# Oregon Health Authority

# 2023 Compliance Monitoring Review Report

*for*

Eastern Oregon CCO, LLC

*December 2023*

HSAG HEALTH SERVICES ADVISORY GROUP

# Table of Contents

# 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;<br>42 CFR §438.214 | | ✓ | |
| Standard VI—Subcontractual Relationships and Delegation | 42 CFR §438.230 | | ✓ | |
| Standard VII—Member Rights and Protections | 42 CFR §438.100–<br>42 CFR §438.102 | ✓ | | |
| Standard VIII—Confidentiality | 42 CFR §438.224 | | | ✓ |
| Standard IX—Enrollment and Disenrollment | 42 CFR §438.3<br>42 CFR §438.56 | | | ✓ |
| Standard X—Grievance and Appeal Systems | 42 CFR §438.228;<br>42 CFR §438.400–<br>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<br>*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<br>*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<br>*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<br>*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<br>*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<br>*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 Eastern Oregon CCO, LLC (EOCCO) 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 EOCCO 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 EOCCO'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 EOCCO'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 EOCCO**

| 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 | 6 | 3 | 0 | 83.3% | *Low Confidence* | 83.0% | 85.1% |
| Standard IV—Coverage and Authorization of Services | 18 | 10 | 8 | 0 | 77.8% | *Low Confidence* | 91.0% | 70.1% |
| Standard VII—Member Rights and Protections | 5 | 2 | 3 | 0 | 70.0% | *No Confidence* | 83.0% | 69.4% |
| Standard X—Grievance and Appeal Systems | 27 | 19 | 8 | 0 | 85.2% | *Moderate Confidence* | 82.0% | 85.2% |
| Standard XIV—Member Information | 22 | 14 | 7 | 1 | 79.5% | *Low Confidence* | 80.0% | 80.0% |
| Standard XVI—Emergency and Poststabilization Services | 12 | 8 | 4 | 0 | 83.3% | *Low Confidence* | - | 85.4% |
| **Overall Compliance Score** | **93** | **59** | **33** | **1** | **81.2%** | ***Low Confidence*** | **84.0%** | **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 EOCCO's compliance with all regulatory requirements reviewed based on the overall compliance score of 81.2 percent. HSAG also assigned a confidence level to each standard reviewed for EOCCO in CY 2023. HSAG assigned the CCO a *Moderate Confidence* level for *Grievance and Appeal Systems*; a *Low Confidence* level for *Coordination and Continuity of Care*, *Coverage and Authorization of Services*, *Member Information*, and *Emergency and Poststabilization Services*; and a *No Confidence* level for *Member Rights and Protections*. None of the standards reviewed were assigned a *High Confidence* level. Of the 93 elements, EOCCO received *Met* scores for 59 elements, *Partially Met* scores for 33 elements, and a *Not Met* score for one element.

The overall CY 2023 compliance score of 81.2 percent declined by 2.8 percentage points compared to the overall score of 84.0 percent from the CY 2020 CMR. Additionally, EOCCO's scores improved in *Coordination and Continuity of Care* and *Grievance and Appeal Systems* and declined in *Coverage and Authorization of Services*, *Member Rights and Protections*, and *Member Information* compared to the previous review conducted in CY 2020. EOCCO performed above the overall statewide CCO average by 1 percentage point for the CY 2023 CMR. Of note, EOCCO scored higher than the statewide CCO average compliance score for *Coverage and Authorization of Services* and *Member Rights and Protections.*

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 EOCCO 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, EOCCO 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 83.3 percent in the *Coordination and Continuity of Care* standard due to a lack of operational structure, impacting the CCO's ability to appropriately assess/reassess members for care coordination services, develop treatment plans with member involvement, and ensure health records are maintained in accordance with professional standards. **[Quality, Timeliness, and Access]**<br>**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 with the member's involvement within the appropriate time frames. The CCO also failed to implement mechanisms to ensure the appropriate maintenance of medical records in accordance with professional standards. |

**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. The CCO must also implement mechanisms to ensure the appropriate maintenance of medical records in accordance with professional standards.

