason for the extension and information on the members' right to file a grievance. However, the letter did not specify that members could file a grievance if they disagreed with that decision. The extension notice requirement was not met for the 2023 review. However, written notice requirements provided in the template from or at the direction of OHA will not be captured in the scoring for the 2023 compliance review. The CCO demonstrated ongoing monitoring to ensure the timeliness of authorization decisions internally. However, the CCO did not demonstrate monitoring subcontractor timeliness for authorization decisions. During the site visit, the CCO reported that the monitoring was done quarterly. Further, the CCO was provided an opportunity to submit documentation post-site visit. However, the CCO reported this documentation was unavailable. This requirement was *Partially Met*.		
Required Actions: The CCO must demonstrate adherence to the appropriate time frames for making standard and expedited authorization decisions.		
Recommendations: HSAG recommends that the CCO review the most recent versions of its templates to ensure minimum State and federal requirements are captured. Any omissions in the template should be discussed with OHA and will be assessed during the subsequent compliance review for this standard. The CCO also should ensure that it implements the appropriate version of the template at the CCO and subcontractor levels. The CCO should regularly monitor NOABDs generated internally and by subcontractors to ensure notices meet the language and readability requirements.		

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
10. The CCO has and follows written policies and procedures that include processes for notifying the requesting provider and giving the member written notice of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. (notice to the provider need not be in writing). a. If the CCO denies a request for a service authorization or authorizes a service in an amount, duration or scope less than requested, the CCO mails the notice of adverse benefit determination (NOABD) within the following time frames: i. For standard service authorization decisions that deny or limit services, within 14 calendar days of the request for authorization. ii. For expedited service authorization decisions, within 72 hours of the request for authorization. iii. For service authorization decisions not reached within the required time frames specified in §438.210(d), on the date these time frames expire. *42 CFR §438.210(c);(d)* *Contract: Exhibit B Part 2(3)(b)(11);(17);(18)* *OAR 410-141-3835(10)(d);(e)*	**Suggested Documents:** • Coverage and authorization policies and procedures • UM plan/UR policies and procedures • Service Authorization Handbook • NOABD turn-around-time tracking • NOABD letter template • Three examples of NOABD sent to a member for service authorizations not reached within the required timeframes *HSAG will also use the results of the service authorization and denial file review **Documents Submitted for Desk Review:** • CAS 2022 NOABD Letter Template • CAS Service Auth Handbook Page 3, Paragraph 1 • CAS Denial Letter Monitoring Report • CAS UM CCO 114 NOABD- Entire Policy • UM CCO 110 Expedited Service Determinations, Page 3, #10; Page 5, #16 • CAS UM CCO 111 Standard Service Determination, Page 2, #2 • CAS UM CCO RX PAD 100 Expedite Stand, Page 2-3, #4, #7-#9	☐ Met ☒ Partially Met ☐ Not Met
HSAG Findings: The *Notice of Action- Benefit Determination (NOABD)* policy and procedure stated that the CCO is to comply with the requirements for issuing written notice for standard requests. However, the policy stated for expedited authorization requests for services not previously authorized that the CCO is to provide notice as expeditiously as the member's health condition requires within two business days of		

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
determination. It further stated that such notice is provided no later than 14 calendar days from receipt, which does not align with the requirement to provide written notice within 72 hours. During the site visit, the CCO stated that only an oral response is required within 72 hours of the request. Moreover, CCO staff confirmed its process is to send written notification within two to 14 days of receipt of the request. During the site visit, the CCO demonstrated its process for monitoring when NOABDs are sent to members. This requirement was *Partially Met*.		
Required Actions: The CCO must revise all applicable policies and ensure NOABDs are mailed within the required time frames for expedited service authorization requests.		
11. Policies and procedures for processing authorization requests specify time frames for the following: a. Date and time stamping prior authorization requests when received. b. Determining within a specific number of days from receipt whether a prior authorization request is valid or non-valid. c. The specific number of days allowed for follow-up on pended prior authorization requests to obtain additional information. d. The specific number of days following receipt of the additional information that an approval or denial shall be issued. e. Providing services after office hours and on weekends that require prior authorization. *42 CFR §438.210(b)(1)* *OAR 410-141-3835(10)(f)(C)*	**Suggested Documents:** • Coverage and authorization policies and procedures • UM plan/UR policies and procedures **Documents Submitted for Desk Review:** • CAS UM CCO 110 Expedited Service Determination, Page 2-3, #9 • CAS UM CCO 111 Standard Service Determination, Page 2-3, #10 • CAS UM CCO RX PAD 100 Expedite Stand, Page 3-7 "Procedure" • CAS 2021ACHHC-TimelinesGuideline • CAS DailyInloadedMedList-11am-Monitoring report • CAS 7_3 Report Daily8amRxStat-Monitoring report • CAS DailyAuthLettersReportChanges-Monitoring report	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
12. If the CCO denies payment for a service, in whole, or in part, the CCO mails the notice of adverse benefit determination at the time of any denial affecting the claim. **A payment denied solely because the claim does not meet the definition of a "clean claim" defined in 42 CFR §447.45(b) is not an adverse benefit determination.* *42 CFR §438.404(c)* *Contract: Exhibit I(3)(b)(2)* *OAR 410-141-3875(1)(C)*	**Suggested Documents:** • Claims denial of payment policies and procedures • Plan documents outlining requirement to provide NOABD at the time of any denial affecting the claim • Workflow for payment denial on a claim to trigger NOABD • Three examples of NOABD sent to a member for the denial of payment on a claim • NOABD turn-around-time tracking • Denial of claims payment NOABD letter template *HSAG will also use the results of the service authorization file review **Documents Submitted for Desk Review:** • CAS Claims Auto Adjudication Build • CAS Claims CCO NOABD example 12-29-2022 • CAS Claims CCO NOABD example 11-15-2022.pdf • CAS Claims CCO NOABD example 12-15-2022	☐ Met ☒ Partially Met ☐ Not Met
HSAG Findings: The *AllCare Auto Adjudication Build and Edit* policy and procedure outlined the CCO's claims procedure for processing claims and ensuring appropriate denial. However, the policy did not address mailing a NOABD at the time of any adverse benefit determination that affects the claim for denial of payment, excluding claims that do not meet the definition of a clean claim. The CCO provided evidence notifying members when a claim is denied. Additionally, the CCO did not provide evidence of monitoring whether claim denials were being sent appropriately. This requirement was *Partially Met*.		

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Required Actions: The CCO must demonstrate evidence, including policies, procedures, and workflows or other documents, to demonstrate that the CCO mails NOABDs at the time of any denial affecting the claim.		
13. If the CCO proposes to reduce, suspend, or terminate a previously authorized Medicaid-covered service, the CCO gives advance notice (notice of adverse benefit determination) at least ten (10) days before the proposed effective date **except** when: a. The CCO gives notice on or before the date of action if: i. The agency has factual information confirming the death of a member. ii. 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. iii. The member has been admitted to an institution where he/she is ineligible under the plan for further services. iv. The member's whereabouts are unknown, and the post office returns agency mail directed to him/her indicating no forwarding address. v. The agency establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth. vi. A change in the level of medical care is prescribed by the member's physician.	**Suggested Documents:** • Coverage and authorization policies and procedures • Service Authorization Handbook • UM plan/UR policies and procedures • Advance NOABD letter template • NOABD turn-around-time tracking for previously authorized services • Three examples of an NOABD sent to a member for the termination, suspension, or reduction of a previously authorized service • Three examples of an NOABD sent to a member due to probable fraud *HSAG will also use the results of the service authorization file review **Documents Submitted for Desk Review:** • CAS UM CCO 111 Standard Service Determination, Page 3, #11-12 • CAS UM CCO 111 NOABD, Procedure #3 • CAS 10 day notice NOA	☐ Met ☒ Partially Met ☐ Not Met

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
vii. The notice involves an adverse determination made with regard to the preadmission screening requirements. b. If probable member fraud has been verified, the CCO gives notice five (5) calendar days before the date of action. *42 CFR §438.404(c); §431.211; §431.213; §431.214* *Contract: Exhibit I(3)(b)(1)* *OAR 410-141-3885(5);(6)*		
HSAG Findings: The *Notice of Action-Benefit Determination – NOABD* policy and procedure asserted that the CCO complies with (a) (i–v) and (b). However, the policy did not address (a)(vi) and (vii). The CCO provided sample NOABDs for previously authorized services. This requirement was *Partially Met*.		
Required Actions: The CCO must revise the *Notice of Acton-Benefit Determination—NOABD* policy and procedure to include requirements (a)(vi) and (vii). The CCO must demonstrate evidence, including policies, procedures, and workflows or other documents, to demonstrate that the CCO gives advance notice at least ten days before the CCO proposes to reduce, suspend, or terminate a previously authorized Medicaid-covered service.		
14. The notice of adverse benefit determination must be in writing and meet the language and format requirements of 42 CFR §438.10(c). *42 CFR §438.404(a)* *Contract: Exhibit I(3)(a)(1)* *OAR 410-141-3835(10)(e)*	**Suggested Documents:** • Coverage and authorization policies and procedures • Service Authorization Handbook • NOABD letter template **Documents Submitted for Desk Review:** • CAS 2022 NOABD Letter Template • CAS UM CCO 114 NOABD, Page 2 #2, • CAS 2022 Daily-AltMaterials List-Monitoring report	☐ Met ☒ Partially Met ☐ Not Met

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: The *Notice of Action-Benefit Determination – NOABD* policy and procedure stated that the CCO's NOABDs are to be in writing and meet the language and format requirements of 42 CFR §438.10(c). However, the record reviews for the CCO and its subcontractors revealed readability above the sixth-grade reading level. This requirement was *Partially Met.*		
Required Actions: The CCO must ensure all NOABDs sent to members by the CCO and its subcontractors meet the readability requirements specified in this element.		
Recommendations: HSAG recommends that the CCO review the most recent versions of its templates to ensure minimum State and federal requirements are captured. Any omissions in the template should be discussed with OHA and will be assessed during the subsequent compliance review for this standard. The CCO also should ensure that it implements the appropriate version of the template at the CCO and subcontractor levels. The CCO should regularly monitor NOABDs generated internally and by subcontractors to ensure notices meet the language and readability requirements.		
15. The notice of adverse benefit determination explains the following: a. Language access statement clarifying that oral interpretation is available for all languages and how to access it and a non-discrimination statement stating that CCO may not treat members unfairly due to their age, color, disability, gender identity, marital status, national origin, race, religion, sex, or sexual orientation; b. CCO contact information including name, address, and telephone number; c. Date of the notice; d. Name of the member's primary care provider (PCP), primary care dentist (PCD), or behavioral health professional if the member has an assigned practitioner. If the member has not yet been assigned a practitioner due to recent enrollment, the NOABD should state that PCP, PCD, or behavioral health professional assignment has not occurred;	**Suggested Documents:** • Coverage and authorization policies and procedures • Service Authorization Handbook • NOABD letter template *HSAG will also use the results of the service authorization file review **Documents Submitted for Desk Review:** • CAS 2022 NOABD Letter Template • CAS UM CCO 114 NOABD, Page 2, #2, Page 5, #12	☐ Met ☒ Partially Met ☐ Not Met

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
e. Member's name, date of birth, address, and OHP ID number; f. Description and explanation of the service(s) requested and the adverse benefit determination the CCO intends to make, including whether the CCO is denying, terminating, suspending, or reducing a service; g. Date the service was requested by the provider or member; h. Name of the provider who requested the service; i. Effective date of the adverse benefit determination if different from the date of the NOABD; j. Diagnosis and procedure codes submitted with the authorization request, including a description in plain language if the CCO is denying a requested service because of line placement on the prioritized list or the diagnosis and procedure code do not pair on the prioritized list; k. Other conditions CCO considered including but not limited to: co-morbidity factors if the service was below the funding line on the prioritized list; statement of intent governing the use and application of the prioritized list to requests for health care services including the placement of the condition/diagnosis code on the prioritized list; and other coverage for services addressed in the State 1115 Waiver; l. Clear and thorough explanation of the specific reasons for the adverse benefit determination; m. A reference to the specific sections of the statutes and administrative rules to the highest level of specificity		

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
for each reason and specific circumstances identified in the NOABD; n. The member's right or, if the member provides written consent as required under OAR 410-141-3890(1), the provider's right to file a written or oral appeal of CCO's adverse benefit determination with CCO, including information on exhausting CCO's one level of appeal, and the procedures to exercise that right; o. The member's or the provider's right to request a contested case hearing with OHA only after CCO's notice of appeal resolution or where CCO failed to meet appeal timelines in OAR 410-141-3890 and 410-141-3895, and the procedures to exercise that right; p. The circumstances under which an expedited appeal resolution and an expedited contested case hearing are available and how to request; q. The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of the services; r. The member's right to receive from CCO, 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; and s. Copies of the appropriate forms as listed in OAR 410-141-3885. *42 CFR §438.404(b)* *Contract: Exhibit I(3)(a)(2)* *OAR 410-141-3835(10)(e)*		

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**

HSAG Findings: The *Grievance and Appeal System Binder* policy and procedure specified that NOABDs must include all requirements listed in this element except (j) and (s).

However, file reviews of NOABDs revealed the letters were inconsistently sent by the CCO and across subcontractors. Further, the letters included the following omissions in the various member samples reviewed:

- Description and explanation of the service(s) requested and the adverse benefit determination the CCO intends to make, including whether the CCO is denying, terminating, suspending, or reducing a service.
- Name of the provider who requested the service.
- Diagnosis and procedure codes submitted with the authorization request. This includes a description in plain language if the CCO is denying a requested service because of line placement on the prioritized list or the diagnosis and procedure code do not pair on the prioritized list.
- Other conditions the CCO considered, including:
  - Co-morbidity factors if the service was below the funding line on the prioritized list.
  - Statement of intent governing the use and application of the prioritized list to requests for health care services, including the placement of the condition/diagnosis code on the prioritized list.
  - Other coverage for services addressed in the State 1115 Waiver.
- Clear and thorough explanation of the specific reasons for the adverse benefit determination.

This requirement was not met for the 2023 review. However, written notice requirements provided in the template from or at the direction of OHA will not be captured in the scoring for the 2023 compliance review. However, this element has other unmet elements, including policy omissions. This requirement was *Partially Met*.

Required Actions: The CCO must revise its policy to include all requirements listed in this element.

Recommendations: HSAG recommends that the CCO review the most recent versions of its templates to ensure minimum State and federal requirements are captured. Any omissions in the template should be discussed with OHA and will be assessed during the subsequent compliance review for this standard. The CCO also should ensure that it implements the appropriate version of the template at the CCO and subcontractor levels. HSAG also recommends that the CCO implement processes to regularly monitor NOABDs generated internally and by subcontractors to ensure notices contain appropriate content and clearly communicate information to members.

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
16. The CCO must provide appeal information to members in accordance with Ex. B, Part 3, Sec. 4 and, at a minimum, provide Members with the following information: a. The sixty (60) days' time limit for filing an Appeal; b. The toll-free numbers that the Member can use to file an Appeal by phone; c. The availability of assistance in the filing process; d. The process to request a Contested Case Hearing after an Appeal; e. The rules that govern representation at the Contested Case Hearing; and f. The right to have an attorney or Member Representative present at the Contested Case Hearing and the availability of free legal help through Legal Aid Services and Oregon Law Center, including the telephone number of the Public Benefits Hotline, 1-800-520-5292, TTY 711. *Contract: Exhibit I (4)(a)(4)*	**Suggested Documents:** • Appeal policies and procedures • Member materials, such as the member handbook • NOABD notices *HSAG will also review compliance through file reviews. **Documents Submitted for Desk Review:** • CAS Appeal website screenshot • CAS 2022 NOABD Letter Template • CAS Member Handbook 2022, page 140-147	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
17. The CCO provides that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual to deny, limit, or discontinue medically necessary services to any member. *42 CFR §438.210(e)* *Contract: Exhibit B Part 2(2)(d)* *OAR 410-141-3835(9)(d)*	**Suggested Documents:** • UM plan/UR policies and procedures • UM staff messaging/training materials • Three examples of staff attestations **Documents Submitted for Desk Review:** • CAS Employee Handbook, Page 24-25 "Gifts"	☒ Met ☐ Partially Met ☐ Not Met

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• CAS Relias Employee Handbook Training • CAS UM CCO 108 Decision Making, Page 5(1n) • CAS Code of conduct, Page 4, "Offering Business Courtesies" • CAS Code of Conduct training	
HSAG Findings: This requirement was *Met.*		
Required Actions: None.		
18. The MCE provides response within 24 hours of a request for authorization for all covered outpatient drug authorization decisions as described in Section 1927(d)(5)(A) of the Social Security Act: Provide response by telephone or other telecommunication device within 24 hours of request for prior authorization. *42 CFR §438.210(d)(3)* *42 U.S. Code §1396r-8(d)(5)* *Contract: Exhibit B Part 2(3)(b)(13)* *OAR 410-141-3835(10)(b)*	**Suggested Documents:** • Coverage and authorization policies and procedures • Service Authorization Handbook • UM plan/UR policies and procedures • Pharmacy authorization turn-around-time tracking *HSAG will also use the results of the prior authorization and denial file review **Documents Submitted for Desk Review:** • CAS UM CCO RX PAD 100 Expedite Stand, page 3, "Procedure". • CAS DailyInloadedMedList-11am, Monitoring report • CAS 7_3 Report Daily8amRxStat, Monitoring report • CAS RX 24 HR confirmation faxed • CAS RX 24 HR confirmation inload	☒ Met ☐ Partially Met ☐ Not Met

Standard IV—Coverage and Authorization of Services (42 CFR §438.210)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		

Results for Standard IV—Coverage and Authorization of Services							
Total	Met	=	9	X	1.0	=	9.0
	Partially Met	=	9	X	0.5	=	4.5
	Not Met	=	0	X	0.0	=	0.0
Total Applicable		=	18	**Total Score**		=	13.5

Total Score ÷ Total Applicable	=	**75.0%**

Standard VII—Member Rights and Protections

Standard VII—Member Rights and Protections (42 CFR §438.100)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. The CCO has written policies regarding the member rights specified in this standard, complies with all federal and State laws, and contractual requirements, that pertain to member rights, and ensures that employees and contracted providers observe and protect those rights. In addition to written policies, the CCO must: a. Communicates these policies and procedures to employees and participating providers; and b. Monitor compliance with these policies and procedures, take corrective action as needed, and report findings to the Quality Improvement Committee (QIC) defined under OAR 410-141-3525. *42 CFR §438.100(a)(1) and (2)* *Contract: Exhibit B Part 3 (2)* *OAR 410-141-3590 (1)*	**Suggested Documents:** • Member rights policies and procedures • Provider communications, such as, the provider manual and relevant training materials • Employee training materials • Compliance monitoring mechanisms (grievances) • QIC meeting minutes related to member rights **Documents Submitted for Desk Review:** • 2022 CCO -Enrollee Rights and Protections Policy • New Hire Training outline • CCO Provider Manual, pages 25 – 27 • 2022 CCO Member Rights and Responsibilities Booklet, page 1	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
2. The CCO's policies and procedures ensure that each member is guaranteed the right to: a. Be treated with respect and with due consideration for his or her dignity and privacy.	**Suggested Documents:** • Member rights policies and procedures • Member handbook • Other applicable member materials • Provider manual	☐ Met ☒ Partially Met ☐ Not Met

Standard VII—Member Rights and Protections (42 CFR §438.100)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
b. Receive information in accordance with information requirements (42 CFR §438.10). c. Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition, preferred language, and ability to understand. d. Participate in decisions regarding his or her healthcare, including the right to refuse treatment, including: i. Being actively involved in the development of treatment plans and have family involved in such treatment planning. ii. Having the opportunity to execute a statement of wishes, including the right to accept or refuse medical, surgical, or behavioral health treatment iii. Executing directives and powers of attorney for health care established under ORS 127.505 to 127.660 and the Omnibus Budget Reconciliation Act of 1990 -- Patient Self-Determination Act. e. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. f. Request and receive a copy of his or her medical records and request that they be amended or corrected. g. Be furnished with health care services in accordance with § 438.206 through 438.210. h. Choose their own health professional from available participating providers and facilities to the extent possible and appropriate.	**Documents Submitted for Desk Review:** • 2022 CCO -Enrollee Rights and Protections Policy • 2022 CCO Member handbook, pages 26 – 31 • CCO Provider Manual, pages 25 – 27 • 2022 CCO Member Rights and Responsibilities Booklet, page 1	