## *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 77.8 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 adhere to federal and State requirements for authorizing services and to ensure proper and timely notification of adverse benefit determinations. **[Quality, Timeliness, and Access]**

**Rationale:** The CCO's policies and procedures did not align with federal and State requirements. Additionally, the CCO demonstrated reversing service authorization decisions outside of the appeal process. The CCO also failed to adhere to requirements for appropriate decision-makers; proper outreach to obtain information needed to process authorization requests; and required content, readability, 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 demonstrate adherence to federal and State requirements for authorization requests and required content, readability, and time frames for notification of adverse benefit determinations. The CCO must also demonstrate proper outreach to retrieve the information needed to process service authorization requests.

## 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 70.0 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 and that advance directive requirements are met. **[Quality and Access]**
**Rationale:** The CCO's policies and procedures and provider-facing materials did not align with federal and State requirements.
**Required action(s):** The CCO must revise its policies and procedures 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. The CCO also failed to adhere to requirements for the required content for grievance resolution notices, maintenance of an expedited process, time frames for acknowledging appeals, and extension requirements. The CCO also failed to communicate grievance and/or appeal requirements to 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 adhere to federal and State requirements for the required content for grievance resolution notices, maintenance of an expedited process, time frames for acknowledging appeals, and extension requirements. The CCO must also demonstrate implementation of federal and State requirements within communications to 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 79.5 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 failed to track and monitor the timely provision of required member information.
**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 notify members of the availability of member information. Additionally, the CCO must track and monitor the timely provision of required 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 83.3 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 that emergency and poststabilization services are covered appropriately. **[Timeliness and Access]**
**Rationale:** The CCO's policies and procedures did not align with federal and State requirements. The CCO also failed to ensure provider materials communicated the appropriate requirements.
**Required action(s):** The CCO must revise its policies and procedures to align with federal and State requirements. The CCO must also revise its provider materials to define "emergency and poststabilization services" and communicate the appropriate requirements.

## CY 2022 Improvement Plan Review

EOCCO 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 EOCCO's summary of findings for the CY 2022 IP review. HSAG's evaluation of EOCCO's approach to addressing the nine IP findings issued during CY 2022 and unresolved findings from CY 2021 and CY 2020 revealed four findings remain unresolved, indicating continued noncompliance with State and federal regulatory requirements.

**Table 3-2—Summary of Findings for EOCCO'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*** | 1 | 1 | 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 | 3 | 1 | 25.0% |

| Standard | Total # of Findings | Total # of Resolved Findings | Total # of Unresolved Findings | Total % of Unresolved Findings |
|---|---|---|---|---|
| Standard X—Grievance and Appeal Systems* | N/A | N/A | N/A | N/A |
| Standard XI—Practice Guidelines*** | 1 | 1 | 0 | - |
| Standard XII—Quality Assessment and Performance Improvement | 2 | 0 | 2 | 100.0% |
| Standard XIII—Health Information Systems, including ISCA | N/A | N/A | N/A | N/A |
| Standard XIV—Member Information* | 1 | 0 | 1 | 100% |
| Standard XVI—Emergency and Poststabilization Services** | N/A | N/A | N/A | N/A |
| **Total** | **9** | **5** | **4** | **44.4%** |

* 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

EOCCO 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 EOCCO'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.<br>a. The member must be provided information on how to contact their designated person or entity.<br>*42 CFR § 438.208(b)(1)*<br>*Contract: Exhibit B Part 4 (2)(l)*<br>*OAR 410-141-3860 (6)(b)* | **Suggested Documents:**<br>• Care Coordination and/or Care Management Program Descriptions<br>• Care Coordination and/or Care Management policies and procedures<br>• Member Welcome Letter or other outreach letter<br>• Member Handbook<br>**Documents Submitted for Desk Review:**<br>• EOCCO Care Coordination Policy.pdf<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>– Pg. 20-22<br>• EOCCO Case Management Flyer.pdf<br>• EOCCO HRA Letter.signed.doc<br>• EOCCO CM Training Manual draft 8 (1).docx<br>• ICC Tier Definitions.docx<br>• Multi Disciplinary DC Rounds 2022.xlsx<br>• CC Sample 1.pdf<br>• CC Sample 2.pdf<br>• ICC Sample 1.pdf<br>• ICC Sample 2.pdf<br>• ICC Sample 3.pdf<br>• ICC Sample 6.pdf<br>• ICC Assessment.pdf | ☐ Met<br>☒ Partially Met<br>☐ Not Met |

| Standard III—Coordination and Continuity of Care (42 CFR §438.208) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | • Template -2023_ExhibitA-1_PlanSummary Exhibit.docx | |

**HSAG Findings:** The *EOCCO Care Coordination* policy described the CCO's care coordination and care management processes. The policy stated that care coordination activities include early identification of members eligible for Intensive Case Management (ICM) services; assistance with access to care; coordination with medical, long-term services and supports (LTSS) providers and case managers; assistance with capitated services and discharge planning; and coordination with community services. The policy and the ICC Tier Definitions documents stated that the CCO's care coordination programs are stratified into three tiers and described the essential services, members eligible, locale of care, outcomes, and monitoring metrics. The policy defined the first tier (Tier 1) as the lowest level of care coordination available to all members. The policy stated that members have access to a source of care for members' health needs and a designated person who is primarily responsible for coordinating the member's services. The policy stated that the designated person responsible for care management could be a traditional health worker (THW) or an EOCCO care coordinator. The policy further stated that members are to be informed of the designated person by letter at the time of enrollment and when that person is replaced. The CCO provided an HRA Letter that included a case manager's contact information and informed members that they could contact the person for assistance with completing the health risk assessment form or for other questions. However, the health risk assessment (HRA) form did not inform members of their ongoing source of care appropriate to their needs nor the person or entity formally designated as primarily responsible for services coordination of the members nor their contact information.

The policy stated that Tier 2 is the ICC program, available to members identified with higher complexity or comorbidities, including members in state-prioritized populations. The policy stated that each member enrolled in the ICC program is assigned a designated person responsible for care management (e.g., case manager, registered nurse, or qualified mental health professional). The CCO provided ICC sample records demonstrating that ICC members are provided a letter after enrollment in the program introducing the care coordinator and providing his/her contact information.

The policy also described the Tier 3 program as the ICM program, which is designated for members who need a higher level of care management. This includes members who need specialized services, such as Assertive Community Treatment (services for members with serious and persistent mental illness), wrap-around care coordination, or targeted case management. However, the policy did not identify the care coordination staff responsible for the member's care while in the program, nor did it address how the members are informed of how to contact their designated person.

The member handbook described the CCO's care coordination and ICC care coordination offerings, those responsible for care coordination, and provided the information to request a care coordinator. During the site visit, CCO staff asserted that members also were provided with separate welcome letters and identification cards, informing them of their primary care provider.