Standard VII—Member Rights and Protections (42 CFR §438.100)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
i. Be made aware of their civil rights under Title VI of the Civil Rights Act and ORS Chapter 659A and has a right to report a complaint of discrimination by contacting Contractor, OHA, the Bureau of Labor and Industries, or the Office of Civil Rights. *42 CFR §438.100(b)(2-3)* *Contract Exhibit B Part 3 (2)* *OAR 410-141-3590 (2)*		
HSAG Findings: The CCO's *Enrollee Rights and Protections* policy provided a list of member rights that did not include all rights required in the element. The policy stated that members had a right to be treated with dignity and respect but did not include the right to privacy. The policy affirmed the member's right to participate in decisions regarding his or her health care, including the right to refuse treatment and to execute directives and powers of attorney for health care as established under ORS 127. However, the policy did not include the Patient Self-Determination Act in the regulatory foundation for that right. The policy did not include the member's right to request and receive a copy of his or her medical records and request that they be amended or corrected, instead stating that members had a right to have a clinical record and to transfer the record between providers. The policy did not include the member's right to be made aware of his or her civil rights under Title VI of the Civil Rights Act and ORS Chapter 659A, as well as a right to report a complaint of discrimination by contacting the CCO, OHA, the Bureau of Labor and Industries (BOLI), or the Office of Civil Rights (OCR). AllCare's member handbook provided all member rights appropriate to a member audience, including the right to be treated with consideration for privacy. However, the member handbook is not a substitute for policy. AllCare's provider manual reflected the rights found in the *Enrollee Rights and Protections* policy and presented similar deficiencies by omitting the right to privacy and the right to report a complaint of discrimination to the appropriate entities. This requirement was *Partially Met*.		
Required Actions: AllCare must ensure that all member rights listed in the element are present within and consistent across relevant policies, procedures, and materials, including the member rights booklet and provider manual.		
Recommendations: HSAG recommends, as a best practice, that the list of member rights or an assertion of an obligation to observe and protect member rights also appear in the CCO's code of conduct to reinforce staff member compliance, with the understanding that such an addition would not substitute for the list of rights appearing in a policy and procedure.		
3. The CCO ensures that each member is free to exercise his or her rights and that the exercise of those rights does not	**Suggested Documents:** • Member rights policies and procedures • Member handbook	☐ Met ☒ Partially Met ☐ Not Met

Standard VII—Member Rights and Protections (42 CFR §438.100)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
adversely affect the way the CCO, its network providers, or the State treats the member. *42 CFR §438.100(c)* *Contract: Exhibit B Part 3 (2)(o)*	• Other applicable member materials **Documents Submitted for Desk Review:** • 2022 CCO -Enrollee Rights and Protections Policy • 2022 CCO Member handbook, pages 26 – 31 • 2022 CCO Member Rights and Responsibilities Booklet, page 1	
HSAG Findings: The CCO's *Enrollee Rights and Protections* policy did not articulate a commitment to ensuring all parties understand the policy against intimidation or discouragement of members from exercising their rights. While the member handbook contained a statement that members could use their rights without any adverse action or discrimination against them, this was not asserted in either the provider manual or the member rights booklet. The CCO's provider agreement template stipulated that members were free to exercise their rights and that exercising those rights would not adversely affect how members are treated. However, the member handbook and provider agreement are not substitutes for policy. This requirement was *Partially Met.*		
Required Actions: AllCare must update its relevant policies and procedures to directly articulate its commitment to ensuring members are free to exercise their rights and that exercising those rights would not adversely affect how the CCO, its network providers, or the State treats the member.		
4. The CCO has written policies regarding compliance with other federal and State laws and must: a. Provide written notice to members of CCO's nondiscrimination policy and process to report a complaint of discrimination on the basis of race, color, national origin, religion, sex, sexual orientation, marital status, age, or disability in accordance with all applicable laws Title VI of the Civil Rights Act and ORS Chapter 659A by contacting the MCE, OHA, the Bureau of Labor and Industries, or the Office of Civil Rights. b. Provide equal access for both males and females under 18 years of age to appropriate facilities, services and	**Suggested Documents:** • Nondiscrimination policies and procedures • Provider communications, such as, the provider manual • Member communications, such as the Nondiscrimination notice and member handbook • Provider contract • Provider manual • Grievances related to discrimination	☐ Met ☒ Partially Met ☐ Not Met

Standard VII—Member Rights and Protections (42 CFR §438.100)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
treatment under the CCO Contract, consistent with OHA obligations under ORS 417.270. c. Comply with any other federal and State laws that pertain to member rights including Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91, the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972 (regarding education programs and activities), Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act and ensures that its employees and contracted providers observe and protect members' rights. *42 CFR §438.100(a)(2);(d)* *Contract: Exhibit B Part 3 (2)(b-d)*	**Documents Submitted for Desk Review:** • 2022 CCO Member handbook, page 3 • AllCare CCO Direct Provider Agreement CCO Provider Manual, page 55 • Calendar year 2022 AllCare CCO did not receive any Grievances in regards to Discrimination	
HSAG Findings: Although the CCO's *Enrollee Rights and Protections* policy did not address the requirement, following the site visit, the CCO provided additional documentation, including several policies which, in concert, offered both policy language and a process for members to report a complaint of discrimination to the CCO, OHA, BOLI, or OCR, and which expressed compliance with applicable federal and State laws. However, no policy asserted the provision of equal access for both males and females under 18 years of age to appropriate facilities, services, and treatment under the CCO Contract, consistent with OHA obligations under ORS 417.270. The member handbook and Nondiscrimination Statement included compliant assertions of nondiscrimination as well as contact information for filing civil rights complaints. The provider agreement template contained requirements for providers to adhere to practices of nondiscrimination and required equal access to covered services for both male and female members under 18 years of age. However, the member handbook, CCO Nondiscrimination Statement, and provider agreement template are not a substitute for policy. This requirement was *Partially Met*.		
Required Actions: AllCare must ensure that it has policies and procedures which articulate the CCO's commitment to the provision of equal access for both males and females under 18 years of age to appropriate facilities, services, and treatment under the CCO Contract, consistent with OHA obligations under ORS 417.270.		

Standard VII—Member Rights and Protections (42 CFR §438.100)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
5. The CCO maintains written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care by or through the CCO. The CCO's policies, procedures and written information provided to adult members include the following: a. Members' rights under the State (advance directives) law to make decisions concerning medical care, including the right to refuse or accept treatment and the right to formulate advance directives. b. The CCO's written policies respecting the implementation of those rights, including a clear and precise statement of limitation if the CCO cannot implement an advance directive as a matter of conscience. At a minimum, this statement must do the following: i. Clarify the difference between institution-wide conscientious objections and those raised by individual physicians. ii. Identify the State legal authority permitting such objection. iii. Describe the range of medical conditions or procedures affected by the conscientious objection. c. Provisions for providing information regarding advance directives to the member's family or surrogate if the member is incapacitated at the time of initial enrollment due to an incapacitating condition or mental disorder and unable to receive information. d. Provisions for providing advance directive information to the incapacitated member once he or she is no longer incapacitated, and follow-up procedures in place to	**Suggested Documents:** • Advance directive policies and procedures • Member handbook • Other member materials related to advance directives • Staff training or orientation materials related to advance directives • Evidence of community education about advance directives **Documents Submitted for Desk Review:** • 2022 CCO Member Handbook, page 138 – 139 • AdvanceDirectivePolicy2022 • https://www.allcarehealth.com/medicaid/resources/plan-materials • https://www.allcarehealth.com/media/4155/advance-directive.pdf	☐ Met ☒ Partially Met ☐ Not Met

Standard VII—Member Rights and Protections (42 CFR §438.100)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
ensure that the information is given to the individual directly at the appropriate time e. Provisions for documenting in a prominent part of the member's medical record whether or not the member has executed an advance directive. f. Provisions that the decision to provide care to a member is not conditioned on whether the member has executed an advance directive, and that members are not discriminated against based on whether they have executed an advance directive. g. Provisions for ensuring compliance with State laws regarding advance directives. h. Provisions for informing members of changes in State laws regarding advance directives as soon as possible, but no later than **90 days** following the changes in the law. i. Provisions for the education of staff concerning its policies and procedures on advance directives. j. Provisions for community education regarding advance directives that include: i. What constitutes an advance directive. ii. Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment. iii. Description of applicable State law concerning advance directives. k. Complaints regarding advance directives may be filed with the State Survey Agency.		

Standard VII—Member Rights and Protections (42 CFR §438.100)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
l. Information must be provided to the member at the time of the initial enrollment. *42 CFR §438.3(j)* *42 CFR §422.128* *Contract: Exhibit E (14)*		

HSAG Findings: The CCO's *Advance Directive* policy articulated members' rights under State law to create an advance directive or other document describing their end-of-life wishes, appoint a representative in case of incapacitation, and accept or reject health care. While the CCO's policy stated that AllCare "cannot implement an Advance Directive as a matter of conscience," there was no subsequent written statement in the policy that clarified the difference between institutional limitations and those raised by individual physicians. The policy also did not identify the legal State authority allowing such a limitation or describe the range of medical conditions or procedures affected by the conscientious objection. During the site visit, CCO staff asserted that AllCare did not place institutional limitations on advance directives. Reviewers concluded that this indicated an error in the *Advance Directive* policy.

The *Advance Directive* policy did not include the requirement of applicable providers (i.e., hospitals, critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care [and for Medicaid purposes, providers of personal care services], hospices, and religious nonmedical health care institutions) to comply with 42 CFR §489.102 by maintaining written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care or patient care. Although CCO staff articulated a process during the site visit for regularly educating providers on their roles and responsibilities with advance directives, this was not a substitute for a documented policy or process. The policy did not include a process for the provision of advance directive information to a member's family or surrogate in the case of a member's incapacitation, instead stating only that members could be provided with advance directive information once they were no longer incapacitated. The policy stated that the CCO's Care Coordination team is to document in the member's health record whether a member had an advance directive on file or if the member declined to complete one. The provider manual stated that it was the responsibility of a member's PCP to record the status of an advance directive in a member's records to providers. The policy asserted that members are not to be discriminated against or the provision of care predicated on whether or not a member had executed an advance directive. The policy did not address the State requirement for providers to honor advance directives. While the policy stated that it is to inform members of changes in State laws concerning advance directives within 90 days, it did not describe a process for doing so (e.g., provide a mailing, change the member handbook). However, during the site visit, CCO staff articulated a process wherein if a change were to occur in State laws, the CCO would pull a report of all members with an advance directive and conduct direct outreach to notify them, update the member portal, and update materials as necessary. The policy restated the requirement for "provisions for the education of staff concerning its policies on Advance Directives," but did not provide a process for doing so. Prior to the site visit, in-person training documentation and evidence of online advance directive education for members via the CCO's website was provided. During the site visit, CCO staff described a practice of conducting regular trainings with other departments and with providers throughout the year, including on the topic of advance directives.

Standard VII—Member Rights and Protections (42 CFR §438.100)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
The CCO's member handbook provided members' rights under State law to create an advance directive or other document describing their end of life wishes, to appoint a representative in case of their incapacitation, and to accept or reject health care. While the member handbook stated that members were not required to have an advance directive, it did not assert that the provision of care was not conditioned on the execution of an advance directive, nor that members would not be discriminated against based on whether they had executed an advance directive. Additionally, it did not identify the correct office for filing complaints related to advance directives. The provider manual stated that members had a right to create an advance directive, living will, or other document describing their end of life wishes, to appoint an individual to speak when they are incapacitated, and to accept or reject health care. The provider agreement included the requirement to adhere to the CCO's written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care or patient care. Neither the provider manual nor provider agreement required applicable providers to distribute advance directive information to family members or surrogates when a member was incapacitated, or to the member should they no longer be incapacitated. The provider manual stated that it was the responsibility of the provider to document in a prominent place in the member's medical record whether or not the member had executed an advance directive. While the provider manual listed the right of a member to execute an advance directive, it did not state that members were not required to have one, nor did it indicate that services could not be withheld if a member did not have an advance directive. The provider agreement stated that providers were required to comply with all legally compliant advance directives. This requirement was *Partially Met*.		
Required Actions: AllCare must make the following updates to its policies, procedures, member-facing materials, and provider-facing materials: • Update its *Advance Directive* policy to: – Include any CCO limitations on implementation of an advance directive as a matter of conscience, describe the range of medical conditions or procedures affected by the conscientious objection, clarify whether the limitations were institution-wide or those raised by individual physicians, and identify the State legal authority permitting the specific limitations; or provide an affirmative statement that the CCO does not impose any limitations on implementation of members' advance directives. – Include the requirement for applicable providers (as referenced in 42 CFR §422.128 and defined in 42 CFR §489.102—hospitals, critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care [and for Medicaid purposes, providers of personal care services], hospices, and religious nonmedical health care institutions) to abide by the same policy and member information requirements regarding conscientious objections. – Include the requirement for applicable providers (as referenced in 42 CFR §422.128 and defined in 42 CFR §489.102—hospitals, critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care [and for Medicaid purposes, providers of personal care services], hospices, and religious nonmedical health care institutions) to provide advance		

Standard VII—Member Rights and Protections (42 CFR §438.100)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
directive information to a family member or surrogate when a member is incapacitated and provide information to the member once he or she is no longer incapacitated. The policy should also outline follow-up procedures to ensure that the information is given to the member at the appropriate time. • Ensure provider-facing materials: – Inform providers of their obligations to provide advance directive information to a family member or surrogate when a member is incapacitated and provide information to the member once he or she is no longer incapacitated. – Assert that the decision to provide care to a member is not conditioned on whether the member has executed an advance directive, and that members may not be discriminated against based on whether they have executed an advance directive. • Ensure member-facing materials: – Communicate that decisions to authorize or provide care are not conditioned on whether or not the member executed an advance directive and that members are not discriminated against based on whether they have an advance directive. – Communicate the correct office for filing complaints related to advance directives (as given in the OHA model member handbook).		
Recommendations: HSAG recommends that AllCare ensure that any statements presented in the member handbook regarding limitations on advance directives be reviewed for clarity and alignment with the CCO's operations and policies. HSAG also recommends, as a best practice, that AllCare update the *Advance Directive* policy and procedure to include how the CCO is to inform members of changes to advance directive laws and policies within 90 days other than via the annual member handbook. AllCare should also utilize the OHA model member handbook to identify the correct OHA department for submitting complaints related to advance directives.		

Standard VII—Member Rights and Protections							
Total	Met	=	1	X	1.0	=	1.0
	Partially Met	=	4	X	0.5	=	2.0
	Not Met	=	0	X	0.0	=	0.0
Total Applicable		=	5	**Total Score**		=	3.0

Total Score ÷ Total Applicable	=	**60.0%**

Standard X—Grievance and Appeal Systems

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. The CCO has established internal grievance and appeal policies and procedures under which members, or providers acting on their behalf, may challenge the denial of coverage of, or payment for, medical assistance. The CCO must have a grievance and appeal system in place to handle appeals of an adverse benefit determination and grievances, as well as processes to collect and track information about them. The CCO must not: a. Discourage a member from using any aspect of the grievance, appeal, or hearing process. b. Encourage any member to withdraw a grievance, appeal, or contested case hearing request already filed. c. Use the filing or resolution of a grievance, appeal, or contested case hearing request as a reason to retaliate against a member or as a basis for requesting member disenrollment. d. Take punitive action against a provider who requests an expedited resolution or supports a member's grievance or appeal. *42 CFR §438.400(a)(3) and (b)* *Contract: Exhibit I* *OAR 410-141-3875 (10)* *OAR 410-141-3895 (2)*	**Suggested Documents:** • Grievance and appeal policies and procedures • Reports • (Throughout this standard, HSAG will use results from grievance and appeal record reviews to score the related requirements.) **Documents Submitted for Desk Review:** • CCO Appeal and Hearing Policy, a through d: Pg. 3, first paragraph. • Grievance Policy and Procedure Pg. 1 first paragraph, Pg. 5 paragraph 1 and 2,	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met.*		
Required Actions: None.		

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
2. The CCO defines "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. *A payment denied solely because the claim does not meet the definition of a clean claim under 42 CFR §447.45(b) is not an adverse benefit determination.* d. The failure to provide services in a timely manner, as defined by the State. e. The failure to act within the time frames defined by the State for 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 rights to obtain services outside the network under the following circumstances: i. The service or type of provider (in terms of training, expertise, and specialization) is not available within the CCO's network. ii. The provider is not part of the network, but is the main source of a service to the beneficiary – provided that: – The provider is given the opportunity to become a participating provider under the same	**Suggested Documents:** • Policies and procedures that address denials/adverse benefit determination • Staff training materials • Member handbook • Provider materials, such as provider manual **Documents Submitted for Desk Review:** • CCO Appeal and Hearing Policy, a through c Pg. 4 definition. d and e, Pg. 2 second paragraph letter f, • Grievance Policy and Procedure • Pg. 2, definitions • Element g: AllCare does not have any cost sharing. • UM CCO policy 106: Out of Network provider Element f.	☐ Met ☒ Partially Met ☐ Not Met

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
requirements for participation in the CCO's network as other providers of that type. – If the provider chooses not to join the network, or does not meet the qualification requirements, the member will be transitioned to a participating provider within 60 calendar days after being given the opportunity to choose a participating provider. g. The denial of a member's request to dispute a member's financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other). *42 CFR §438.400(b)* *42 CFR §438.52(b)(2)(ii)* *Contract: Exhibit A* *OAR 410-141-3875 (1)(b)*		
HSAG Findings: AllCare's *Grievance* and *Appeal and Hearing* policies and procedures addressed (a)–(c) in the definition of "adverse benefit determination." However, the policy does not include the components of (d)–(g) of the requirement. Members and providers were informed of the circumstances regarding denials within the member handbook and provider manual. This requirement was *Partially Met*.		
Required Actions: The CCO must update applicable policies to include (d)–(g) in its definition of "adverse benefit determination."		
3. The CCO defines "appeal" as a review by the CCO of an adverse benefit determination. *42 CFR §438.400(b)* *Contract: Exhibit A* *OAR 410-141-3875 (1)(a)*	**Suggested Documents:** • Grievance and appeals policies and procedures • Staff training materials • Member handbook • Provider materials, such as provider manual **Documents Submitted for Desk Review:** • CCO Appeal and Hearing Policy, Pg. 5, third definition • Grievance Policy and Procedure Pg. 2 definitions	☐ Met ☒ Partially Met ☐ Not Met

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: AllCare's Grievance policy and procedures and *Appeal and Hearing* policy adequately addressed the definition of "appeal." It also described how the CCO handles contact from members or their representatives regarding appeals. The provider manual and the member handbook appropriately addressed appeals. However, the staff training included an outdated definition for "appeal." This requirement was *Partially Met*.		
Required Actions: The CCO must ensure that all plan documents include the correct definition of "appeal."		
4. The CCO defines "grievance" as an expression of dissatisfaction about any matter other than an adverse benefit determination. a. 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. Grievance includes a member's right to dispute an extension of time proposed by the CCO to make an authorization decision. *42 CFR §438.400(b)* *Contract: Exhibit A* *OAR 410-141-3875 (1)(f)*	**Suggested Documents:** • Grievance and appeal policies and procedures • Staff training materials • Member handbook • Provider materials, such as provider manual **Documents Submitted for Desk Review:** • CCO Appeal and Hearing Policy: Pg. 6 definitions • Grievance Policy and Procedure Pg. 3	☐ Met ☒ Partially Met ☐ Not Met
HSAG Findings: AllCare's *Grievance* policy and procedures and *Appeal and Hearing* policy included the correct definition of "grievance." The provider manual and the member handbook appropriately addressed appeals. However, the staff training included an outdated definition of "grievance." This requirement was *Partially Met.*		
Required Actions: The CCO must ensure that all plan documents include the correct definition of "grievance."		
5. The CCO has provisions for who may file: a. A member may file a grievance (with the State or the CCO), a CCO-level appeal, and may request a contested case hearing. b. With the member's written consent, a provider or authorized representative may file a grievance (with the	**Suggested Documents:** • Grievance and appeal policies and procedures • Member handbook • Provider materials, such as provider manual • Staff training materials	☒ Met ☐ Partially Met ☐ Not Met

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
State or the CCO), an CCO-level appeal, and may request a contested case hearing on behalf of a member. *42 CFR §438.402(c)* *Contract: Exhibit I (1)(c)* *Contract: Exhibit I (1)(c)* *OAR 410-141-3880 (1)*	**Documents Submitted for Desk Review:** • CCO Appeal and Hearing Policy, PG. 8: A.1 a through d. • Grievance Policy and Procedure Pg. 6 A, 1 – 3. And page 8 • Appeals and Grievance handbook Page 11, Complaint process Pg. 8 letter c, filing with the state • Member Appeals and Grievance Handbook page 4, 3rd paragraph "Who can file an appeal"	
HSAG Findings: This requirement was *Met.*		
Required Actions: None.		
6. The CCO must: a. Allow members to file a grievance at any time. *42 CFR §438.402(c)(2)(i)* *Contract: Exhibit I (1)(d)(1)* *OAR 410-141-3880 (1)*	**Suggested Documents:** • Grievance and appeal policies and procedures • Member handbook • Provider materials, such as provider manual • Staff training materials **Documents Submitted for Desk Review:** • Grievance Policy and Procedure Pg. 8, E #2 • Member Appeals and Grievance Handbook Pg. 11 and 12 bottom and top of page.	☒ Met ☐ Partially Met ☐ Not Met