| Standard III—Coordination and Continuity of Care (42 CFR §438.208) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| EOCCO's Case Manager (CM) training manual outlined how members are identified for case management through several sources, such as self-referral, member representative, provider, and Aging and People with Disabilities/LTSS), which require follow-up within one business day. The CM training manual indicated other referral sources included HRA; emergency department (ED) rounds; trigger diagnosis (Dx) notifications through Collective, Flexible Service requests; high-risk lists from OHA; Hep C Corridor; Multidisciplinary team requests; concurrent review; and the appeals/grievance team. The CM training manual also discussed that referrals are assigned at the end of each workday. During the site visit, the CCO discussed its care management referral process and indicated that its case management program is a "referral-based" program. Outside of the HRA process and other operational processes, the CCO was unable to describe its mechanisms (e.g., risk stratification) for identifying its members who could benefit from care coordination or care management services. The CCO staff indicated that members are encouraged to call in for any assistance needed.<br>During the site visit, CCO staff also described offering separate behavioral and physical health case management, while the structure of the programs is the same. CCO staff stated that behavioral health services are provided by licensed professional counselors or social workers, and physical health case managers are registered nurses. This requirement was *Partially Met*. | | |
| **Required Actions:** The CCO must revise its policy or procedure to identify how all members are informed of their designated source of care coordination, (e.g., their case manager and primary care provider[PCP]), including those enrolled and not enrolled in case management. The CCO must also provide evidence of implementing the requirement for all levels of care coordination, even those members not enrolled in care management. | | |
| **Recommendations:** HSAG recommends that the CCO implement risk stratification methods to proactively identify members or specific populations that may benefit from care coordination and case management. | | |
| 2. The CCO implements procedures to coordinate services the CCO furnishes the member:<br>a. Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays;<br>b. With the services the member receives from any other MCE;<br>c. With the services the member receives in FFS Medicaid; and<br>d. With the services the member receives from community and social support providers. | **Suggested Documents:**<br>• Policies and procedures that address care coordination and/or continuity of care for services outlined in the requirement<br>• Processes or workflows for coordinating with other entities (outlined in the requirement) and identification of responsibilities<br>• One example showing the CCO coordinating care with each of the following entities listed in letters (a) through (d) of the requirement<br>**Documents Submitted for Desk Review:** | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard III—Coordination and Continuity of Care (42 CFR §438.208) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| *42 CFR § 438.208(b)(2)*<br>*Contract: Exhibit B Part 4 (1)(c)*<br>*Contract: Exhibit M (11)(b)*<br>*OAR 410-141-3860 (3)* | • EOCCO CM Training Manual draft 8 (1).docx<br>• EOCCO Care Coordination Policy.pdf<br>• EOCCO Participating Provider Agreement.docx<br>• MDT_referral.pdf<br>• EOCCO MDT Referral Form Guidance.pdf<br>• Current EOCCO Provider Manual 10.5.22.pdf<br>• CC Sample 1.pdf<br>• CC Sample 2.pdf<br>• ICC Sample 1.pdf<br>• ICC Assessment.pdf<br>• Care Coordination Assessment.pdf<br>• EOCCO Coordination with Long Term Psychiatric Care Policy.pdf<br>• Case Sample 1 BH ICM.pdf<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>– Pg.22<br>• Case Sample 3 BH ICM.pdf<br>• Case Sample 4 Care Coord with MCE- Medicare.pdf<br>• Case Sample 5 ICM FFS Medicaid.pdf<br>• Case Sample 6 ICC Social Supports.pdf<br>• BH Auth Case Sample Hold_Acute_DC plan with County.pdf<br>• Case Sample 2 BH ICM Wraparound.pdf | |