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: This requirement was *Met.*		
Required Actions: None.		
7. The CCO must: a. Accept grievances orally or in writing. *42 CFR §438.402(c)(3)(i)* *Contract: Exhibit I (e)(2)* *OAR 410-141-3880 (1)*	**Suggested Documents:** • Grievance and appeal policies and procedures • Member handbook • Provider materials, such as provider manual • Grievances and appeals turn-around-time tracking • Staff training materials *HSAG will also assess compliance through file reviews. **Documents Submitted for Desk Review:** • Grievance Policy and Procedure Pg. 8, E #1 • Member Appeals and Grievance Handbook page 11 bottom paragraph, 12 top paragraphs.	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met.*		
Required Actions: None.		
8. The CCO provides written acknowledgement of grievance within five business days providing the following information: a. An explanation of the decision; or b. Informing the member that a decision will be made within 30 calendar days from the date of the CCO's	**Suggested Documents:** • Grievance and appeal policies and procedures • Member handbook • Provider materials, such as provider manual	☐ Met ☒ Partially Met ☐ Not Met

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
receipt of the grievance and the reason additional time is necessary. **The CCO may provide its decision related to oral grievances orally but must also respond to oral grievances in writing.* *42 CFR §438.406(b)(1)* *Contract: Exhibit I (2)(f)(1)* *OAR 410-141-3880(2)*	• Grievances and appeals turn-around-time tracking • Staff training materials *HSAG will also assess compliance through file reviews. **Documents Submitted for Desk Review:** • Grievance Policy and Procedure Pg. 10, 6 F and 7 a, I and ii. Appeals and Grievance Handbook, Pg. 12 last paragraph. Pg. 13 2nd paragraph. • Member Handbook Pg. 140, paragraph 3 and 4.	
HSAG Findings: AllCare's *Grievance* policy and procedures asserted compliance with this element. The member handbook communicated this information and informed the member that acknowledgement letters would be sent to the member within five days of receipt of the original grievance, and the resolution letter would be sent to the member within 30 days. However, the record review revealed the CCO/subcontractors were out of compliance with sending the acknowledgment letter within the appropriate time frame. This requirement was *Partially Met.*		
Required Actions: The CCO must provide written acknowledgement of grievances within five business days of receiving a grievance.		
9. The CCO provides written notice of grievance resolution as expeditiously as the members health requires, or no later than 30 calendar days from the day in which the CCO receives the grievance. **The CCO may provide its decision related to oral grievances orally but must also respond to oral grievances in writing.* *42 CFR §438.408 (b)(1)* *Contract: Exhibit I (2)(f)(2)(a)* *OAR 410-141-3880 (2)*	**Suggested Documents:** • Grievance and appeal policies and procedures • Member handbook • Provider materials, such as provider manual • Grievances and appeals turn-around-time tracking • Staff training materials *HSAG will also assess compliance through file reviews.	☐ Met ☒ Partially Met ☐ Not Met

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Documents Submitted for Desk Review: • Grievance Policy and Procedure • Pg. 10, #7 a: I, i and ii #1 • Member handbook Pg. 140, paragraph 3 and 4. • Member Appeals and Grievance Handbook page 13, 2nd paragraph	
HSAG Findings: AllCare's *Grievance* policy and procedures asserted compliance with this element. The member handbook communicated this information and informed members they would receive their written grievance resolution letter within 30 days. The provider manual contained this information as well. During the site visit, the CCO demonstrated monitoring compliance with time frames. However, the record review demonstrated that the CCO/subcontractor did not comply with providing written notice within 30 calendar days. This requirement was *Partially Met.*		
Required Actions: The CCO must provide written notice of grievance resolution as expeditiously as the member's health requires or no later than 30 calendar days from the day the CCO receives the grievance.		
10. The grievance resolution notice must meet the following requirements: a. The notice shall address each aspect of the member's grievance and explain the reason for CCO's decision. b. The language in the notice shall be sufficiently clear that a layperson could understand the disposition of the grievance. i. The notice must be in a format and language that may be easily understood by the member. c. The notice shall advise all affected members that they have the right to present their grievance to OHP Client Services Unit (CSU) or OHA's Ombudsperson by	**Suggested Documents:** • Grievance policies and procedures • Grievance resolution notice template *HSAG will also assess compliance through file reviews. **Documents Submitted for Desk Review:** • Grievance Policy and Procedure Pg. 7 C, 3 and 4. Pg. 11, I 1-2, a, b • Member handbook page 140, paragraph 5	☐ Met ☒ Partially Met ☐ Not Met

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
telephone. Such telephone numbers shall be included in the notice and are as follows: i. For CSU: 800-273-0557, and ii. For OHA's Ombudsperson: 503-947-2346 or toll free at 877-642-0I'll do that450. *42 CFR §438.408 (d)(1)* *Contract: Exhibit I (2)(f)(2)* *OAR 410-141-3880 (4)*		
HSAG Findings: AllCare's *Grievance* policy and procedures asserted compliance with this element. The file reviews demonstrated that grievance notices for the CCO's subcontractors were above the state-required sixth-grade reading level and used a font size smaller than 12 point font. Although, the font size was not met for the 2023 review, at the direction of OHA, written notice requirements provided in the template from or at the direction of OHA will not be captured in the scoring for the 2023 compliance review. However, the CCO had other unmet requirements for this element, such as adhering to the appropriate reading level. This requirement was *Partially Met.*		
Required Actions: The CCO must ensure that the grievance resolution notice is in a format and language that may be easily understood by the member, including adherence to the state-required sixth-grade reading level.		
11. In handling grievances and appeals, the CCO must give members reasonable assistance in completing any 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, providing interpreter services and toll-free numbers that have adequate Teletypewriter/ Telecommunications Device for the Deaf (TTY/TDD) and interpreter capability. *42 CFR §438.406(a)* *Contract: Exhibit I (1)(e)(5)* *OAR 410-141-3875(9)*	**Suggested Documents:** • Grievance and appeals policies and procedures • Member handbook • Provider materials, such as provider manual *HSAG will also assess compliance through file reviews. **Documents Submitted for Desk Review:** • CCO Appeal and Hearing Policy, Pg. 9, paragraph C #2. • Grievance Policy and Procedure Pg. 6-7, C, 2	☒ Met ☐ Partially Met ☐ Not Met

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• Member Appeals and Grievance Handbook, page 4 2nd paragraph • Member handbook Pg. 140 paragraph 1	
HSAG Findings: This requirement was *Met.*		
Required Actions: None.		
12. The CCO ensures that the individuals who make decisions on grievances and appeals are individuals who: a. Were not involved in any previous level of review or decision-making nor a subordinate of any such individual. b. Have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding any of the following: i. An appeal of a denial that is based on lack of medical necessity. ii. A grievance regarding the denial of expedited resolution of an appeal. iii. A grievance or appeal that involves clinical issues. c. Take into account all comments, documents, records, and other information submitted by the member or his or he representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. *42 CFR §438.406(b)(2)* *Contract: Exhibit I (1)(e)(8-9)* *OAR 410-141-3875(5)(d)*	**Suggested Documents:** • UR policies and procedures • Grievance and appeals policies and procedures *HSAG will also review compliance through file reviews. **Documents Submitted for Desk Review:** • CCO Appeal and Hearing Policy a through c: Pg. 14 and 15, #13 a. i-iii and I – IV. • Grievance Policy and Procedure Pg. 11-12 I 1 and 2 a, b, c i, ii, iii. components. • Member Handbook Pg. 141, paragraph 3. (letter a only)	☐ Met ☒ Partially Met ☐ Not Met
HSAG Findings: AllCare's *Grievance* policy and procedures asserted compliance with this element. The member handbook also addressed this requirement. However, the record review demonstrated that the CCO's subcontractors, CDC and Options, did not comply with the requirement		

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
to ensure that the individuals who make decisions on grievances have the appropriate clinical expertise, in treating the member's condition or disease if deciding on a grievance that involves clinical issues. This requirement was *Partially Met.*		
Required Actions: The CCO must ensure that the individuals who make decisions on grievances have the appropriate clinical expertise in treating the member's condition or disease if deciding on a grievance that involves clinical issues.		
13. A member may file an appeal with the CCO within 60 calendar days from the date on the notice of adverse benefit determination. *42 CFR §438.402(c)(2)(ii)* *Contract: Exhibit I (1)(d)(2)* *OAR 410-141-3890 (6)(b)*	**Suggested Documents:** • Grievance and appeal policies and procedures • Member handbook • Provider materials, such as provider manual • Training materials *HSAG will also review compliance through file reviews. **Documents Submitted for Desk Review:** • CCO Appeal and Hearing Policy, Pg. 3 first sentence. • Also Pg. 12, D #1 a. • Member handbook: Pg. 141, paragraph 2. • Member Appeals and Grievance Handbook, Pg.5, 1st paragraph	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met.*		
Required Actions: None.		

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
14. The member may file an appeal either orally or in writing, and the CCO must treat oral appeals in the same manner as appeals received in writing. The CCO may not require that oral requests for an appeal be followed with a written appeal. *42 CFR §438.402(c)(3)(ii); 438.406(b)(3)* *Contract: Exhibit I (1)(e)* *OAR 410-141-3890 (6)*	**Suggested Documents:** • Member handbook • Grievance and appeal policies and procedures • Provider materials, such as provider manual • Training materials *HSAG will also review compliance through file reviews. **Documents Submitted for Desk Review:** • CCO Appeal and Hearing Policy, page 3 Also, page 12, E 1 • Member handbook, Page 141, paragraph 3 • Member Appeals and Grievance Handbook, Pg. 6, 1st. paragraph	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met.*		
Required Actions: None.		
15. The CCO acknowledges receipt of each appeal in writing within the following timeframes: a. For non-expedited/standard appeals: in writing within five business days of receipt, and b. For all expedited appeals: orally and in writing within one business day of receipt. *42 CFR §438.406(b)(1)* *Contract: Exhibit I (4)(a)(1)*	**Suggested Documents:** • Grievance and appeal policies and procedures • Training materials *HSAG will also review compliance through file reviews. **Documents Submitted for Desk Review:** • CCO Appeal and Hearing Policy, Pg. 13, F #6 and Pg. 14, #7.	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met.*		
Required Actions: None.		

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
16. The CCO's appeal process must provide: a. That the CCO may have only one level of appeal for members (or providers acting on their behalf). 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 time frame 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 documents considered, relied upon, or generated by the CCO in connection with the appeal. This information must be provided free of charge and sufficiently in advance of the appeal resolution time frame. d. That adjudication of appeals in a member grievance and appeals process may not be delegated to a subcontractor. e. That included, as parties to the appeal, are: i. The member and his or her representative; ii. The provider acting on the behalf of a member, with written consent from the member; iii. The CCO; and iv. The legal representative of a deceased member's estate. *42 CFR §438.402(b);438.406(b)(4-6)* *Contract: Exhibit I (1)(e)(11)* *OAR:410-141-3890(2);(7)* *OAR 410-141-3875 (14)*	**Suggested Documents:** • Grievance and appeal policies and procedures • Member handbook • Provider materials, such as provider manual *HSAG will also review compliance through file reviews. **Documents Submitted for Desk Review:** • CCO Appeal and Hearing Policy, a and b Pg. 10, 4 – 6. • Letter C: Pg. 13, #5 • Letter d: Pg. 2 under policy, and Pg. 27 #4 • Letter e: Pg. 8 A, 1 • Member Appeals and Grievance Handbook, Pg. 6 last paragraph, Pg. 7 top 2 paragraphs letters a - c.	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met.*		

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Required Actions: None.		
17. 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: a. The CCO ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. b. If the CCO denies a request for expedited resolution of an appeal, it must: i. Transfer the appeal to the time frame for standard resolution. ii. Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution (including as necessary multiple calls at different times of day) iii. Follow up within two calendar days with a written notice of the denial of expedition and inform the member of the right to file a grievance if he or she disagrees with the decision to deny an expedited resolution. *42 CFR §438.410* *Contract: Exhibit I (4)(b)(3)* *OAR 410-141-3895(2)(6)*	**Suggested Documents:** • Grievance and appeal policies and procedures • Member handbook • Provider materials, such as provider manual • Staff training materials *HSAG will also review compliance through file reviews. **Documents Submitted for Desk Review:** • CCO Appeal and Hearing Policy Letter a, Pg. 3 top under policy a) ix, II b) Item i, ii and iii, Pg. 18 letter viii: I, II and III Pg. 18 I • Provider Manual Pg. 50 paragraph 2 member's complaints and appeals • Member Appeals and Grievance Handbook, Pg.6 paragraph 4. Letter b.	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: AllCare's *Appeal and Hearing* policy appropriately discussed the expedited review process. The member handbook and provider manual discussed expedited appeals. However, the record review revealed the CCO's written notice of the denial of the expedition did not inform the member of the right to file a grievance if he or she disagrees with the decision to deny an expedited resolution. Although the written notices for denial of expedition did not include the appropriate content and that requirement was not met for the 2023 review, at the		

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
direction of OHA, written notice requirements provided in the template from or at the direction of OHA will not be captured in the scoring for the 2023 compliance review. This requirement was *Met.*		
Required Actions: None.		
Recommendations: HSAG recommends that the CCO review the most recent versions of its templates to ensure minimum state and federal requirements are captured; any omissions in the template should be discussed with OHA and will be assessed during the following compliance review for this standard. The CCO should also ensure that it implements the appropriate version of the template.		
18. 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: a. For standard resolution of appeals, within 16 days from the day the CCO receives the appeal. b. For expedited resolution, within 72 hours after the CCO receives the appeal. c. For notice of expedited resolution, the CCO must make reasonable efforts to provide oral notice of resolution. d. Written notice of appeal resolution must be in a format approved by OHA and written in language that at a minimum, meets the standards described 42 CFR §438.10. *42 CFR §438.408(b)(2); (3); (d)(2)* *Contract: Exhibit I (4)(b)* *OAR 410-141-3890(3)*	**Suggested Documents:** • Grievance and appeal policies and procedures • Member handbook • Provider materials, such as provider manual • Staff training materials *HSAG will also review compliance through file reviews. **Documents Submitted for Desk Review:** • CCO Appeal and Hearing Policy a through d, Pg. 18: top letter i, iv, v • Member handbook: Pg. 143 last paragraph – 144 first paragraph. • Member Appeals and Grievance Handbook, Pg. 4 last paragraph. Letters a – b.	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met.*		
Required Actions: None.		
19. The CCO may extend the time frames for resolution of grievances or appeals by up to 14 calendar days if:	**Suggested Documents:**	☒ Met ☐ Partially Met

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
a. The member requests the extension; or b. 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. c. If the CCO extends the time frames for resolution of grievances or appeals, it must—for any extension not requested by the member: i. Make reasonable efforts to give the member prompt oral notice of the delay (including as necessary multiple calls at different times of day). ii. Within two calendar days, give the member written notice of the reason for the decision to extend the timeframe and inform the member of the right to file a grievance if he or she disagrees with that decision. iii. Resolve the appeal as expeditiously as the member's health condition requires and no later than the date on which the extension expires (14 calendar days following the expiration of the original appeal resolution time frame). d. If the CCO fails to adhere to the notice and timing requirements for extension of the appeal resolution time frame, the member is deemed to have exhausted the appeal process and may request a Contested case hearing. *42 CFR §438.408(c)* *Contract: Exhibit I (4)(b)(2-3)* *OAR 410-141-3890 (3)(a);(b);(c)*	• Grievance and appeal policies and procedures • Member handbook • Provider materials, such as provider manual • Staff training materials *HSAG will also review compliance through file reviews. **Documents Submitted for Desk Review:** • CCO Appeal and Hearing Policy Page 18: letters vii, I, II, III, and IV • Member Handbook Page 143, paragraph 5. • Member Appeals and Grievance Handbook, Pg.5, Extended Time frames.	☐ Not Met
HSAG Findings: This requirement was *Met.*		
Required Actions: None.		

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
20. Appeal resolution notices must be in writing, meet the language and format requirements of §438.10, and must include: a. The results of the resolution process and the date it was completed. b. For appeals not resolved wholly in favor of the member: i. How to request the continued services. ii. Reasons for the resolution and a reference to the particular sections of the statutes and rules involved for each reason identified in the Notice of Appeal Resolution relied upon to deny the Appeal. iii. The right of the Member to request a standard or expedited Contested Case Hearing with OHA within 120 days from the date of CCO's Notice of Appeal Resolution and how to do so, which includes sending the Notice of Hearing Rights (DMAP 3030) available at: https://sharedsystems.dhsoha.state.or.us/forms/ and the Hearing Request Form (MSC 0443) or Appeal and Hearing Request (OHP 3302) available on the OHA Website at: https://www.oregon.gov/oha/HSD/OHP/Pages/Forms.aspx. iv. Explanation to the member that an expedited Hearing will not be granted for post-service denials; v. The right to continue to receive benefits pending a Contested Case Hearing and how to do so; vi. Information explaining that if CCO's Adverse Benefit Determination is upheld in a Contested Case	**Suggested Documents:** • Notice of appeal resolution template • Grievance and appeal policies and procedures *HSAG will also review compliance through file reviews. **Documents Submitted for Desk Review:** • CCO Appeal and Hearing Policy a and b Pg. 20: #1, b, c i, ii, iii, iv, v, vii, viii. Pg. 21: J, 1-3. • Member Handbook Pg. 145, Contested case hearing, Benefits and services during a hearing.	☒ Met ☐ Partially Met ☐ Not Met

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Hearing, the member may be liable for the cost of any continued benefits. *Note: Continuation of benefits/services applies only to previously authorized services for which the CCO provides 10-day advance notice to terminate, suspend, or reduce the services.* *42 CFR §438.408(e)* *Contract: Exhibit I (4)(b)(4)* *OAR 410-141-3890 (11)*		
HSAG Findings: This requirement was *Met.*		
Required Actions: None.		
21. The member may request a Contested case hearing after receiving notice that the CCO is upholding the adverse benefit determination, within 120 calendar days from the date of the notice of appeal resolution. a. The parties to the 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)(1)–(3)* *Contract: Exhibit I (5)* *OAR 410-141-3890 (7)* *OAR 410-141-3900 (1)(b);(2)(a)*	**Suggested Documents:** • Grievance and appeal policies and procedures • Contested case hearing policies and procedures • Member handbook • Provider materials, such as provider manual • Staff training materials **Documents Submitted for Desk Review:** • CCO Appeal and Hearing Policy Pg. 22 #8 a, b, and c • Member Appeals and Grievance Handbook, PG. 9 3rd paragraph.	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met.*		
Required Actions: None.		