| **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** |
| 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:<br>a. Within 90 days of the effective date enrollment; or<br>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<br>c. Sooner than the timeframes required if required by the member's health condition.<br><br>***The CCO shall maintain documentation on the health risk screening process, including subsequent attempts if the initial attempt to contact the member is unsuccessful.*<br><br>*42 CFR § 438.208(b)(3)*<br>*CCO Contract: Exhibit B Part 4 (1)*<br>*OAR 410-141-3865 (3)(b)(A-C)* | **Suggested Documents:**<br>• Initial health risk screening policies and procedures<br>• Description of need stratification mechanism used to identify members receiving LTSS or members of a priority population (as defined in OAR 410-141-3870 (2))<br>• Sample of the initial health risk screening form/template<br>• Samples of completed health risk screenings (one each) for the following:<br>– Member not meeting criteria for screening in less than 90 days;<br>– Member of prioritized population;<br>– Member with special health care needs (SHCN); and<br>– Member receiving LTSS.<br>**Additional examples may be requested during the onsite.*<br>• Timeliness tracking of outreach and health risk screening completions<br>**Documents submitted for desk review:**<br>• EOCCO Initial Health Risk Assessment Policy.pdf<br>• HRA Survey.pdf<br>• Sample HRA 1.pdf<br>• Sample HRA 1 Referral.msg<br>• Sample HRA 2 Prioritized Population.pdf<br>• Sample HRA 2 Referral.msg | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard III—Coordination and Continuity of Care (42 CFR §438.208) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | • Sample HRA 3 SHCN.pdf<br>• Sample HRA 3 Referral.msg<br>• Sample HRA 4 LTSS.pdf<br>• Sample HRA 4 Referral.msg<br>• Master HRA Tracker.xlsx<br>• EOCCO Special Healthcare Needs.pdf<br>• ICC Sample 3.pdf<br>• ICC Sample 6.pdf<br>• Case Sample 1 HRA ICC Referral SHCN.pdf<br>• Case Sample 2 HRA ICC Referral Prior Pop.pdf<br>• HRA Referrals 2022.xlsx<br>• CM Manual.pdf | |
| **HSAG Findings:** This requirement was *Met*. | | |
| **Required Actions:** None. | | |
| 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.<br>*42 CFR § 438.208(b)(4)*<br>*Contract: Exhibit B Part 4 (2)(g)(3)*<br>*OAR 410-141-3865(4)(c)* | **Suggested Documents:**<br>• Care Coordination and/or Care Management policies and procedures<br>• Sample documentation showing sharing of assessments with relevant entities involved in the member's care<br>*HSAG will also use the results of the care coordination file review<br>**Documents Submitted for Desk Review:**<br>• EOCCO Care Coordination Policy.pdf<br>• EOCCO Special Healthcare Needs Policy.pdf<br>• EOCCO Participating Provider Agreement.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard III—Coordination and Continuity of Care (42 CFR §438.208) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | • EOCCO CM Training Manual draft 8 (1).docx<br>• MOU 2022 Final.pdf<br>• EOCCO Bidirectional BAA – Advantage Dental LLC 01.01.2020 – fully executed.pdf<br>• EOCCO Bidirectional BAA – GOBHI 01.01.2020 – fully executed.pdf<br>• EOCCO Bidirectional BAA – ODSCH 01.01.2020 – executed.pdf<br>• EOCCO Bidirectional BAA – ODS 01.01.2020 – fully executed.pdf<br>• ICC Sample 1.pdf<br>• Case Sample 1 ICC Sharing Assessments, APD, Hospital, Surgery.pdf<br>• Case Sample 2 ICC_ PCP Letter Example 2022.pdf<br>• CM Manual.pdf | |
| **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.<br>*42 CFR § 438.208(b)(5)* | **Suggested Documents:**<br>• Care Coordination and/or Care Management policies and procedures<br>• Policies guiding health record disclosure for care coordination<br>• Health/dental record documentation requirements or policies<br>• Provider Manual, Provider Agreement, or other provider messaging regarding documentation requirements | ☐ Met<br>☒ Partially Met<br>☐ Not Met |