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
22. The CCO provides for continuation of benefits/services while the CCO-level appeal and the Contested case hearing are pending if: a. The member files in a timely manner* for continuation of benefits—defined as on or before the later of the following: i. Within 10 days of the CCO mailing the notice of adverse benefit determination. ii. The intended effective date of the proposed adverse benefit determination. b. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. c. The services were ordered by an authorized provider. d. The period covered by the original authorization has not expired. e. The member requests an appeal within 60 days following the adverse benefit determination. *Note: This definition of "timely filing" only applies for this scenario—i.e., when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced.* *Note: The provider may not request continuation of benefits on behalf of the member (page 27510, 2016 Federal Register).* *42 CFR §438.420(a);(b)* *Contract: Exhibit I (6)* *OAR 410-141-3910 (1)*	**Suggested Documents:** • Grievance and appeal policies and procedures • Staff training materials *HSAG will also review compliance through file reviews. **Documents Submitted for Desk Review:** • CCO Appeal and Hearing Policy Pg. 22 • CCO Appeal and Hearing Policy Pg. 23, 24, K: 1, a, b. 2 a, b, c, d and e. • Member handbook, Pg. 145, paragraph 2. • Member Appeals and Grievance Handbook, Pg. 8 Continuation of Benefits, letters a – d.	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
23. If, at the member's request, the CCO continues or reinstates the benefits while the appeal or contested case hearing is pending, the benefits must be continued until one of the following occurs: a. The member withdraws the appeal or request for a contested case hearing. b. The member does not request a contested case hearing and continuation of benefits within 10 days from when the CCO mails the notice of appeal resolution. c. A contested case hearing officer issues a hearing decision adverse to the member. *42 CFR §438.420(c)* *Contract: Exhibit I (6)(c)* *OAR 410-141-3910 (1)(d)*	**Suggested Documents:** • Grievance and appeal policies and procedures • Staff training materials *HSAG will also review compliance through file reviews. **Documents Submitted for Desk Review:** • CCO Appeal and Hearing Policy Pg. 24, L. 1 a- d. • Member Handbook, Pg. 145 last paragraph, Pg. 146, first paragraph.	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Action: None.		
24. Member responsibility for services furnished while the appeal or contested case hearing is pending: a. 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)* *OAR: 410-141-3910(1)(e)*	**Suggested Documents:** • Grievance and appeal policies and procedures • Contested case hearing policies and procedures • Member handbook **Documents Submitted for Desk Review:** • CCO Appeal and Hearing Policy Pg. 24, M, 1. • Member handbook Pg. 146, paragraph 2	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Required Actions: None.		
25. Effectuation of reversed appeal resolutions: a. If the CCO or the Contested case hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the CCO or officer must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than 72 hours from the date it receives notice reversing the determination. b. If the CCO or the 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 must pay for those services, in accordance with State policy and regulations. *42 CFR §438.424* *Contract: Exhibit I (7)* *OAR: 410-141-3910(2)*	**Suggested Documents:** • Grievance and appeal policies and procedures • Contested case hearing policies and procedures • Contested case tracking reports *HSAG will also review compliance through file reviews. **Documents Submitted for Desk Review:** • CCO Appeal and Hearing Policy Pg. 25, N. 1a, 2a. • Member Appeals and Grievance Handbook, Pg. 9, Paragraph 1. Letter a	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
26. The CCO maintains records of all grievances and appeals. The records must be accurately maintained in a manner accessible to the State and available on request to CMS. The record of each grievance and appeal must contain, at a minimum, all of the following information: a. A general description of the reason for the appeal or grievance and the supporting reasoning for its resolution; b. The member's name and ID;	**Suggested Documents:** • Grievance and appeal policies and procedures • Grievance and appeal tracking reports *HSAG will also review compliance through file reviews. **Documents Submitted for Desk Review:** • CCO Appeal and Hearing Policy	☒ Met ☐ Partially Met ☐ Not Met

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
c. The date CCO received the grievance or appeal filed by the member, subcontractor, or provider; d. The NOABD; e. If filed in writing, the appeal or grievance; f. If filed orally, documentation that the grievance or appeal was received orally; g. Records of the review or investigation at each level of the appeal, grievance, or contested case hearing; h. Notice of resolution of the grievance or appeal, including dates of resolution at each level; i. Copies of correspondence with the member and all evidence, testimony, or additional documentation provided by the member, the member's representative, or the member's provider as part of the grievance, appeal, or contested case hearing process; and j. All written decisions and copies of all correspondence with all parties to the grievance, appeal, or contested case hearing. k. Resolution at each level of the appeal or grievance process, as applicable. l. Date of resolution at each level of the appeal or grievance process, as applicable. *42 CFR §438.416* *Contract: Exhibit I (9)(b)* *OAR 410-141-3915*	Pg. 26, Paragraph 1, a - l • CCO Grievance policy Pg. 13 K, 1 a – l.	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
27. The CCO provides the information about the grievance, appeal, and contested case hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: a. The member's right to file grievances and appeals. b. The requirements and time frames for filing grievances and appeals. c. The right to a Contested case hearing after the CCO has made a decision on an appeal which is adverse to the member. d. The availability of assistance in the filing processes. e. The fact that, when requested by the member: f. Services that the CCO seeks to reduce or terminate will continue if the appeal or request for Contested case hearing is filed within the time frames specified for filing. g. The member may be required to pay the cost of services furnished while the appeal or Contested case hearing is pending, if the final decision is adverse to the member. h. Written notification of updates to these procedures and timeframes **within 5 business days** after approval of such updates by OHA. *42 CFR §438.414* *Contract: Exhibit I (1)(b)*	**Suggested Documents:** • Grievance and Appeal policies and procedures • Provider agreement • Provider materials, such as provider manual • Subcontractor Contract **Documents Submitted for Desk Review:** • CCO Appeal and Hearing Policy Pg. 3, paragraph 3 • AllCare CCO direct provider agreement 3.10.2 and 4.2. appendix E (link to provider portal) • AllCare CCO Provider Manual Pg. 49 through 51.	☐ Met ☒ Partially Met ☐ Not Met
HSAG Findings: AllCare's *Appeal and Hearing* policy described the CCO's system for providing information about grievances, appeals, and contested case hearings to providers and subcontractors; however, the policy does not specifically address (a)–(b) or (d)–(g). Additionally, the CCO did not provide evidence that this occurs. The CCO submitted its provider manual; however, this is a provider-facing document, and it is not clear how the CCO provides the required information to subcontractors. Also, the provider manual was missing some of the required information. This requirement was *Partially Met*.		

Standard X—Grievance and Appeal Systems (42 CFR §438.228)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Required Actions: The CCO must provide participating providers and subcontractors when they enter into a subcontract written notification of procedures and time frames for grievances, NOABDs, appeals, and contested case hearings as outlined in Ex. I of the CCO contract, including the information outlined in elements a through f. The CCO must also provide written notification of updates to these procedures and time frames within five business days after approval of such updates by OHA. Evidence of providing the appropriate information could include attachments or supplemental documentation or emails provided to subcontractors and providers at the time of contracting, evidence of providing the provider manual during the onboarding process, evidence of providing any updates to the procedures and time frames within five business days after OHA approval, and/or detailed processes/procedures that outline how the information is provided.		

Results for Standard X—Grievance and Appeal Systems							
Total	Met	=	19	X	1.0	=	19.0
	Partially Met	=	8	X	0.5	=	4.0
	Not Met	=	0	X	0.0	=	0.0
Total Applicable		=	27	**Total Score**		=	23.0

Total Score ÷ Total Applicable	=	**85.2%**

Standard XIV—Member Information

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. The CCO provides all required member information to members in a manner and format that may be easily understood (6th grade reading level) and is readily accessible by members. *Note: Readily accessible means electronic information which complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines.* *42 CFR §438.10(c)(1)* *Contract: Exhibit B Part 3 (4)(d)(4);(6)* *OAR 410-141-3585 (2)*	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • (HSAG will evaluate the reading level of letters, handbooks, and other materials submitted for requirements throughout this standard.) **Documents Submitted for Desk Review:** • 2022 CCO Member handbook, page 1 • 2022 CCO BH Member Handbook, page 1 • 2022 CCO Member Rights and Responsibilities Booklet, page 1 • 2022 Providing Member Materials Policy	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
2. The CCO has in place a mechanism to help members understand the requirements and benefits of the plan. *42 CFR §438.10(c)(7)* *Contract: Exhibit B Part 3 (2)(f)* *OAR 410-141-3585(3)*	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Internal protocols/training materials for staff • Member-facing communications **Documents Submitted for Desk Review:** • 2022 Providing Member Materials Policy	☒ Met ☐ Partially Met ☐ Not Met

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• New Hire training outline • Members can contact AllCare Customer Care by phone, email, LiveChat, Walk-in, and secure messaging through the Member Portal.	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
3. For consistency in the information provided to members, the CCO uses the following as developed by the State: a. Definitions for managed care terminology, including appeal, copayment, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, grievance, habilitation services and devices, health insurance, home healthcare, hospice services, hospitalization, hospital outpatient care, medically necessary, network, nonparticipating provider, participating provider, physician services, plan, preauthorization, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, and urgent care. b. Model member handbooks and member notices. *42 CFR §438.10(c)(4)* *Contract: Exhibit A; Exhibit B Part 3 (5)(a)*	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Member handbook • Training or other materials that include definitions • (HSAG will assess policies and procedures submitted throughout.) **Documents Submitted for Desk Review:** • 2022 CCO Member Handbook, pages 148 – 155 • 2022 Providing Member Materials Policy • New Hire Training outline	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
4. The CCO makes written materials that are critical to obtaining services available in prevalent non-English languages in its service area and in alternative formats upon member request at no cost. a. Written materials that are critical to obtaining services include provider directories, member handbooks, welcome letters, appeal and grievance notices, and denial and termination notices. b. All written materials for members must: i. Use a font size no smaller than 12 point. ii. Be available in alternative formats and through provision of auxiliary aids and service that takes into consideration the special needs of members with disabilities or limited English proficiency. iii. Include taglines for written materials critical to obtaining services printed in a conspicuously visible (18-point) font size and prevalent non-English languages explaining the availability of written translations or oral interpretation to understand the information provided, information on how to request auxiliary aids and services, and the toll-free and TTY/TDD of the CCO's customer service number. *42 CFR §438.10(d)(3);(6)* *Contract: Exhibit B Part 3 (4)(d)* *OAR 410-141-3585 (5)(a-b)*	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Interpretation/translation/alternate format/communication policies and procedures • Methodology for providing copies of translated member handbooks to members • Member marketing materials • Examples of materials available in the prevalent non-English language (Spanish). • (HSAG will assess materials submitted throughout this standard.) **Documents Submitted for Desk Review:** • 2022 Providing Member Materials Policy • 2021 Grievance Policy and Procedure, page 4 • 2022 CCO-Creating Health Equitable Materials Policy - Language Access, page 7 • 2022 CCO-P&P Directory-Josephine-SPN, page 1 • 2022 CCO-P&P Directory-Jackson-SPN, page 1 • 2022 CCO-P&P Directory-Curry-SPN, page 1 • 2022 CCO Member Handbook-SPN • 2022- Member Welcome Letter-SPN-PQ	☐ Met ☒ Partially Met ☐ Not Met

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: The CCO's *Creating Health Equitable Materials* policy asserted that member materials are to include information referenced in the element, including the availability of written materials that are critical to obtaining services in prevalent non-English languages in the CCO's service area and in alternative formats upon member request at no cost, written and oral interpretation to understand the information, information on how to obtain auxiliary aids and services, and TTY/TDD phone numbers. However, the policy did not stipulate that documents are to use a font size no smaller than 12-point. The policy asserted that materials are to be readily available in Spanish, the prevalent non-English language within the member community. While the policy defined prevalent non-English languages as any language spoken by 5 percent or more of its member population, this did not reflect the full definition of "prevalent non-English language" as given in OAR 410-141-3575, which defines it as the lesser of 5 percent of the CCO's total OHP enrollment *or* 1,000 of the CCO's OHP members. The member handbook and provider directory were available via the AllCare website in English and Spanish. The member handbook, provider directory, and welcome letter were generally compliant with format and language requirements; availability of alternate formats (e.g., Braille, larger font, interpretation) and information within documents explaining the availability of written translations or oral interpretation; how to request auxiliary aids and services; and toll-free TTY/TDD numbers. The member handbook, provider directory, and welcome letter contained 18-point font tag lines explaining the availability of additional services. However, the CCO's PDF version of its provider directory used an 11-point rather than a 12-point font. This requirement was *Partially Met*.		
Required Actions: The CCO must ensure that its policy and process for determining the prevalent non-English languages spoken by members and member materials being readily available is based on the full definition of "prevalent non-English language" provided in OAR 410-141-3575, which defines it as the lesser of 5 percent of the CCO's total OHP enrollment or 1,000 members. The CCO must also ensure that written materials for members use no smaller than 12-point font and that the requirement is reflected in the relevant policies and procedures.		
5. If the CCO makes information available electronically—Information provided electronically must meet the following requirements: a. The format is readily accessible (see definition of readily accessible above). b. The information is placed in a website location that is prominent and readily accessible. c. The information can be electronically retained and printed. d. The information complies with content and language requirements.	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • If the requirement for providing the handbook or provider directory is met through availability of the materials in an electronic format, submit an example of how members are notified how to access the materials electronically (welcome letter, etc.)	☐ Met ☒ Partially Met ☐ Not Met

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
e. The member is informed that the information is available in paper form without charge upon request and is provided within five business days. *42 CFR §438.10(c)(6)* *Contract: Exhibit B Part 3 (4)(d)(6)* *OAR 410-141-3585 (5)(c)*	• Example of how members are informed that materials accessed electronically are available in paper form within five business days. • Policies and procedures on dissemination of information to members • Sample member communications **Documents Submitted for Desk Review:** • https://www.allcarehealth.com/medicaid/resources/plan-materials • Member Welcome Letter 2022-PQ • 2022 Providing Member Materials Policy	
HSAG Findings: AllCare's *Providing Member Materials* policy stated that electronic versions of the member handbook and provider directory are to be available on the CCO's website. The policy indicated that online materials are to be reviewed monthly and made readily accessible by a vendor, Rhythm Agency, which was confirmed by CCO staff during the site visit. The policy asserted that members could request member-related materials in their desired format via the website contact form and that all materials requests were to be processed within five business days. During the site visit, CCO staff described a process for the receipt, handling, fulfillment, and tracking of such requests via its EZ-CAP software platform, including a weekly timeliness check. Although the policy did not explicitly state that other materials would be made available on the website, AllCare's website included an electronic version of the formulary in addition to the member handbook and provider directories for each county. The documents could be easily accessed, electronically retained, and printed as PDF files. However, while the documents available on the website complied with most content and language requirements (e.g., reading level, 18-point font taglines) and were readily available in both English and Spanish, the formulary and provider directory documents used 11-point font rather than the minimum 12-point font as required. Additionally, while the website, provider handbook, and provider directories offered consistent messaging that all documents were available in other languages, other formats, and print, the formulary did not provide this information. This requirement was *Partially Met.*		
Required Actions: The CCO must ensure that all member materials posted to its website meet readability and formatting requirements, including the use of fonts no smaller than 12-point size and messaging that all documents are available in other languages, formats, and in print.		

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
6. The MCE makes the following pharmacy information available to its members in electronic or paper form: a. Which medications are covered (both generic and name brand). b. What tier each medication is on. c. The formulary drug list must be available on the MCE's website in a machine-readable file and format as specified by the Secretary of Health and Human Services. *45 CFR §180.20 defines "machine-readable" format as a digital representation of data or information in a file that can be imported or read into a computer system for further processing. Examples of machine-readable formats include, but are not limited to, XML, JSON, and CSV formats.* *42 CFR §438.10 (h)(4)(i)* *Exhibit B, Part 2 (7)(e)(7)* *OAR 410-141-3585(7)*	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Link to Formulary List, including machine-readable. • CCO website address **Documents Submitted for Desk Review:** • https://www.allcarehealth.com/medicaid/formulary • 2022 Providing Member Materials Policy • AllCare CCO Formulary Print 10_01_22	☐ Met ☒ Partially Met ☐ Not Met
HSAG Findings: The CCO's *Providing Member Materials* policy stated that the member handbook is to contain information on how to obtain the formulary online or in another format free of charge. The member handbook provided the URL for the formulary-specific page on the CCO's website. The formulary was available in both English and Spanish. The website offered PDF files of the formulary but nothing in a machine-readable format (e.g., JavaScript Object Notation [JSON]). The formulary provided by AllCare for review (i.e., the formulary effective October 1, 2022) listed medications and their tiers. The current online formulary provided a legend at the bottom of each page, providing the full terms for each shorthand annotation without sufficient explanation for a member audience (e.g., "Step Therapy"). The current formulary included the statement that AllCare required generic drugs to be used when available and listed brand names in parentheses. This requirement was *Partially Met*.		
Required Actions: The CCO must ensure that its formulary indicates which prescription drugs are covered, including generic and name-brand versions, and must ensure that the formulary is available on its website in a machine-readable format (e.g., JSON) in addition to the current format (i.e., PDF or another human-readable format).		
Recommendations: Although the CCO provided members and providers with its formularies from each quarter over the last year, HSAG recommends that the CCO maintain only one formulary available on its website and in print to avoid confusion for its audience. Additionally,		

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG recommends including a legend in the formulary explaining shorthand annotations, such as (but not limited to) "PA," "QL," "MS," and "Step Therapy," and the use of italics or parentheses to meet the intent of providing formulary information to members as well as providers.		
7. The CCO makes interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and written translation is available in prevalent languages, and how to access these services. a. This includes oral interpretation and use of auxiliary aids such as TTY/TDD and American Sign Language. b. The CCO notifies members that auxiliary aids and services are available upon request and at no cost for members with disabilities, and how to access them. *42 CFR §438.10(d)(4-5)* *Contract: Exhibit B Part 3 (4)(d)(3)* *OAR 410-141-3585 (10)*	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Member handbook • Interpretation/translation/alternate format/ communication policies and procedures **Documents Submitted for Desk Review:** • 2022 CCO Member Handbook, pages 4 - 9 and 32 • 2022 Providing Member Materials Policy • 2022 CCO-Creating Health Equitable Materials Policy - Language Access, page 8	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
8. The CCO must make a good faith effort to give written notice of termination of a contracted provider within 15 calendar days after the receipt or issuance of the termination notice or 30 calendar days prior to the effective date of the termination, whichever is later, to each member who received his or her primary care from, or was seen on a regular basis by, the terminated provider. *42 CFR §438.10(f)(1)* *OAR 410-141-3585(13)(f)*	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Redacted example letter • Template letter **Documents Submitted for Desk Review:** • CCO Mbr Letter-provider Change • 2022 Providing Member Materials Policy	☐ Met ☒ Partially Met ☐ Not Met

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: The CCO's *Providing Member Materials* policy did not address the requirement. During the site visit, CCO staff described a process for identifying members affected by a provider termination, including tracking the timeliness of member outreach. However, CCO staff also confirmed during the site visit that the CCO had no written policy or procedure for notifying members who were regularly seen by or who received primary care from a terminated provider. The sample member letter regarding a provider change included a calendar date, but without additional context or documentation, there was no way to determine whether the letter was sent in a timely manner. This requirement was *Partially Met*.		
Required Actions: The CCO must have a documented process for complying with the required written notice time frames regarding notice to members regularly seen by or receiving primary care from a terminated provider.		
9. The CCO must make available, upon request, within five business days, additional information that the CCO has created that has been pre-approved by OHA and is otherwise available, including information on the CCO's structure and operations, and any physician incentive plans in place as set forth in §438.3. *42 CFR §438.10(f)(3)* *Contract: Exhibit B Part 3(4)(g)*	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Member communication templates on incentive plans and structure/operations **Documents Submitted for Desk Review:** • 2022 CCO Member Handbook, page 85	☐ Met ☐ Partially Met ☒ Not Met
HSAG Findings: AllCare did not submit a policy that addressed the requirement. While the member handbook stated that members had the right to request information on physician payment arrangements from its Customer Care department, the handbook is not a substitute for a policy or procedure. During the site visit, CCO staff stated that when members requested information on physician incentive plans, the CCO would resend the member welcome letter because it contained this information. However, the member welcome letter did not contain such information. This element was *Not Met*.		
Required Actions: The CCO must ensure that it has a documented process for timely fulfillment of member requests for information regarding physician incentive plans that OHA has pre-approved.		
10. The CCO makes available to members in paper form upon request, and electronic form, a provider directory that includes the following information about contracted network physicians (including specialists), hospitals, pharmacies, and behavioral health providers (as applicable), dentists, dental	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members	☐ Met ☒ Partially Met ☐ Not Met

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
and oral health providers, NEMT providers, and LTSS providers (as appropriate): a. The provider's name and group affiliation, street address(es), telephone number(s), website URL (as appropriate), specialty (as appropriate), and whether the providers will accept new members. b. The provider's cultural and linguistic capabilities, including languages (including American Sign Language) spoken by the provider or skilled medical interpreters offered by the provider or an Authority-approved qualified and, as applicable, certified health care interpreter(s) at no cost to members at the provider's office. c. Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment. d. Whether the provider offers both telehealth and in-person appointments; e. Availability of auxiliary aids and services for all members with disabilities upon request and at no cost. f. Whether the provider's office or facility is accessible and has accommodations for people with physical disabilities, including but not limited to information on accessibility of providers' offices, exam rooms, restrooms, and equipment. *42 CFR §438.10(h)(1)* *Contract: Exhibit B Part 3 (6)(e);(f)* *OAR 410-141-3585(6)*	• Provider directory **Documents Submitted for Desk Review:** • 2022 CCO-P&P Directory-Curry-ENG • 2022 CCO-P&P Directory-Jackson-ENG • 2022 CCO-P&P Directory-Josephine-ENG • https://www.allcarehealth.com/medicaid/find-a-doctor-and-facility/find-a-doctor • https://www.allcarehealth.com/medicaid/find-a-doctor-and-facility/find-a-facility-or-pharmacy • https://www.allcarehealth.com/medicaid/resources/plan-materials • 2022 CCO Member Handbook, pages 5, 70 - 85, 99 - 100, 117	
HSAG Findings: Before and during the site visit, CCO staff described a process for developing and maintaining the CCO's provider directory through quarterly outreach and a provider portal, with changes to provider information shared between CCO departments as relevant.		

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
The electronic (i.e., online) version of the CCO's provider directory took the form of a searchable website with the option to search either a list of "doctors" or "facilities," which included pharmacies. To search for oral health care (i.e., "dentist"), members were instructed to contact their dental care plan or the CCO if members did not know which dental plan they had. Contact information and URL addresses were provided for two dental plans, Advantage Dental and Capitol Dental Care. However, there were still options and search results for dental specialists and oral surgeons within AllCare's searchable provider directory. The individual provider directory included information about contracted network physicians, including specialists, behavioral health providers, dentists, oral surgeons, and individual pharmacists. Contact information for non-emergency medical transportation (NEMT) services was provided in a separate but easily located section of the website, which met the intent of the requirement. The facility directory included information for hospitals, pharmacies, and facilities for physicians, specialty care, behavioral health, and dental health. Individual provider results included the provider's name and group affiliation, street address, telephone numbers, specialty, and whether the provider was accepting new patients. While URLs were not provided, links to websites were available. Information was available regarding the languages spoken by the provider. No information was provided in the online directory regarding the availability of free interpretation support or other auxiliary aids. The directory included information on whether a provider or facility was listed as "ADA Accessible" without specific information on accommodations for people with physical disabilities, including but not limited to offices, exam rooms, restrooms, and equipment. The directory provided information on whether providers offered telehealth appointments. Reviewers noted that the search functionality was potentially limited and confusing for users, with the only way to search for providers across the entire network or greater than 25 miles from a given ZIP Code (rather than a physical address) being to leave the ZIP Code and distance options blank. This was compounded by the member handbook's section explaining how to use the search tool, which instructed members to use the ZIP Code and travel distance parameters to find a provider. The CCO's printed provider directory comprised three different directories separated by service region counties and surrounding areas. During the site visit, CCO staff stated that this county separation was for members' convenience and in response to member feedback to provide more local information and that members were not restricted geographically in their provider selection. The directories included information on physicians, specialists, pharmacies, behavioral health providers, dental care, and oral surgeons. However, no hospitals were listed in the provider directories, as required for Jackson or Josephine counties, despite several being within the network as listed in the online directory; two hospitals were listed in the printed Curry County provider directory. Entries included information about a provider's name, group affiliation, street address, phone number, specialty, and whether new members were accepted. While there were indicators for whether providers offered telehealth appointments, some provider entries with telehealth options did not include telephone numbers, and no URLs were given for providers. The directories included information on whether individual providers spoke English or Spanish. However, all providers were listed as speaking English, and none listed as speaking Spanish, including providers identified in the online directory as speaking Spanish and other languages, indicating information inaccuracies across the separate directories. The provider directories stated that interpreter services were available at all providers and facilities. Indicators were given for "Accessibility," but there was no clarity on whether this meant that accommodations were or were not available for people with physical disabilities. This requirement was *Partially Met*.		

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Required Actions: The CCO must ensure that all required informational elements within the electronic and print versions of the provider directory are present, accurate, in agreement, and current, including entries for all available hospitals, telephone contact information, web URLs, and languages spoken.		
Recommendations: While the CCO's provider directories included indicators for ADA accessibility, this is a broad category of certification. It does not provide information on specific accommodations for people with physical disabilities, including but not limited to the accessibility of providers' offices, exam rooms, restrooms, and equipment. HSAG recommends explaining what is included in the term "ADA Accessible" in the provider directory. HSAG also recommends including an option in the online directory to search beyond 25 miles for a provider or facility.		
11. The provider directory in: a. A paper format must be updated at least: i. Monthly, if the CCO does not have a mobile-enabled, electronic directory; or ii. Quarterly, if the CCO has a mobile-enabled, electronic provider directory. b. An electronic format must be updated no later than 30 calendar days after the CCO receives updated provider information. *The term "mobile-enabled" means a mobile website or application that makes provider directory information usable for smartphone or mobile technology users. 2020 Medicaid and CHIP Final Rule Federal Register Preamble, page 72800.* *42 CFR §438.10(h)(3)* *Contract: Exhibit B Part 3(6)(g)* *OAR 410-141-3585(6)(m)*	**Suggested Documents:** • Policies and procedures for managing and updating provider directory information • PDF of hard copy provider directory • Link to online provider directory • Link to machine-readable format **Documents Submitted for Desk Review:** • 2022 CCO-P&P Directory-Curry-ENG • 2022 CCO-P&P Directory-Jackson-ENG • 2022 CCO-P&P Directory-Josephine-ENG	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
12. Provider directories must be made available on the CCO's website in a machine-readable file and format as specified by the Secretary of Health and Human Services. *45 CFR §180.20 defines "machine-readable" format as a digital representation of data or information in a file that can be imported or read into a computer system for further processing. Examples of machine-readable formats include, but are not limited to, XML, JSON, and CSV formats.* *42 CFR §438.10(h)(4)* *Contract: Exhibit B Part 3(6)(j)* *OAR 410-141-3585 (6)(m)*	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Link to the CCO's provider directory on the website **Documents Submitted for Desk Review:** • 2022 CCO-P&P Directory-Curry-ENG • 2022 CCO-P&P Directory-Jackson-ENG • 2022 CCO-P&P Directory-Josephine-ENG • 2022 CCO-P&P Directory-Curry-SPN • 2022 CCO-P&P Directory-Jackson-SPN • 2022 CCO-P&P Directory-Josephine-SPN • https://www.allcarehealth.com/medicaid/resources/plan-materials	☐ Met ☐ Partially Met ☒ Not Met
HSAG Findings: The CCO's provider directories were unavailable in a machine-readable file and format on its website. This requirement was *Not Met*.		
Required Actions: The CCO must ensure its provider directory is available on its website in a machine-readable file and format as specified by the Secretary of Health and Human Services (i.e., as referenced in 45 CFR §180.20).		
13. Within 14 days of the CCO receiving notice of a member's enrollment, MCEs shall mail a welcome packet to new members and to members returning to the CCO 12 months or more after previous enrollment. The packet shall include, at a minimum: a. A welcome letter, b. A member handbook, and	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Evidence of providing member materials • Vendor tracking of timeliness	☒ Met ☐ Partially Met ☐ Not Met

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
c. Information on how to access a provider directory, including a list of any in-network retail and mail-order pharmacies. *42 CFR §438.10(g)(1)* *OAR 410-141-3585 (8)*	**Documents Submitted for Desk Review:** • 2022 CCO Member Welcome Letter • 2022 CCO Member Handbook • 2022 Health Risk Survey • 2022 Notice of Privacy Policy • 2022 PCP-Dental Selection Form • 2022 CCO BH Member Handbook • 2022 CCO Dental Brochure • ReadyRide flyer_AllCareHealth • Nurse Helpline-Rack Card • 2022 Providing Member Materials Policy • 2022 CCO Member Handbook, page 104 • Screenshots for Standard XV Member Information	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
14. For existing members, the CCO shall notify members annually of the availability of a member handbook and provider directory and how to access those materials. a. The CCO shall send hard copies upon request within five days. *Contract: Exhibit B Part 3 (5)(c)* *OAR 410-141-3585 (9)*	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Evidence of providing annual notices • Evidence of tracking timeliness **Documents Submitted for Desk Review:** • Screenshots for Standard XV Member Information	☐ Met ☒ Partially Met ☐ Not Met

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: The CCO's *Providing Member Materials* policy stated that members are to be notified annually of their right to receive member information via a Member Rights and Responsibilities brochure. However, the sample brochure did not state that the member handbook and provider directory were available online or in hard copy. Following the site visit, CCO staff provided HSAG with an annual notification that was currently under development. However, the notification did not state that the CCO would supply members with hard copies upon request within five days. Instead, it stated that the materials were available online and that members should call Customer Care if they had questions or needed help. This requirement was *Partially Met*.		
Required Actions: The CCO must ensure that its annual notification to members of the available member handbook and provider directory includes the option to request hard copies.		
15. The member handbook provided to members following enrollment includes: a. The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that members understand the benefits to which they are entitled, and to effectively use the managed care program. b. Procedures for obtaining benefits, including authorization requirements and/or referrals for specialty care and for other benefits not furnished by the member's primary care provider. c. The extent to which and how members may obtain benefits, including family planning services and supplies from out-of-network providers. d. An explanation that the CCO cannot require the member to obtain a referral before choosing a family planning provider in- or out-of-network. e. The process of selecting and changing the member's primary care provider. f. Any restrictions on the member's freedom of choice among network providers.	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Member handbook **Documents Submitted for Desk Review:** • 2022 CCO Member Handbook, pages 58 – 59, 61 – 65 • 2022 Providing Member Materials Policy	☐ Met ☒ Partially Met ☐ Not Met

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
g. In the case of a counseling or referral service that the CCO does not cover due to moral or religious objections, the CCO informs the member that the service is not covered by the CCO and how the member can obtain information from the State about how to access such services. *42 CFR §438.10(g)(2)* *Contract: Exhibit B Part 3 (5)(a)(1)* *OAR 410-141-3585 (12)*		
HSAG Findings: AllCare's member handbook provided information on the amount, duration, and scope of benefits available to them in sufficient detail to understand their benefits and how to use them. This was accomplished in tables that provided categories of benefits or services, prior authorization requirements if any were applicable, and limits to care (e.g., available for pregnant women and children 20 years and younger; no limit, etc.). These benefit tables addressed physical, mental, and oral health benefits, NEMT, and pharmacy benefits. The handbook explained how to obtain referrals to specialists from PCPs and obtain prior authorization when necessary. The handbook clearly stated that referrals were not required when seeking family planning services or supplies, and that members were permitted to receive family planning services or supplies from any provider or facility that served OHP members. The handbook provided a clear and detailed explanation of selecting and changing a PCP. Restrictions on the member's freedom of choice among network providers were limited to obtaining a referral to a specialist, except that members with SHCN or receiving long-term health care services and supports were permitted direct access to specialty care. The handbook clearly stated that the CCO had no moral or religious objections to providing care. However, the member handbook provided seemingly contradictory information with regard to obtaining out-of-network care. In one section, the member handbook stated that members would need CCO approval to see an out-of-network provider, while a different section stated that services from out-of-network providers did not require a referral or prior authorization. Additionally, the handbook stated that members could only change their PCP twice every 12 months, which does not comply with 42 CFR §438.52 and CCO contract language. This limitation was also not consistent with OHA's 2023 model member handbook, which removed all language related to limiting members' ability to change PCPs. During the site visit, CCO staff clarified that AllCare did not limit how often a member could change PCPs. This requirement was *Partially Met*.		
Required Actions: The CCO must ensure that explanations of benefits regarding restrictions on out-of-network care are accurate and consistent throughout the member handbook. The CCO also must ensure its policies, procedures, and member materials comply with 42 CFR §438.52, regarding limitations on a member's ability to change PCPs. Specifically, the CFR and CCO Contract, Exhibit B, Part 3 (2)(g) directs CCOs to "Allow each Member to choose the Member's own Health Care Professional from available Participating Providers and facilities to the extent possible and [as] appropriate. For a member in a service area serviced by only one CCO, any limitation [the] contractor imposes on the		

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
member's freedom to change between Primary Care Providers or to obtain services from Non-Participating Providers if the service or type of provider is not available with Contractor's Provider Network may be no more restrictive than the limitation on disenrollment under Sec. 9, below of this Ex. B, Part 3."		
16. The member handbook provided to members following enrollment includes member rights and responsibilities. As specified in 42 CFR §438.100, a member has the right to: • Receive information in accordance with information requirements (42 CFR §438.10). • Be treated with respect and with due consideration for his or her dignity and privacy. • Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. • Participate in decisions regarding his or her health care, including the right to refuse treatment. • Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation. • Request and receive a copy of his or her medical records, and request that they be amended or corrected. • Be furnished health care services in accordance with requirements for access, coverage, and coordination of medically necessary services (42 CFR §438.206 through 42 CFR §438.210). • Freely exercise his or her rights, and the exercising of those rights will not adversely affect the way the CCO, its network providers, or the State Medicaid agency treats the member. *42 CFR §438.10(g)(2)(ix)* *Contract: Exhibit B Part 3 (5)(a)(1)* *OAR 410-141-3585 (12)*	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Member Handbook **Documents Submitted for Desk Review:** • 2022 CCO Member handbook, pages 26 – 31 • 2022 Providing Member Materials Policy • 2022 CCO-Member Rights and Responsibilities Booklet	☒ Met ☐ Partially Met ☐ Not Met

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
17. The member handbook provided to members following enrollment includes the following information regarding the grievance, appeal, and contested case hearing procedures and time frames: a. The right to file grievances and appeals. b. The requirements and time frames for filing a grievance or appeal. c. The right to a request a Contested case hearing after the CCO has made a determination on a member's appeal which is adverse to the member. d. The availability of assistance in the filing process for grievances and appeals. e. The fact that, when requested by the member: i. Benefits that the CCO seeks to reduce or terminate will continue if the member files an appeal or a request for Contested case hearing is filed within the time frames specified for filing. ii. If benefits continue during the appeal or Contested case hearing process, the member may be required to pay the cost of services while the appeal or Contested case hearing is pending if the final decision is adverse to the member. *42 CFR §438.10(g)(2)(xi)* *Contract: Exhibit B Part 3 (5)(a)(1)* *OAR 410-141-3585 (12)*	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Member handbook **Documents Submitted for Desk Review:** • 2022 CCO Member Handbook, pages 140-147	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
18. The member handbook provided to members following enrollment includes the extent to which and how after-hours and emergency coverage are provided, including: a. What constitutes an emergency medical condition and emergency services. b. The fact that prior-authorization is not required for emergency services. c. The fact that the member has the right to use any hospital or other setting for emergency care. *42 CFR §438.10(g)(2)(v)* *Contract: Exhibit B Part 3 (5)(a)(1)* *OAR 410-141-3585 (12)*	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Member handbook **Documents Submitted for Desk Review:** • 2022 CCO Member handbook, pages 89 - 95	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
19. The member handbook provided to members following enrollment includes: a. Cost-sharing, if any is imposed under the State plan. b. How and where to access any benefits that are available under the State plan but not covered under the Medicaid managed care contract. c. How transportation is provided. d. The toll-free telephone number for member services, medical management, and any other unit providing services directly to members. e. Information on how to report suspected fraud or abuse. f. How to access auxiliary aids and services, including information in alternative formats or languages. *42 CFR §438.10(g)(2)(ii, viii, xiii, xiv, xv)* *Contract: Exhibit B Part 3 (5)(a)(1)* *OAR 410-141-3585 (12)*	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Member handbook **Documents Submitted for Desk Review:** • 2022 CCO Member Handbook, pages 3, 5, 7, 60 - 61, 70 – 87, 135 - 137	☒ Met ☐ Partially Met ☐ Not Met

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
20. The member handbook provided to members following enrollment includes how to exercise an advance directive as required in §438.3 (j). *42 CFR §438.10(g)(2)(xii)* *Contract: Exhibit B Part 3 (5)(a)(1)* *OAR 410-141-3585 (12)*	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Member handbook **Documents Submitted for Desk Review:** • 2022 CCO Member handbook, pages 138 – 139 • AdvanceDirectivePolicy2022	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
21. The CCO must give members written notice of any significant change (as defined by the State) in the information required at 42 CFR §438.10(g) at least 30 days before the intended effective date of the change. *42 CFR §438.10(g)(4)* *Contract: Exhibit B Part 3 (4)(i)* *AR 410-141-3585 (3)(f)*	**Suggested Documents:** • Example notification (if applicable within the last year) • Template letter (if available) **Documents Submitted for Desk Review:** •	☐ Met ☒ Partially Met ☐ Not Met
HSAG Findings: The CCO did not submit any documentation for desk review for this requirement. HSAG reviewers found that the CCO's *Providing Member Materials* policy stated that in the event of any service or benefit changes, notice would be mailed to all current enrollees, posted on the CCO's website and provider portal, and inserted into the member handbook. During the site visit, CCO staff stated that if such changes occurred, a report would be pulled of those "negatively impacted," and outreach to them would follow. However, CCO staff also stated that outreach would not be conducted when a "positive" outcome occurred, which did not meet the intent of the requirement. Additionally, the policy did not include the requirement to notify members at least 30 days before the intended effective date of the change, nor provide a process for monitoring notification timeliness. This requirement was *Partially Met*.		

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Required Actions: The CCO also must ensure that its relevant policies and procedures include the requirement to notify members at least 30 days before the intended effective date of any significant change (as defined by the State) relevant to coverage and benefits. The CCO must ensure a documented process for tracking the timeliness of its notification to members.		
Recommendations: The CCO should ensure it submits documentation for desk review for all requirements.		
22. The CCO provides member information by either: a. Mailing a printed copy of the information to the member's mailing address. b. Provides the information by email after obtaining the member's agreement to receive the information by email. c. Posts the information on the web site of the CCO and advises the member in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost. d. Provides the information by any other method that can reasonably be expected to result in the member receiving that information. *42 CFR §438.10(g)(3)* *Contract: Exhibit B Part 3 (4)(d)*	**Suggested Documents:** • Policies and procedures on member materials and dissemination of information to members • Member welcome or introductory materials • Website links/screenshots • Evidence of mailings • Evidence of emails **Documents Submitted for Desk Review:** • 2022 CCO Member Welcome Letter • https://www.allcarehealth.com/medicaid/resources/plan-materials • Screenshots for Standard XV Member Information	☐ Met ☒ Partially Met ☐ Not Met
HSAG Findings: The CCO's *Providing Member Materials* policy stated that new member packets were mailed to members, which included the welcome letter, notice of privacy practices, PCP and dental plan selection forms, and the member handbook, with information on how to obtain additional information directly from the CCO or its website. While the member handbook stated that information could be emailed to members with their permission, there was no statement within the policy about this. During the site review, CCO staff stated that prior to CY 2023, email was not used for communication with members. This was a contradiction with the language of its member handbook. CCO staff also stated that AllCare had recently launched an online member portal that allowed for direct and secure process and that consent to communicate with members was gained by their portal sign ups. This requirement was *Partially Met*.		

Standard XIV—Member Information (42 CFR §438.10)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Required Actions: The CCO must ensure that a written policy or procedure is in place providing a process for supplying member information by email or other secure messaging with the member's written consent. Additionally, the CCO must ensure that its member-facing materials (e.g., the member handbook, welcome letter) do not assert the availability of any non-existent functionality (e.g., communication with the CCO via email).		

Results for Standard XIV—Member Information							
Total	Met	=	11	X	1.0	=	11.0
	Partially Met	=	9	X	0.5	=	4.5
	Not Met	=	2	X	0.0	=	0.0
Total Applicable		=	22	**Total Score**		=	15.5

Total Score ÷ Total Applicable	=	**70.5%**

Standard XVI—Emergency and Poststabilization Services

Standard XVI—Emergency and Poststabilization Services (42 CFR §438.114)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. The CCO defines "emergency medical condition" as a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: a. Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; b. Serious impairment to bodily functions; or c. Serious dysfunction of any bodily organ or part. *42 CFR §438.114(a)* *Contract: Exhibit A* *OAR 410-120-0000*	**Suggested Documents:** • Emergency and poststabilization services coverage policies and procedures • Member handbook • Provider handbook or other provider messaging **Documents Submitted for Desk Review:** • Emergency and Poststabilization Services_UM-CCO-135 Emergency, Urgent and Post-Stabilization Services Page 2 Section "Definitions" • Emergency and Poststabilization Services_2022ACCCO-Member Handbook-FINAL-REVISED 4.29.22 Page 93-94 Section "Emergency Care" • Emergency and Poststabilization Services_CCO Provider Manual Page 29 Section "Emergency Care"	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
2. The CCO defines "emergency services" as covered inpatient or outpatient services furnished by a provider that is qualified to furnish these services under this title and are needed to evaluate or stabilize an emergency medical condition. *42 CFR §438.114(a)*	**Suggested Documents:** • Emergency and poststabilization services coverage policies and procedures • Member handbook	☒ Met ☐ Partially Met ☐ Not Met

Standard XVI—Emergency and Poststabilization Services (42 CFR §438.114)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Contract: Exhibit A *OAR 410-120-0000*	• Provider handbook or other provider messaging **Documents Submitted for Desk Review:** • Emergency and Poststabilization Services_UM-CCO-135 Emergency, Urgent and Post-Stabilization Services Page 2 Section "Definitions" • Emergency and Poststabilization Services_2022ACCCO-Member Handbook-FINAL-REVISED 4.29.22 Page 93-94 Section "Emergency Care" and "Hospitals" • Emergency and Poststabilization Services_CCO Provider Manual Page 29 Section "Emergency Care" & Page 52 see highlighted section	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
3. The CCO defines "poststabilization care services" as covered services related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized condition or provided to improve or resolve the member's condition. *42 CFR §438.114(a)* *Contract: Exhibit A*	**Suggested Documents:** • Emergency and poststabilization services coverage policies and procedures • Member handbook or other member messaging • Provider handbook or other provider messaging **Documents Submitted for Desk Review:** • Emergency and Poststabilization Services_UM-CCO-135 Emergency, Urgent	☐ Met ☒ Partially Met ☐ Not Met

Standard XVI—Emergency and Poststabilization Services (42 CFR §438.114)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	and Post-Stabilization Services Page 3 Section "Definitions" • Emergency and Poststabilization Services_2022ACCCO-Member Handbook-FINAL-REVISED 4.29.22 Page 94 Section "Care after an Emergency" • Emergency and Poststabilization Services_CCO Provider Manual Page 29 Section "Emergency Care"	
HSAG Findings: The *Emergency, Urgent and Post-stabilization Services* policy and procedure included the definition of "poststabilization care services" as specified in this element. The member handbook included a member-appropriate definition of "poststabilization care services." The provider manual did not include a definition of "poststabilization care services." This requirement was *Partially Met.*		
Required Actions: The CCO must revise the provider handbook to include the required definition of "poststabilization care services."		
4. The CCO may not require prior authorization for emergency services. *42 CFR §438.10(g)(2)(v)(B)* *Contract: Exhibit B Part 2(4)(a)(1)* *OAR 410-141-3835(2)* *OAR 410-141-3840(4)*	**Suggested Documents:** • Emergency and poststabilization services coverage policies and procedures **Documents Submitted for Desk Review:** • Emergency and Poststabilization Services_UM-CCO-135 Emergency, Urgent and Post-Stabilization Services Page 3 Section "Policy: Coverage" #5 • Emergency and Poststabilization Services_2022ACCCO-Member Handbook-FINAL-REVISED 4.29.22 Page 93 Section "Emergency Care" see highlighted sentence	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		

Standard XVI—Emergency and Poststabilization Services (42 CFR §438.114)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
5. The CCO covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the CCO. *42 CFR §438.114(c)(1)(i)* *Contract: Exhibit B Part 2(4)(a)(3)*	**Suggested Documents:** • Emergency and poststabilization services coverage policies and procedures • Claims payment workflows and/or protocols – specific to payment of emergency services **Documents Submitted for Desk Review:** • Emergency and Poststabilization Services_UM-CCO-135 Emergency, Urgent and Post-Stabilization Services Page 4 Section "Policy: Payment" #1 • Emergency and Poststabilization Services_ AllCare CCO OHP Emergency and Urgent Care Services – Claims Process & Policy	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
6. The CCO may not deny payment for treatment obtained under either of the following circumstances: a. A representative of the CCO's organization (including the member's primary care provider) instructed the member to seek emergency services. b. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would *not* have resulted in the following outcomes specified in the definition of an emergency medical condition.	**Suggested Documents:** • Emergency and poststabilization services coverage policies and procedures • Claims payment workflows and/or protocols – specific to payment and denials of emergency services **Documents Submitted for Desk Review:** • Emergency and Poststabilization Services_UM-CCO-135 Emergency, Urgent and Post-Stabilization Services Page 4 Section "Policy: Payment" #2	☒ Met ☐ Partially Met ☐ Not Met

Standard XVI—Emergency and Poststabilization Services (42 CFR §438.114)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
i. Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; ii. Serious impairment to bodily functions; or iii. Serious dysfunction of any bodily organ or part. *Note: The CCO bases its coverage decisions for emergency services on the severity of the symptoms at the time of presentation and covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. 42 CFR §438.114--Preamble* *42 CFR §438.114(c)(1)(ii)* *Contract: Exhibit B Part 2(4)(a)(5) and (11)* *OAR 410-141-3840(4) and (5)*	• Emergency and Poststabilization Services_ AllCare CCO OHP Emergency and Urgent Care Services – Claims Process & Policy	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
7. The CCO does not: a. Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms. b. Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, the CCO, or State agency 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) and (10)* *OAR 410-141-3840(4)(b) and (c)*	**Suggested Documents:** • Emergency and poststabilization services coverage policies and procedures • Claims payment workflows and/or protocols – specific to payment and denials of emergency services **Documents Submitted for Desk Review:** • Emergency and Poststabilization Services_UM-CCO-135 Emergency, Urgent and Post-Stabilization Services Page 4 Sections "Policy: Coverage" #7 and "Policy: Payment" #3	☒ Met ☐ Partially Met ☐ Not Met

Standard XVI—Emergency and Poststabilization Services (42 CFR §438.114)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• Emergency and Poststabilization Services_ AllCare CCO OHP Emergency and Urgent Care Services – Claims Process & Policy	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
8. The CCO does not hold a member who has an emergency medical condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42 CFR §438.114(d)(2)* *Contract: Exhibit B Part 2(4)(a)(9)* *OAR 410-141-3840(4)*	**Suggested Documents:** • Emergency and poststabilization services coverage policies and procedures • Claims payment workflows and/or protocols – specific to coverage of poststabilization services • Provider messaging **Documents Submitted for Desk Review:** • Emergency and Poststabilization Services_ UM-CCO-135 Emergency, Urgent and Post-Stabilization Services Page 1 Section "Purpose" • Emergency and Poststabilization Services_ AllCare CCO OHP Emergency and Urgent Care Services – Claims Process & Policy	☐ Met ☒ Partially Met ☐ Not Met
HSAG Findings: The *Emergency, Urgent and Post-stabilization Services* policy and procedure specified the requirements of this element. The *Emergency and Urgent Care Services* policy and procedure did not specifically state that members are not held liable for payment of subsequent screening. However, it specified that the CCO pays for screening and stabilization. The CCO did not provide system screen shots, internal workflows, or claims processes to demonstrate how it ensures payment of subsequent screening and treatment for members with emergency medical conditions. This requirement was *Partially Met*.		
Required Actions: The CCO must demonstrate how it ensures payment of subsequent screening and treatment for members with emergency medical conditions.		

Standard XVI—Emergency and Poststabilization Services (42 CFR §438.114)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
9. The CCO allows the attending emergency physician, or the provider actually treating the member, to be responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the CCO who is responsible for coverage and payment. *42 CFR §438.114(d)(3)* *Contract: Exhibit B Part 2(4)(a)(9)*	**Suggested Documents:** • Emergency and poststabilization services coverage policies and procedures • Claims payment workflows and/or protocols – specific to poststabilization services • Provider messaging **Documents Submitted for Desk Review:** • Emergency and Poststabilization Services_ UM-CCO-135 Emergency, Urgent and Post-Stabilization Services Page 1 Section "Purpose" • Emergency and Poststabilization Services_ AllCare CCO OHP Emergency and Urgent Care Services – Claims Process & Policy	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: The *Emergency, Urgent and Post-stabilization Services* policy and procedure specified the requirements of this element. The *Emergency and Urgent Care Services* policy and procedure did not specifically address the requirements of this element. The CCO did not submit evidence of consultation with attending emergency physicians or internal workflows to demonstrate this as standard practice. During the site visit, the CCO discussed that the attending emergency physician is responsible for emergency care decisions. The CCO reported only working with the attending physician to provide support, especially for prolonged stays. This requirement primarily comes into play when emergency services are provided out of network. That is, the CCO typically wants to remove the member from the out-of-network facility, either through discharge or transfer to an in-network facility primarily to control costs. The CCO must respect the treating physician's judgment and not force early discharge or transfer. This requirement was *Met*.		
Required Actions: None.		
Recommendations: The CCO should develop training and/or desk protocols for UM physicians or other UM or care coordination staff working with the out-of-network facilities to arrange discharge or transfer to ensure an understanding of what is permitted.		

Standard XVI—Emergency and Poststabilization Services (42 CFR §438.114)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
10. The CCO is financially responsible for poststabilization services that are: a. ***Pre-approved*** by a plan provider or CCO representative, regardless of whether they are provided within or outside the CCO's network of providers. b. Obtained within or outside the network that are ***not pre-approved*** by a plan provider or other organization representative but are administered to maintain the member's stabilized condition within one hour of a request to the organization for pre-approval of further poststabilization care services. c. Obtained within or outside the network that are ***not pre-approved*** by a plan provider or other organization representative, but are administered to maintain, improve, or resolve the member's stabilized condition if: i. The organization does not respond to a request for pre-approval within one hour; ii. The organization cannot be contacted; or iii. Services are provided and when the organization 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 organization must give the treating physician the opportunity to consult with a plan physician, and the treating provider may continue with care of the patient until a plan provider is reached or one of the criteria in §422.113(c)(3) is met. *42 CFR §438.114(e); 422.113(c)(2)(i-iii)* *Contract: Exhibit A and Exhibit B Part 2(4)(a)(6) and (8)* *OAR 410-141-3840(5)*	**Suggested Documents:** • Emergency and poststabilization services coverage policies and procedures • Claims payment workflows and/or protocols – specific to poststabilization services • Provider messaging **Documents Submitted for Desk Review:** • Emergency and Poststabilization Services_UM-CCO-135 Emergency, Urgent and Post-Stabilization Services Page 5 Section "Policy: Post-Stabilization" #1 & 2 • Emergency and Poststabilization Services_AllCare CCO OHP Emergency and Urgent Care Services – Claims Process & Policy	☐ Met ☒ Partially Met ☐ Not Met

Standard XVI—Emergency and Poststabilization Services (42 CFR §438.114)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: The *Emergency, Urgent and Post-stabilization Services* policy and procedure and the *Emergency and Urgent Care Services* policy and procedure specified the requirements of this element. The CCO did not submit prior authorization policies or internal workflows to demonstrate that it responds to poststabilization pre-approval requests within one hour, or pays for them when there is no response. Nor did the CCO demonstrate that it covers poststabilization services when the CCO cannot be contacted or if the CCO and treating physician cannot reach an agreement concerning the member's care. This requirement was *Partially Met*.		
Required Actions: The CCO must demonstrate that it responds to poststabilization pre-approval requests within one hour or pays for them when there is no response. It must further demonstrate that it covers poststabilization services when the CCO cannot be contacted or if the CCO and treating physician cannot reach an agreement concerning the member's care.		
11. The CCO's financial responsibility for poststabilization 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 plan representative and the treating physician reach an agreement concerning the member's care; or d. The member is discharged. *42 CFR §438.114(e); 422.113(c)(3)(i-iv)* *Contract: Exhibit B Part 2(4)(a)(7)* *OAR 410-141-3840(6)*	**Suggested Documents:** • Emergency and poststabilization services coverage policies and procedures • Claims payment workflows and/or protocols - specific to poststabilization services **Documents Submitted for Desk Review:** • Emergency and Poststabilization Services_UM-CCO-135 Emergency, Urgent and Post-Stabilization Services Page 5 Section "Policy: Post-Stabilization" #4 • Emergency and Poststabilization Services_ AllCare CCO OHP Emergency and Urgent Care Services – Claims Process & Policy	☒ Met ☐ Partially Met ☐ Not Met
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		
12. In the event the member receives emergency or poststabilization services from a provider outside the CCO's network, the CCO must limit charges to the member to an amount no greater than what the CCO would charge if he or	**Suggested Documents:** • Emergency and poststabilization services coverage policies and procedures	☒ Met ☐ Partially Met ☐ Not Met

Standard XVI—Emergency and Poststabilization Services (42 CFR §438.114)		
Requirement	**Evidence as Submitted by the CCO**	**Score**
she had obtained the services through an in-network provider. *42 CFR §438.114(e); 422.113(c)(2)(iv)* *Contract: Exhibit B Part 2(4)(a)(6)* *OAR 410-141-3840(8)*	• Example of communication to out-of-network emergency provider • Member messaging related to financial liability **Documents Submitted for Desk Review:** • Emergency and Poststabilization Services_UM-CCO-135 Emergency, Urgent and Post-Stabilization Services Page 5 Section "Policy: Post-Stabilization" #3	
HSAG Findings: This requirement was *Met*.		
Required Actions: None.		

Standard XVI—Emergency and Poststabilization Services							
Total	Met	=	9	X	1.0	=	9.0
	Partially Met	=	3	X	0.5	=	1.5
	Not Met	=	0	X	0.0	=	0.0
Total Applicable		=	12	**Total Score**		=	10.5

Total Score ÷ Total Applicable	=	**87.5%**

Appendix B. CY 2022 Improvement Plan Findings

Following this page is the completed CY 2022 IP that includes HSAG's assessment of resolution for AllCare's findings from previous CMRs.

2021 Findings

Standard I—Availability of Services	
Element #7	Regarding timely access to care and services, the CCO: a. Ensures that network providers offer hours of operation that are no less than the hours of operation offered to commercially insured members or comparable to Medicaid FFS, if the provider serves only Medicaid members. b. Has a mechanism to ensure compliance with timely access standards and hours of operation. c. Monitors network providers regularly to determine compliance. d. Takes corrective action if a network provider fails to comply with these access requirements. *42 CFR §438.206(c)(1)* *Contract: Exhibit G (1)(d)* *Contract: Exhibit B Part 4 (2)(a),(d)* *OAR 410-141-3515 (13)*
Finding: The *Network Adequacy* policy asserted the CCO would call 1 percent of contracted providers to assess hours of operation and confirm information collected within the provider profile; however, it did not include the requirement to assess appointment availability or take corrective action when providers failed to meet network standards. The *Oral Health Timely Access to Care* policy included the expectation of oral health plans to monitor access and take corrective action when trends were identified; however, the regulation did not permit the CCO to delay corrective action until trends were identified. Results for oral and behavioral health care appointment monitoring were submitted; however, there was no evidence of corrective action taken for providers out of compliance with network standards. This requirement was *Not Met*.	
Required Action: AllCare must ensure the following: • Established mechanisms are in place to monitor hours of operation and appointment compliance of network providers. • Corrective action is taken when providers fail to comply with network standards. • The *Oral Health Timely Access to Care* policy is updated to include the requirement to take corrective action when providers fail to meet access standards. • Oversight is provided to ensure all subcontractors meet monitoring and corrective action requirements.	

Standard I—Availability of Services			
CCO Improvement Plan			
CCO Action Plan/Interventions		**Individual(s) Responsible**	**Completion Date**
AllCare did identify gaps within the policy that did not adequately monitor oral health access. AllCare has added this to network adequacy monitoring and will be working with Subcontractors to implement and prepare any Corrective Action Plans if necessary.		• Stick Crosby	6/1/2022
Documentation Submitted as Evidence	• CRM\Network Adequacy PolicyV3.pdf • CRM\AllCare_Organization_Provider_Site_Audit_Tool_02-28-2022.xlsx		
HSAG Assessment of Resolution	AllCare submitted its revised *Network Adequacy V3* policy, which included the addition of oral health care appointment standards. The policy included a provision of the CCO to conduct a site visit when the Credentialing Department receives three or more site related patient complaints, which will include an assessment of the quality, safety, appearance, and accessibility of the office site. The policy indicated site visits must yield a score of 85% and must completely meet the standard for areas weighted at five or higher on the audit tool; however, it was unclear which elements met this criterion. AllCare's policy did not include a process for regularly monitoring appointment availability or taking corrective actions when providers fail to meet network standards and the CCO removed its process of calling network providers to assess hours of operation. The current process includes monitoring member complaints, not regularly monitoring provider compliance with meeting timely access standards and hours of operation as required by OAR 410-141-3515 (13) and the CCO Contract, Exhibit B, Part 4 (3)(a)(2)(g). During the virtual "onsite" review, AllCare reported the *Network Adequacy* policy submitted for the IP was not the correct version and the CCO implemented a process to monitor hours of operation and appointment availability for all provider types and a corrective action process for providers that fail to meet network access standards.		☐ Resolved ☐ Resolved, with recommendations ☒ Not Resolved

Standard I—Availability of Services		
	Following the virtual "onsite" review, AllCare submitted its *Network Adequacy V4* policy, which also did not include a process for regularly monitoring appointment availability or taking corrective actions when providers fail to meet network standards. AllCare also submitted a sample ACCO Access Issues report, which showed how the CCO uses the data from provider self attestation surveys and compares wait times to provider counts for individual specialty providers. While this demonstrates the CCO is comparing appointment wait time data to the provider network, which is a vital component of monitoring the adequacy of the provider network, the CCO did not demonstrate that it has an established mechanism for monitoring hours of operation and provider compliance with appointment access standards or provide evidence of regular monitoring and taking corrective action when providers fail to meet network access standards. Evidence should include a written process, evidence of regular monitoring (e.g., results of provider self attestation surveys for physical, specialty, behavioral, and oral health providers), and evidence of corrective action taken for all providers identified as being out of compliance during monitoring activities. HSAG recommends AllCare update its *Network Adequacy* policy or develop a desk procedure to outline its monitoring processes to ensure compliance. This finding remains **unresolved.**	
CCO Status Update	All documentation has been reviewed to ensure consistency. AllCare has also followed HSAG recommendations and is directly reaching out to providers offices when there are gaps in submission time frames. Desk procedure in policy has been updated on page 8 and is in effect.	
Documentation Submitted as Evidence	• Network Adequacy V6 (Page 6) • 2023ACCCO-Provider Manual-WEB (page 13) • 2023ACCCO-Member Handbook-4.17.23-PROOF1(Pages 76 and 77) • AllCare_Organization_Provider_Site_Audit_Tool (Sheet tab "Tool" rows 101-111) LINK to OAR: **See Pre-Site Visit CCO Response from CCO (7/21/23)** AllCare meet monthly with Subcontractor and discusses access issues and capacity concerns. Please see:	

Standard I—Availability of Services		
	• October 2022- ACHP Exhibit A. Appointment Access - Availability Monitoring TNAA.xlsx • December 2022- ACHP Exhibit A. Appointment Access - Availability Monitoring TNAA.xlsx • December 2022- ACHP Exhibit A. Appointment Access - Availability Monitoring TNAA._1xlsx Physical Health/Specialty: • CY2022 Provider Complaint trends • Availability of Services Element 7-Wait Time from Auth to Appointment • Availability of Services Element 7-Robert Bents, MD Q4 2022 • Availability of Services Element 7-Patrick Denard, MD Q4 2022 • Availability of Service Element 7-Wait Time to Appointment Behavioral Health: Review the policies. Looking at complaints. Access measures in the APM. • Availability of Services _ Element 7_ BH APM Report Q42022 • Availability of Services _ Element 7_ Statewide MH PIP_Quarterly Report Q42022 • Availability of Services _ Element 7_ Monthly AllCare and Adapt Subcontractor meeting minutes_April 2022	
HSAG Assessment of Resolution	The revised *Network Adequacy V6* policy included the CCO's process (reported during the CY 2022 CMR) for quarterly provider portal surveys to verify facility and provider appointment availability and monitor compliance with timely access standards. The policy also stated that any facility or provider not compliant with access standards will be issued a corrective action plan and will have 30 days to resolve the standard, verified by a phone call, onsite review, or documentation. If the corrective action plan is not resolved within 18 months, the CCO will send a termination of network participation letter. The CCO submitted its provider site visit tool. However, it did not appear to have been updated to include critical elements as identified in the CY 2022 IP review. Following its initial review, HSAG requested additional documentation from the CCO demonstrating regular monitoring and evidence of corrective actions taken for out-of-compliance providers during monitoring activities. Except for dental providers, the CCO did not submit evidence of regular monitoring of appointment availability or hours of operations. Further, the CCO did not provide evidence of any	☐ Resolved ☐ Resolved, with recommendations ☒ Not Resolved

Standard I—Availability of Services		
	corrective actions taken for providers identified as being out of compliance during monitoring activities. To resolve this finding, the CCO must submit evidence of regular monitoring (e.g., results of provider self-attestation surveys for physical, specialty, behavioral, and oral health providers for pregnant and children/non-pregnant individuals) and corrective action taken for all providers identified as being out of compliance during monitoring activities. The reviewer also noted that the CCO's policy, member handbook, and provider site audit tool included oral health time frame standards of eight weeks for non-urgent and well-care appointments, with urgent care visits scheduled within one week. However, oral health standards are: • For children and non-pregnant individuals: eight weeks for routine oral care and two weeks for urgent dental care. • For pregnant individuals: four weeks for routine oral care and one week for urgent care. The provider manual reflected a one-week urgent care time frame for both pregnant and children/non-pregnant individuals. These findings were not part of the initial finding and will not affect the resolution of this specific IP. However, the CCO must ensure its policies, provider manual, and member handbook correctly reflect all state-established network adequacy time frames to receive a *Met* finding in the CY 2024 Availability of Services standard review. This finding remains **unresolved**.	

Standard I—Availability of Services	
Element #8	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. For physical health, the member is 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 fin accordance with OAR 410-141-3840. c. *Emergency care:* Seen and treated immediately or referred immediately to an emergency department depending on the member's condition. *42 CFR §438.206(c)(1)(i)* *Contract Exhibit B Part 4 (2)(a)* *OAR 410-141-3515 (11)(a)* *OAR 410-141-3840*
Finding: The *Network Adequacy* policy and member handbook did not include physical health appointment time frame standards. The provider manual and subcontractor agreement included an incorrect time frame for urgent care visits, citing 48 hours, and did not include the expectation for emergency care. This requirement was *Not Met*.	
Required Action: AllCare must revise its policy, member handbook, provider manual, and subcontractor agreement to include state-established physical health appointment time frames. In addition, the CCO must communicate (e.g., via the member handbook) physical health access standards to members, including required appointment time frames.	

CCO Improvement Plan

CCO Action Plan/Interventions	Individual(s) Responsible	Completion Date
The policy, site visit tool and Provider manual has been updated to include the appropriate timeframes.	• Stick Crosby	04/30/2022

Documentation Submitted as Evidence	• CRM\Network Adequacy PolicyV3.pdf • CRM\AllCare_Organization_Provider_Site_Audit_Tool_02-28-2022.xlsx • Provider Manual page 13

Standard I—Availability of Services		
HSAG Assessment of Resolution	AllCare submitted its revised *Network Adequacy V3* policy, which correctly stated well care and emergency care appointment time frames. However, the policy and provider site visit tool did not align with the state-established time frame of within 72 hours "or as indicated in the initial screening" for urgent care. All physical health time frames were correctly stated in the provider manual; however, the member handbook did not include the updates. During the virtual "onsite" review, AllCare reported the *Network Adequacy* policy submitted for the IP was not the correct version. AllCare was given the opportunity to submit the correct version of its policy and draft revisions to the member handbook. Following the virtual "onsite" review, the CCO submitted its *Network Adequacy V4* policy, which was revised with the correct urgent care scheduling time frame; however, the member handbook submitted did not include draft revisions. AllCare must ensure the member handbook includes physical health care appointment scheduling time frames. AllCare must also ensure the provider site visit tool aligns with state-established physical health network access standards. This finding remains **unresolved.**	☐ Resolved ☐ Resolved, with recommendations ☒ Not Resolved
CCO Status Update	All documentation has been reviewed to ensure consistency.	
Documentation Submitted as Evidence	• Network Adequacy V6 (Page 6) • 2023ACCCO-Provider Manual-WEB (page 13) • 2023ACCCO-Member Handbook-4.17.23-PROOF1(Pages 76 and 77) • AllCare_Organization_Provider_Site_Audit_Tool (Sheet tab "Tool" rows 101-111)	
HSAG Assessment of Resolution	The *Network Adequacy V6* policy, provider manual, member handbook, and provider site audit tool correctly stated the state-established physical health network access standards. This finding is **resolved**.	☒ Resolved ☐ Resolved, with recommendations ☐ Not Resolved

Standard I—Availability of Services	
Element #10	For behavioral health, the member is seen, treated, or referred within the following timeframes: a. *Urgent behavioral health treatment:* Within 24 hours. b. *Routine behavioral health treatment:* Seen for an intake assessment within 7 days of the request, with a second appointment occurring as clinically appropriate. *42 CFR §438.206(c)(1)(i)* *Contract Exhibit B Part 4 (2)(a)* *OAR 410-141-3515 (11)(c)(A)*
Finding: The *Behavioral Health Access* policy correctly stated behavioral health scheduling time frames. However, behavioral health access standards were not included in the provider manual or member handbook. This requirement was *Partially Met*.	
Required Action: AllCare must communicate (e.g., via the member handbook and provider manual) behavioral health access standards to providers and members.	

CCO Improvement Plan

CCO Action Plan/Interventions	Individual(s) Responsible	Completion Date
AllCare CCO has updated the member handbook to reflect the addition of the timeframes for urgent behavioral health treatment.	• Erin Porter	01/20/2022
Documentation Submitted as Evidence	CRM\Network Adequacy PolicyV3.pdf CRM\AllCare_Organization_Provider_Site_Audit_Tool_02-28-2022.xlsx 2022accco-Member Handbook, page 62 and following and 128. Provider Manual page 12-13	
HSAG Assessment of Resolution	AllCare submitted its member handbook and provider manual, which correctly stated the behavioral health appointment time frames. The *Network Adequacy V3* policy and provider site visit tool were also submitted, which incorrectly stated "urgent" behavioral health appointments are scheduled within 7 days and "emergency" behavioral health visits are scheduled within 24 hours. During the virtual "onsite" review, AllCare reported the *Network Adequacy* policy submitted for the IP was not the correct version. Following the virtual "onsite" review, the CCO submitted its *Network Adequacy V4* policy, which also incorrectly	☐ Resolved ☐ Resolved, with recommendations ☒ Not Resolved

Standard I—Availability of Services		
	stated "urgent" behavioral health appointments are scheduled within 7 days and "emergency" behavioral health visits are scheduled within 24 hours. AllCare must ensure its policy and provider site visit tool accurately reflects the state-established behavioral health network access standards. In addition, HSAG recommends AllCare communicate appointment time frame standards for all service types in a more user-friendly format (i.e., table), rather than in narrative format throughout the member handbook. CCOs are encouraged to use the OHA model member handbook template, which includes a table format. This finding remains **unresolved.**	
CCO Status Update	All documentation has been reviewed to ensure consistency.	
Documentation Submitted as Evidence	• Network Adequacy V6 (Page 6) • 2023ACCCO-Provider Manual-WEB (page 13) – OAR 410-141-3840 (referred by PH, BH, OH provider) • 2023ACCCO-Member Handbook-4.17.23-PROOF1(Pages 76 and 77) • AllCare_Organization_Provider_Site_Audit_Tool (Sheet tab "Tool" rows 101-111)	
HSAG Assessment of Resolution	The *Network Adequacy V6* policy was revised to state that routine behavioral health treatment is scheduled within seven days. Furthermore, the revisions specified urgent behavioral health treatment is scheduled within 24 hours or as indicated in the initial screening in accordance with OAR 410-141-3840. However, the policy did not assert that the second appointment must occur as clinically appropriate. In addition, the provider site visit audit tool was not updated and continued to state that "urgent" behavioral health appointments are scheduled within seven days and "emergency" behavioral health visits are scheduled within 24 hours. The CCO must ensure that its policy and provider site visit audit tool accurately reflect the state-established behavioral health network access standards for "routine" and "urgent" behavioral health treatment. This finding remains **unresolved**.	☐ Resolved ☐ Resolved, with recommendations ☒ Not Resolved

Standard I—Availability of Services	
Element #11	For **specialty behavioral health care** for priority populations, the member is seen, treated, or referred within the following timeframes: 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 must be comparable to the original services requested based on the level of care and may include referrals, methadone maintenance, 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 intellectual/developmental disability (I/DD) population: Immediate assessment and entry. 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 including heroin: Immediate assessment and entry. Admission for treatment in a residential level of care is 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 entry within 72 hours e. Medication assisted treatment: As quickly as possible, not to exceed 72 hours for assessment and entry f. Children with serious emotional disturbance as defined in 410-141-3500. *42 CFR §438.206(c)(1)(i)* *OAR 410-141-3515 (11)(c)(B)*
Finding: The *Behavioral Health Access* policy correctly stated scheduling time frames for specialty behavioral health care for priority populations. However, the access standards were not included in the provider manual or member handbook. This requirement was *Partially Met*.	
Required Action: AllCare must communicate (e.g., via the member handbook and provider manual) specialty behavioral health access standards to members and providers, including required appointment time frames.	

Standard I—Availability of Services			
CCO Improvement Plan			
CCO Action Plan/Interventions		**Individual(s) Responsible**	**Completion Date**
AllCare CCO has updated the member handbook to reflect the addition of the timeframes for urgent behavioral health treatment.		• Erin Porter	01/20/2022
Documentation Submitted as Evidence	2022accco-Member Handbook, page 62 and following and 128. Provider Manual page 12-13		
HSAG Assessment of Resolution	AllCare submitted its provider manual, which accurately reflected specialty behavioral health access standards. However, the 2022 member handbook did not reflect immediate assessment and entry for unpaid caregivers, families, individuals with individuals with HIV/AIDS or tuberculosis, individuals at the risk of first episode psychosis and the intellectual/developmental disability (I/DD) population. Although the *Network Adequacy V3* policy was not submitted for this finding, the reviewer noted that specialty behavioral health access standards were removed from the policy submitted during the CY 2021 CMR audit and were not included in the provider site visit tool. During the virtual "onsite" review, AllCare reported the *Network Adequacy V3* policy submitted for the IP was not the correct version and was given the opportunity to resubmit the policy and draft revisions for the member handbook. Following the virtual "onsite" review, the CCO submitted its *Network Adequacy V4* policy, which also reflected the omission of specialty behavioral health access standards. In addition, AllCare submitted its 2021 member handbook rather than draft revisions for the 2022 member handbook. AllCare must ensure its current policy, provider site visit, and member handbook include correct specialty behavioral health access standards established by the state, outlined in components (a) through (f) of this element, including all priority populations.		☐ Resolved ☐ Resolved, with recommendations ☒ Not Resolved

Standard I—Availability of Services		
	This finding remains **unresolved.**	
CCO Status Update	All documentation has been reviewed to ensure consistency.	
Documentation Submitted as Evidence	• Network Adequacy V6 (Page 6) • 2023ACCCO-Provider Manual-WEB (page 13) • 2023ACCCO-Member Handbook-4.17.23-PROOF1(Pages 76 and 77) • AllCare_Organization_Provider_Site_Audit_Tool (Sheet tab "Tool" rows 101-111)	
HSAG Assessment of Resolution	The member handbook was revised to include the specialty behavioral health time frames. However, the *Network Adequacy V6* policy and provider site visit tool demonstrated an omission of specialty behavioral health access standards. Additionally, the provider manual submitted with this IP appears to have been updated and no longer includes the specialty behavioral health time frames present within the provider manual submitted with the IP reviewed during the CY 2022 CMR. The CCO must ensure its policy, provider manual, and provider site visit tool include the state-established specialty behavioral health time frames. This finding remains **unresolved**.	☐ Resolved ☐ Resolved, with recommendations ☒ Not Resolved

2022 Findings

Standard IX—Enrollment and Disenrollment	
Element #2	The CCO does not discriminate against individuals eligible to enroll and will not use any policy or practice that has the effect of discriminating on the basis of health status or need for health care services, race, color, or national origin, religion, sex, sexual orientation, marital status, age, gender identity, or disability. *42 CFR §438.3(d)(3-4)* *CCO Contract Exhibit B Part 3(8)(c)*
Finding: The *Maintaining Accurate Medicaid Member Eligibility* policy and procedure included the non-discrimination reasons required by this element. Interviews with AllCare staff members confirmed that the CCO uses the member handbook and the website to inform prospective members about the CCO. A review of the member handbook and the website confirmed that the AllCare *Non-Discrimination* policy includes reasons for non-discrimination; however, the information did not inform members that AllCare does not discriminate against individuals eligible to enroll due to health status or need for health care services. During the virtual "onsite" review, AllCare discussed its annual harassment training completed by staff members, which informs staff of its non-discrimination policies. AllCare submitted the list of employees who completed the harassment training in 2021 to confirm that the CCO monitored completion of the annual training requirement. This requirement was *Partially Met*.	
Required Action: AllCare must update its materials provided to potential members to include that the CCO will not discriminate against individuals eligible to enroll and will not use any policy or practice that has the effect of discriminating on the basis of health status or need for health care services. If AllCare uses the member handbook as a means to affirm its non-discrimination policy related to its enrollment practices, the member handbook must be revised to align with State and federal requirements to assert the CCO does not discriminate against individuals eligible to enroll on the basis of health status or need for health care services, race, color, national origin, religion, sex, sexual orientation, marital status, age, gender identity, or disability. However, as a best practice, AllCare should provide this information to potential members using a more streamlined approach (i.e., single page document or statement on website) to avoid information overload.	

CCO Improvement Plan		
CCO Action Plan/Interventions	**Individual(s) Responsible**	**Completion Date**
The AllCare CCO Member handbook and Website were updated to clearly outline this information.	• Sheila Anders	03/23/2023

Standard IX—Enrollment and Disenrollment		
Documentation Submitted as Evidence	• Enroll Element 2, 5AllCare CCO Member Handbook Pg. 11 • Enroll Element 2-Link to the AllCare Website and screen shot from the website	
HSAG Assessment of Resolution	The CCO has revised its 2023 member handbook and the nondiscrimination policy on its website to include the appropriate requirements. This finding is **resolved**.	☒ Resolved ☐ Resolved, with recommendations ☐ Not Resolved

Standard IX—Enrollment and Disenrollment	
Element #4	The CCO may **not** request disenrollment of a member because of an adverse change in the member's health status or because of the member's: a. Utilization of health services. b. Physical, intellectual, developmental, or mental disability. c. Uncooperative or disruptive behavior resulting from the member's special needs, disability or any condition that is a result of their disability. d. Being in the custody of DHS/Child Welfare. e. Prior to receiving any services, including, without limitation, anticipated placement in or referral to a psychiatric residential treatment facility. f. A member's decision regarding their own medical care with which the contractor disagrees. g. Filing a grievance or exercising any appeal or contested case hearing rights. *42 CFR §438.56(b)(2)* *OAR 410-141-3810(4)(c)* *CCO Contract Exhibit B Part 3(9)(d)*
Finding: The *Request of Member Disenrollment* policy and procedure specified the appropriate reasons AllCare may not request disenrollment of a member as required by this element, except filing a grievance or exercising any appeal or contested case hearing rights. In addition, AllCare lacked evidence of ongoing monitoring of disenrollment requests to ensure compliance with the regulatory requirements. This requirement was *Partially Met*.	
Required Action: AllCare must ensure that plan documents align with state-established reasons that the CCO may not request disenrollment of a member. AllCare also must demonstrate it is monitoring reasons for disenrollment, other than loss of eligibility, when disenrollment of members occurs. Evidence of monitoring may include standard reports and/or QIC meeting minutes that address enrollment changes, including whether or not disenrollment requests are received or initiated.	

CCO Improvement Plan		
CCO Action Plan/Interventions	**Individual(s) Responsible**	**Completion Date**
AllCare CCO has created a spreadsheet where requested disenrollments are recorded and reviewed quarterly at the QIC Committee meeting. The Request for Member Disenrollment Policy was also updated to include information to reflect this requirement.	• Sheila Anders	03/23/2023

Standard IX—Enrollment and Disenrollment		
Documentation Submitted as Evidence	• Enroll Element 4, 5-ACCCO2023-Request of Member Disenrollment Policy-Section Highlighted • Enroll Element 4-QIC Minutes • Enroll Element 4 Disenrollment Spreadsheet	
HSAG Assessment of Resolution	The CCO revised the *Request of Member Disenrollment* policy to align with state-established reasons that the CCO may not request disenrollment of a member. The CCO also has implemented monitoring of disenrollment requests and the reasons for the requests at the QIC. The QIC meeting minutes from December included a discussion of areas that needed improvement. HSAG recommends that the CCO assess the cause of the barriers and implement corrective action if needed. This finding is **resolved**.	☒ Resolved ☐ Resolved, with recommendations ☐ Not Resolved

Standard IX—Enrollment and Disenrollment	
Element #5	The CCO has a process that allows members to disenroll **without cause** for any of the following reasons: a. OHP clients auto-enrolled or manual-enrolled in error may change plans, if another plan is available, within thirty (30) days of the member's enrollment. b. Newly eligible members may change plans, if another plan is available within ninety (90) days of their initial plan enrollment. c. A member may request to change plans, after six (6) months of their initial plan enrollment. d. A member may request disenrollment during "OHP eligibility renewal," which is typically twelve (12) months. e. Full benefit dual eligible members and members who are American Indian/Alaska Native beneficiaries may change plans or disenroll to Fee-for-Service at any time. f. Upon automatic re-enrollment (e.g., a recipient who is automatically re-enrolled after being disenrolled, solely because such recipient loses Medicaid eligibility for a period of two (2) months or less), if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity. g. Whenever the member's eligibility is re-determined by OHA. h. When OHA has imposed sanctions on the CCO, including the suspension of all new enrollment (consistent with 42 CFR 438.702(a)(4). i. Members have one additional opportunity to request a plan change during the eligibility period if none of the above options can be applied *42 CFR §438.56(c)(2) and (g)* *OAR 410-141-3810(1)(b)(A)* *CCO Contract Exhibit B Part 3(9)(c)(1)(a)*
Finding: The *Request of Member Disenrollment* policy and procedure stipulated five of the nine reasons AllCare allows members to disenroll without cause as required by this element. The policy did not contain items e, f, g, and h as reasons members could disenroll without cause. The member handbook contained six of the nine reasons that members can disenroll without cause and was missing items f, g, and h. This requirement was *Partially Met.*	
Required Action: AllCare must ensure that plan documents align with state-established reasons that members are allowed to disenroll without cause as required by this element.	

Standard IX—Enrollment and Disenrollment			
CCO Improvement Plan			
CCO Action Plan/Interventions		**Individual(s) Responsible**	**Completion Date**
AllCare's ACCCO2023-Request of Member Disenrollment Policy now contains all Required reasons that a member may disenroll from AllCare CCO without cause. The ACCCO2023 Member Handbook Pg. now contains the required reasons that member may disenroll from AllCare CCO without cause which aligns with the ACCCO2023 Request Of Member Disenrollment Policy.		• Sheila Anders	03/23/2023
Documentation Submitted as Evidence	• Enroll Element 4, 5-ACCCO2023-Request of Member Disenrollment Policy-Highlighted section • Enroll Element 2, 5-ACCCO2023-Member Handbook Pg. 144		
HSAG Assessment of Resolution	The CCO revised the *Request of Member Disenrollment* policy and its member handbook to align with state-established reasons allowing members to request disenrollment without cause. This finding is **resolved**.	☒ Resolved ☐ Resolved, with recommendations ☐ Not Resolved	

Standard IX—Enrollment and Disenrollment	
Element #6	The CCO has a process to allow members to disenroll **with cause** for any of the following reasons: 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 to be performed at the same time, not all related services are available from the CCO's plan, and the member's primary care provider (or another provider) determines that receiving the services separately would subject the member to unnecessary risk; d. Other reasons, including poor quality of care or lack of access to services covered under the contract or providers experienced with dealing with the member's specific needs. Examples include: • Services not provided in the member's preferred language; • Services not provided in a culturally appropriate manner; • It would be detrimental to the member's health to continue enrollment; • For continuity of care. *42 CFR §438.56(c)* *OAR 410-141-3810(1)(b)(B)* *CCO Contract Exhibit B Part 3(9)(c)(1)(b)*
Finding: The *Request of Member Disenrollment* policy and procedure included all items required by this element. The member handbook included the following reason that members could disenroll with cause on page 39: the member moves out of the AllCare CCO service area. The information on page 39 did not include items b, c, and d as required by this element. The member handbook did contain information on page 50 in the Getting Access to Care section concerning the fact that AllCare does not have any moral or religious objections to providing care. This requirement was *Partially Met*.	
Required Action: AllCare must ensure plan documents align with state-established reasons that members are allowed to disenroll with cause as required by this element.	

CCO Improvement Plan

CCO Action Plan/Interventions	Individual(s) Responsible	Completion Date
2023ACCO-Member Handbook has been revised to reflect the required information regarding member's right to disenroll with cause as reflected in the Member Disenrollment Policy.	• Sheila Anders	3/29/23

Standard IX—Enrollment and Disenrollment		
Documentation Submitted as Evidence	• 2023ACCCO-Member Handbook-Pg. 144 (highlighted section) • 2023ACCCO-Request of Member Disenrollment Policy (highlighted section)	
HSAG Assessment of Resolution	The CCO revised its member handbook to align with state-established reasons allowing members to request disenrollment without cause. This finding is **resolved**.	☒ Resolved ☐ Resolved, with recommendations ☐ Not Resolved

Standard XII—Quality Assessment and Performance Improvement	
Element #3	The CCO's QAPI program includes annually collecting and submitting (to the State): • Performance measure data using standard measures identified by the State; • Data, specified by the State, which enables the State to calculate the CCO's performance using the standard measures identified by the State; or • A combination of the above activities. *42 CFR §438.330(b)(2) and (c)(2)(i-iii)* *CCO Contract Exhibit B Part 10(3)*
Finding: The AllCare Data Proposal Year spreadsheet identified proposed performance measures, including: screening for clinical depression and follow-up plan, controlling high blood pressure—hypertension, diabetes HbA1c poor control, cigarette smoking prevalence, weight assessment and counseling, and drug and alcohol misuse—screening brief intervention and referral to treatment. The CY 2020 Hybrid Final Sample Submission Template included documentation pertaining to the *Colorectal Cancer Screening* and *Prenatal and Postpartum Care—Postpartum Care* measures. The 2020 QAPI Assessment and 2021 Quality Improvement Strategic Plan acknowledged that AllCare met 80 percent of the 2019 Quality Incentive Metrics, citing the coronavirus disease 2019 (COVID-19) pandemic presented many challenges to meeting the established quality benchmarks or improvement targets. The CY 2020 Hybrid Final Sample Submission Template offered measure information related to evidence of postpartum care and colorectal screenings, but there was no evidence that the performance measure data were submitted to OHA, as required. During the review, staff members reported that AllCare submitted the required performance measure data to OHA via secure email; however, AllCare did not present evidence of submission to OHA. This requirement was *Partially Met*.	
Required Action: AllCare must demonstrate evidence of submission of performance measure data annually to the State.	

CCO Improvement Plan

CCO Action Plan/Interventions	Individual(s) Responsible	Completion Date
AllCare submits the performance measure data annually to the State. Please see the receipt for the 2022 submission and the policies to support the activities.	• Natalie Case	03/01/2022

Documentation Submitted as Evidence	QAPI Element 3-2022 Hybrid Measure Submission Receipt QAPI Element 3-2022 Submission Receipt QAPI Element 3-Q5b - EHR based performance measure reporting – ACCCO QAPI Element 3-Q5b - OHA Audit Policy - ACCCO

Standard XII—Quality Assessment and Performance Improvement		
HSAG Assessment of Resolution	AllCare provided evidence of submission of the required performance measure data to the State in 2022. This finding is **resolved**.	☒ Resolved ☐ Resolved, with recommendations ☐ Not Resolved

Standard XII—Quality Assessment and Performance Improvement	
Element #5	The CCO's QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. *42 CFR §438.330(b)(4)* *OAR 410-141-3525(5)(d)* *CCO Contract Exhibit B Part 10(2)(c)(3)*

Finding: The AllCare QAPI program objectives included assessing continuity and coordination of care between practitioners and providers, and implementing interventions for improvement where indicated. The QAPI program objectives and goals included maintaining a system to measure, assess, and improve the quality of care and quality of service outcomes. The *Intensive Care Coordination* policy discussed the core special health care needs (SHCN) and prioritized populations eligible for intensive care coordination.

The *Care Coordination/Population Health* policy specified that, at a minimum, care coordination for member populations includes all member populations identified in the *Intensive Care Coordination* policy; members with special needs; and members who are aged, blind, disabled, have complex medical needs, multiple chronic conditions, mental illness, chemical dependency, or receive Medicaid-funded long-term care (LTC) or long-term services and supports (LTSS). The policy also stated that children and youth are provided intensive care coordination and behavioral health services according to presenting needs.

The 2020 QAPI Assessment and 2021 Quality Improvement Strategic Plan maintained that focused attention to health, wellness, and prevention activities for members with SHCN is a priority that will continue into 2021. Due to the COVID-19 pandemic and the mandatory closure of gyms, enrollment into weight loss and fitness programs dramatically decreased. AllCare implemented efforts to engage members with tele-meetings with personal coaches and program applications. Planned quality activities for members with SHCN included continuing to develop flexible strategies until gyms reopen, two additional hours of personal training, adding metabolic testing and assessment, adding 1:1 life coaching (up to three sessions), identifying barriers, and offering one month of hydro-massage to help with stress and pain.

The *Special Health Care Needs* policy specified that AllCare prioritizes identifying and working with members who have SHCN. The policy applied to members identified as aged, blind, disabled, or with limited mobility; those with complex medical needs, multiple chronic conditions, mental illness, or chemical dependency; those receiving Medicaid-funded LTC or LTSS; and those experiencing health disparities such as cultural and linguistic needs. The policy also stated that children and youth members receive intensive care coordination and behavioral health services according to presenting needs. The QIC meeting minutes dated 2/24/21 documented the committees' review and discussion related to a dental case involving a member with SHCN. The 6/23/21 QIC meeting minutes documented the committees' discussion related to a member with SHCN and the needs for an attendant for ReadyRide services. Although the meeting minutes discussed the outcomes of care efforts provided for those members, review of QIC meeting minutes did not demonstrate routine discussion of the quality and appropriateness of care for members with SHCN as an ongoing agenda item.

AllCare also presented the Care Coordination Program Team Audit form, which included review areas related to the documented plan of care; evidence of coordination with a PCP if the member is not following the plan of care; documentation of pre-home safety survey completion; and interdisciplinary team meetings conducted within 14 days of a transition between levels, setting, or episodes of care. The audit form also

Standard XII—Quality Assessment and Performance Improvement			
included evaluation fields pertaining to the development of plan of care goals, interventions, barriers, and interdisciplinary care team involvement. This requirement was *Partially Met*			
Required Action: AllCare must ensure that the CCO's QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to members with SHCN. Evidence of inclusion of the mechanisms within the QAPI program may include descriptions within policies, program descriptions, and/or the work plan; QIC meeting minutes that address the oversight of the mechanisms to assess the care provided to members with SHCN; and/or QAPI program evaluations that assess the care provided to members with SHCN.			
CCO Improvement Plan			
CCO Action Plan/Interventions		**Individual(s) Responsible**	**Completion Date**
Members with SHCN workflow process is an integrated into the daily workflow for care coordination. On a biannual basis reports are submitted to OHA regarding the work conducted with member who have been identified for intensive care coordination (ICC) which includes the members with SHCN. In addition, monthly monitoring report is generated to monitor the care coordination of members with SHCN. On page 26 of the Quality Program document shows tracking of the members with SCHN in the Wellness program. In addition, there are programs developed to assist members with SHCN to stay in their home (Page 70). On a monthly basis, the Care Coordinators charts are audited by supervisors and part of the audit tool is identifying members who have SHCN, identified under General SN (Special Needs) and DSNP (Dual Special Needs Plan). AllCare has also included a schedule of when topics are to be presented to the QI Committee throughout 2023, which includes members with SHCN and LTSS services.		• Hazel Clements	05/30/2023
Documentation Submitted as Evidence	QAPI-5- PopHealthAuditTool QAPI Element 5, 6- Quality Program Documents (page 26 and 70) QAPI Element 5-Care Coordination Activity Report QAPI Element 5, 6 Agenda QI Committee		
HSAG Assessment of Resolution	The CCO provided documents demonstrating care coordination activities for SHCN members. However, the CCO did not provide evidence of mechanisms to assess the quality and appropriateness of care furnished to SHCN members. Evidence of inclusion of the Quality Assurance and Performance Improvement (QAPI) program mechanisms may include:	☐ Resolved ☐ Resolved, with recommendations ☒ Not Resolved	

Standard XII—Quality Assessment and Performance Improvement		
	• Policy descriptions, program descriptions, and/or the workplan; • QIC meeting minutes addressing the oversight of the care assessment mechanisms provided to SHCN members; and/or • QAPI program evaluations assessing the care provided to SHCN members. This finding remains **unresolved**.	

Standard XII—Quality Assessment and Performance Improvement	
Element #6	For CCOs providing long-term services and supports (LTSS), the CCO's QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to members using LTSS, including: • Assessment of care between settings • A comparison of services and supports received with those set forth in the member's treatment/service plan, if applicable *42 CFR §438.330(b)(5)(i)* *OAR 410-141-3860(8)(d)*

Finding: AllCare submitted its 2021 memorandum of understanding (MOU) with the Aging and People with Disabilities (APD) partner, which outlined the mechanisms utilized to assess LTSS members' care between settings and members' services received compared to their treatment plans. The MOU included the monitoring processes and measures of success for each assessment area. The MOU established the following assessment and improvement mechanisms:

- Prioritization of high needs members
- Interdisciplinary care teams
- Development and sharing of individualized care plans
- Transitional care practices
- Collaborative communication tools and processes
- Linking to supportive resources
- Health promotion and prevention

The 2020 QAPI Assessment and 2021 Quality Improvement Strategic Plan indicated that AllCare leverages health information technology, through the use of Essette, the case management platform that documents referrals to LTSS, emergency department, and behavioral health entities. The 2020 QAPI Assessment and 2021 Quality Improvement Strategic Plan did not address the mechanisms implemented to assess the quality and appropriateness of care furnished to members using LTSS, including assessment of care between settings and a comparison of services and supports received with those set forth in the member's treatment/service plan.

AllCare presented the Care Coordination Program Team Audit form, which included review areas related to the documented plan of care; evidence of coordination with a PCP if the member was not following the plan of care; documentation of pre-home safety survey completion; and interdisciplinary team meetings conducted within 14 days of a transition between levels, setting, or episodes of care. The audit form also included evaluation fields pertaining to the development of plan of care goals, interventions, barriers, and interdisciplinary care team involvement. This requirement was *Partially Met*.

Standard XII—Quality Assessment and Performance Improvement			
Required Action: AllCare must ensure that the CCO's QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to members using LTSS, including assessment of care between settings and a comparison of services and supports received with those set forth in the member's treatment/service plan. Evidence of inclusion of the mechanisms within the QAPI program may include descriptions within policies, program descriptions, and/or the work plan; QIC meeting minutes that address the oversight of the mechanisms to assess the care provided to members using LTSS; and/or QAPI program evaluations that assess the care provided to members using LTSS.			
CCO Improvement Plan			
CCO Action Plan/Interventions		**Individual(s) Responsible**	**Completion Date**
On page 14 of the Quality Program document, includes LTSS services reported via the LTSS MOU deliverable to OHA. In addition, there is a section in the Quality program on page 69 of the Quality Program document that includes oversight of the LTSS MOU and partnering with partners to ensure needs are met. LTSS is scheduled for discussion on the QI Committee for April with an example of the care coordination with a LTSS member. In addition, on a monthly basis the Care Coordinators charts are audited to ensure that LTSS members' needs are being met, please see the attached audit tool under the General Section for LTSS. Furthermore, the AllCare CCO Electronic Health Record, there is now a flag on the members who have LTSS services. AllCare CCO is still developing the LTSS referral report to demonstrate the referrals between ADP and AllCare CCO, this should be completed by 06/01/2023. The AllCare Care Coordination team has an every two week standing meeting with APD regarding the care coordination of LTSS members, Please see minutes from IDT APD Meeting Minutes.		• Hazel Clements	
Documentation Submitted as Evidence	QAPI-5- PopHealthAuditTool QAPI Element 5, 6- Quality Program Documents (page 14, 69) QAPI Element 5, 6Agenda QI Committee QAPI Element 6-IDT APD Meeting 8.17.22 (CCO) QAPI Element 6-IDT APD Meeting 8.3.22 (CCO) QAPI Element 6-IDT APD Meeting 6.15.22 (CCO)		
HSAG Assessment of Resolution	The CCO provided documents demonstrating care coordination activities for members receiving LTSS. During the site visit, the CCO discussed care coordination activities and collaboration with the APD. The CCO also identified mechanisms to assess the quality and appropriateness of care furnished to members using LTSS listed in its QAPI program description. Post-site visit, the CCO reported that the care	☐ Resolved ☒ Resolved, with recommendations ☐ Not Resolved	

Standard XII—Quality Assessment and Performance Improvement		
	coordination team is developing an LTSS monitoring dashboard to gauge the care given to members monthly. The CCO submitted a draft dashboard, which monitored the care of members who: • Have completed a Health Risk Assessment and an Intensive Care Coordination Assessment. • Are in transitions of care. • Have attended Interdisciplinary team meetings and who have had an Interdisciplinary team meeting. • Have a care plan, whose care plan has been shared with their care team. • Are enrolled in both Medicare and Medicaid. The CCO reported that gaps identified will be used to identify additional services needed. HSAG recommends that the CCO use the data gathered from the mechanisms identified to assess outcomes at the population level for members receiving LTSS and use the assessment results to inform its QAPI program structure. This finding is **resolved with recommendations**	

Standard XII—Quality Assessment and Performance Improvement	
Element #8	The CCO has a Quality Improvement (QI) committee that meets the following requirements: • Membership includes, at a minimum, the Medical/Dental Director, the QI Coordinator, and other health professionals who are representative of the scope of the services delivered • Maintains oversight and accountability of any delegated functions • Approves the annual quality strategy and retains oversight and accountability of quality efforts and activities performed by other CCO committees • Meets at least every two months and records minutes that include committee deliberations, recommendations regarding corrective actions to address issues identified, and review of results, progress, and effectiveness of corrective actions recommended at previous meetings *OAR 410-141-3525(11)* *CCO Contract Exhibit B Part 10(2)(c)(2)*
Finding: The AllCare QIC Charter discussed committee membership, roles, responsibilities, meeting frequency, decision making, and work groups. The QIC was comprised of the following AllCare staff: chief compliance and quality officer, director of compliance and quality, chief operating officer, vice president of population health, behavioral health director, director of intensive care coordination program, lead medical director, oral health director, oral health integration manager, pharmacy director, appeals and grievance coordinator, and other staff members, as appropriate. The QIC Charter indicated that the committee, at a minimum, meets monthly, but no less than quarterly. AllCare presented QIC meeting minutes to confirm that meetings were conducted 10 of 12 months during 2021 and that appropriate committee members or designees attended the meetings. QIC meeting minutes dated 8/25/21 confirmed the committees' discussion regarding the Intensive In-Home Behavioral Health Treatment program, which requires delegated staff to work one-on-one with children during in-home visits. The *Quality Program* policy specified that the QIC's overarching role is to recommend an ongoing quality management program in each specialty area; make specific recommendations as required by individual cases or situations; and facilitate quality improvement efforts when opportunities are identified, in addition to monitoring, oversight, and approval of special projects, Transformation and Quality Strategy, PIPs, alternate payment methodologies /value-based payments, performance measures, and incentive measures. AllCare did not present evidence that the QIC approved the annual quality strategy; however, the QIC minutes confirmed the committees' oversight and accountability of quality efforts and activities performed by other committees. This requirement was *Partially Met*.	
Required Action: AllCare must ensure that the QIC approves the annual quality strategy.	

Standard XII—Quality Assessment and Performance Improvement			
CCO Improvement Plan			
CCO Action Plan/Interventions		**Individual(s) Responsible**	**Completion Date**
During the March 30, 2022 QI Committee the Committee reviewed Section 3 of the TQS (ACCCO-2022 TQS-Section 3) which includes the QAPI Program Description, QI Committee Charter, Previous year's minutes, CY2021 QAPI Program Evaluation, CY2022 QAPI Strategy and Work Plan, and TQS. The Committee reviewed the documents and did not have any recommendations, modification or changes per the minutes (03302022 QI Minutes). During the March 22, 2023 QI Committee, the recent QAPI evaluation from CY22 was reviewed along with the TQC, and QI Work Plan for 2023. The Committee reviewed the documents and did not have any recommendations, modification or changes.		• Laura Matola	03/22/2023
Documentation Submitted as Evidence	QAPI Element 8ACCCO-2022 TQS-Section 3 QAPI Element 803302022 QI Minutes QAPI Element 8AllCare-2023 TQS QAPI Element 8Need Draft Minutes from 03222023 meeting		
HSAG Assessment of Resolution	The CCO reported that the annual quality strategy was approved at the March 2023 QIC meeting, without providing evidence. The CCO was given an opportunity to provide evidence after the site visit, however, the CCO reported that the meeting minutes were unavailable. To resolve this finding, the CCO must provide evidence of annual approval of its quality strategy. This finding remains **unresolved**.	☐ Resolved ☐ Resolved, with recommendations ☒ Not Resolved	

Standard XIII—Health Information Systems	
Element #4	The CCO's health information system collects, analyzes, integrates and reports **member data** including the following: a. Member enrollment. b. Member characteristics required to be collected for the community health assessment (CHA) as specified in Contract Exhibit K (6). c. Names and phone numbers of the member's primary care provider or clinic. d. Evidence that the member has been informed of rights and responsibilities. *42 CFR §438.242(b)(2)* *CCO Contract Exhibit J(1)(a)*
Finding: The *Overall Data Flow Diagram* outlined the regulatory requirements, systems, data sources, and general processes used by AllCare to collect, analyze, integrate, and report member data. Additionally, AllCare's responses in the ISCAT along with the *Maintaining Accurate Member Eligibility* policy and diagram addressed internal processes for importing the incoming enrollment file into Facets while other documentation (e.g., *Member Disenrollment Request*) addressed enrollment/disenrollment regulatory requirements and processes. AllCare demonstrated the EZ-CAP platform during the virtual "onsite" review to illustrate compliance with federal and State requirements for capturing key member data elements including member enrollment segments (i.e., historical and current), assigned primary care providers, and member demographics (e.g., disability status, race, ethnicity, language, age, and gender). Additionally, during the virtual "onsite" review and through follow-up documentation (i.e., *REALD Dashboard* screen shots and the *Data Documentation Collection* policy and procedure), AllCare provided evidence of supporting the collection of additional member characteristics through ongoing REAL-D data collection efforts and previous community health assessments, including member health status. However, while most member characteristics needed to support the requirements outlined in Exhibit K, information supporting the collection of data on members' sexual orientation/gender identity (SOGI) was not available. AllCare did provide documentation indicating the collection of SOGI data from its Community Advisory Council membership, but standard collection of this data element via its CHA surveys or other means was not available. AllCare also provided its *Enrollee Rights and Protections* and *Providing Member Materials* policies and procedures that outlined regulatory requirements and procedures supporting the communication of member rights, protections, and responsibilities to members. Together, these documents described the mechanisms for ensuring providers, members, and AllCare staff were made aware of these requirements, including specific mechanisms used to ensure timely mailing. Further, AllCare staff described using the member modules in EZ-CAP to track member requests and communication rights and responsibility materials to members. However, AllCare did not provide any evidence that demonstrated compliance with tracking/monitoring whether members had been informed of their rights and responsibilities (timeliness reports, tracking spreadsheets, sample mailing lists, etc.) This requirement was *Partially Met*.	
Required Action: In alignment with the requirements of Exhibit K, the CCO must collect member characteristics required to be incorporated into its community health assessment, including SOGI. Documentation submitted by AllCare only supported the collection of SOGI data for its Community Advisory Councils members, not for its community or membership at large. Until this information is incorporated in the State's	

Standard XIII—Health Information Systems			
enrollment files, the CCO should expand current CHA data collection tools to incorporate this data element and update its data warehouse to support the collection, integration, and reporting of these data.			
CCO Improvement Plan			
CCO Action Plan/Interventions		**Individual(s) Responsible**	**Completion Date**
HSAG acknowledges the collection and reporting of SOGI data on AllCare's CAC membership; however, collection of this information was limited and not reflective of its larger community and membership. As noted in the finding, HSAG confirmed that AllCare is currently working with OHA and community partners to collect these elements. There were no findings associated with this sub-element.		NA	12/21/2022
Documentation Submitted as Evidence	HIS Element 4-OR2022_AllCare_CMR_Report-Fdbk_F1 **See Pre-Site Visit CCO Response from CCO (7/21/23)** ACCCO_Board Demographic Survey 2023.xlx Element 4-Employee Data Email Element 4-Final Survey_English2.pdf Element 4-Community Health Assessment Questionnaire_Questions_paperversion_Curry_v2.docx		
HSAG Assessment of Resolution	HSAG's response to the CCO's feedback on the 2022 CMR Report was unclear and subsequently misinterpreted by the health plan. The statement that "there were no findings associated with this sub-element" referenced AllCare's specific comment regarding its SOGI data collection for its Community Advisory Council (CAC) members. HSAG acknowledged the availability of that data. However, the 2022 finding was based on SOGI data (1) not being collected for its populations (members and/or community); and (2) not having information systems (i.e., defined data elements) available to support data collection, storage, and reporting. AllCare submitted subsequent documentation upon request. Moreover, it described several internal processes currently in place to collect and use SOGI data, including its Community Health Assessment (CHA) updates, internal IS preparatory updates for incoming 834 Enrollment file changes, and the collection of self-disclosed SOGI data for AllCare staff and its board of directors. The CCO also provided updated draft	☒ Resolved ☐ Resolved, with recommendations ☐ Not Resolved	

Standard XIII—Health Information Systems		
	copies of its county-based CHA surveys, which included demographic questions related to the use of gender pronouns, gender identity, and sexual orientation/identity. This finding is **resolved.**	

Standard XIII—Health Information Systems	
Element #7	The CCO's health information system collects, analyzes, integrates, and reports Measures and Outcomes Tracking System (MOTS) data. *CCO Contract Exhibit J(1)(a)*
Finding: AllCare submitted its *Behavioral Health Access Policy* that outlined access requirements for ensuring members' access to contracted behavioral health providers and covered behavioral health services. Further, the Reporting section of this policy stated that the CCO is to ensure that its contracted behavioral health providers submit all required information as required by OHA, including enrollment in the MOTS program. However, neither the policy nor discussions during the virtual "onsite" review addressed submission requirements or described how the CCO conducts oversight of its behavioral health providers to ensure compliance with contract requirement (reporting, subcontractor or provider contract provisions, etc.). This requirement was *Partially Met*. **Note**: In coordination with OHA, CCOs were not assessed for their ability to collect, integrate, analyze, or report MOTS data within the CCO's HIS.	
Required Action: AllCare must update its behavioral health policy to define mechanisms to ensure provider compliance with MOTS reporting requirements and implement those procedures into its operations and oversight practices.	

CCO Improvement Plan

CCO Action Plan/Interventions	Individual(s) Responsible	Completion Date
AllCare requests and reviews all provider policies pertaining to MOTS enrollment and submissions at each of our behavioral health provider performance reviews. Additionally, at time of the provider performance review, AllCare works with OHA's Health Policy and Analytics Division to obtain the provider's current status with MOTS reporting ensuring they are in compliance with the completion and submission of AllCare members' data. AllCare completes and submits the MOTS Data Report form on OHA's MOTS website when directed by OHA. If there are any deficiencies in provider policies, procedures or if OHA Data Report indicates that the provider is not in compliance with the current OHA expectations for MOTS reporting, AllCare may include issue(s) in the provider's Performance Improvement Plan to assist and support them in getting into compliance. The ACCCO BH Annual Subcontractor Performance Review Policy and Desk Procedure were updated to include these steps and the new language is highlighted within the documents.	Lana McGregor	4/4/23

Standard XIII—Health Information Systems		
Documentation Submitted as Evidence	HIS Element 7 - ACCCO BH-014 ASPR Policy - 2023.docx HIS Element 7 - ACCCO BH-013 ASPR Desk Procedure - 2023.docx **See Pre-Site Visit CCO Response from CCO (7/21/23)** Health Information-Element 7-2023 BH Subcontractor Compliance review tool.xlsx Health Information-Element 7-2022 MOTS Options Performance Report.xlsx	
HSAG Assessment of Resolution	The CCO's *Behavioral Health (BH) Annual Subcontractor Performance Review (ASPR)* policy outlined the regulatory requirements and processes used to monitor the performance of subcontracted BH providers, including provisions regarding oversight of MOTS enrollment and reporting. The BH Annual Subcontractor Performance Review Desk procedure outlined specific steps to conduct the ASPRs, including scheduling, review activities, responsibilities, etc. The document described the MOTS Report Request form submission process to obtain a contractor's current MOTS status and performance report. In response to follow-up questions, the CCO provided a copy of its BH Subcontractor Compliance review tool and a MOTS Performance Report. The subcontractor review tool included a component related to the submission/review of the subcontractor's "MOTS Data Collection Policies." The CCO clarified that the component included the collection and review of MOTS data compliance policies and procedures regarding data collection and reporting requirements as well as a review of any OHA compliance actions taken in the past year related to the submission. The CCO also provided a copy of the MOTS Status and Performance Report, which it receives from OHA but does not currently rely on for assessment compliance. This finding is **resolved**.	☒ Resolved ☐ Resolved, with recommendations ☐ Not Resolved