| Standard III—Coordination and Continuity of Care (42 CFR §438.208) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | • Sample provider chart reviews/audits<br>• Committee meeting minutes demonstrating monitoring of member health records<br>**Documents Submitted for Desk Review:**<br>• Current EOCCO Provider Manual 10.5.22.pdf<br>• EOCCO Care Coordination Policy.pdf<br>• EOCCO Participating Provider Agreement.pdf<br>• EOCCO Business Associate Relationships Policy.pdf<br>• EOCCO Information Security Policy.pdf<br>• Sample Provider Chart Audit 2022.pdf | |
| **HSAG Findings:** The provider manual outlined the CCO's medical record standards for providers and stated that providers would be audited to ensure the criteria were met. During the site visit, the CCO asserted that provider chart audits were conducted. After the visit, the CCO only furnished Health Insurance Portability and Accountability Act (HIPAA) and CFR training and behavioral health provider attestations. However, the CCO did not provide evidence of audits that demonstrated monitoring or auditing for the appropriate maintenance of a member's health record in accordance with professional standards. The *Care Coordination* policy did not address the maintenance of sharing providers' records. The participating provider agreement includes privacy and record retention provisions but does not address medical record standards. The CCO also provided fraud and abuse provider chart audits. This requirement was *Partially Met*. | | |
| **Required Actions:** The CCO must demonstrate implementing procedures to ensure that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards. | | |
| 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.<br>*42 CFR § 438.208(b)(6)* | **Suggested Documents:**<br>• Care Coordination and/or Care Management policies and procedures<br>• Privacy/HIPAA policies and procedures<br>*HSAG will also use the results of the care coordination file review | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard III—Coordination and Continuity of Care (42 CFR §438.208) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| *CCO Contract: Exhibit B Part 4 (1)(a)* | **Documents Submitted for Desk Review**<br>• Moda Employee Privacy and Cybersecurity Standards.pdf<br>• EOCCO CM Training Manual.pdf<br>• Current EOCCO Provider Manual 10.5.22.pdf<br>• EOCCO Participating Provider Agreement.pdf<br>• PHI-disclosure-EOCCO.pdf<br>• EOCCO Website: EOCCO Notice of privacy practices<br>• EOCCO Administrative Safeguards for Paper-Electronic- Oral and Visual Access of Protected Health Information Policy.pdf<br>• EOCCO Care Coordination Policy.pdf<br>• EOCCO Medical Management Program and Clinical Decisions Policy.pdf<br>• EOCCO Safeguarding PHI Policy.pdf<br>• Provider Contract Provisions Template 01.2022.pdf | |
| **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 must use appropriate providers or individuals meeting LTSS service coordination requirements of the State | **Suggested Documents:**<br>• Member onboarding policies and procedures<br>• Care Coordination and/or Care Management policies and procedures addressing ICC assessment processes<br>• Protocols used to determine needs of the member and how the health plan will meet those needs | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard III—Coordination and Continuity of Care (42 CFR §438.208) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| or CCO, as appropriate. The CCO must conduct the ICC assessment:<br>a. Within 10 days of completion of the health risk screening, or sooner if required by their health condition for prioritized populations.<br>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.<br>*42 CFR §438.208(c)(2)*<br>*CCO Contract: Exhibit B Part 4(2)(g)*<br>*CCO Contract: Exhibit B Part 4 (9)(a*<br>*OAR 410-141-3865 (3)(d)*<br>*OAR 410-141-3870 (2),(5)* | • Sample ICC assessment form/template<br>• Sample completed ICC assessment (one each) for the following:<br>– Member of prioritized population;<br>– Member with SHCN;<br>– Member receiving LTSS;<br>– Member identified during the health risk screening with needs or conditions that may indicate a need for ICC services; and<br>– Member referred by self, representative or provider.<br>**Additional examples may be requested during the onsite.*<br>• Sample screenshots, dashboards, or spreadsheets to show tracking to ensure the assessments are completed within the appropriate time frame<br>**Documents Submitted for Desk Review:**<br>• EOCCO CM Training Manual.docx<br>• EOCCO Care Coordination Policy.pdf<br>• ICC Sample 1.pdf<br>• ICC Sample 2.pdf<br>• ICC Sample 3.pdf<br>• ICC Sample 4.pdf<br>• ICC Sample 5.pdf<br>• Tier Screening Tool.pdf<br>• EOCCO Initial Health Risk Assessment Policy.pdf | |

| Standard III—Coordination and Continuity of Care (42 CFR §438.208) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | • Blank Sample BH ICC Assessment.pdf<br>• ICC BH Assessment TAT Report-2022.pdf<br>• ICC BH Assessment Sample, Prior Pop_APD_ LTSS_SUD RES.pdf<br>• ICC BH Assessment Sample_SHCN_LTSS_SNF.pdf<br>• ICC BH Assessment Sample_ Prior Pop_HRA.pdf<br>• ICC BH Sample_ Prior Pop_Self Referral.pdf<br>• Blank BH ICM Assessment.pdf<br>• ICM Blank BH Assessment Trigger.pdf<br>• CM Manual.pdf | |
| **HSAG Findings:** This requirement was *Met*. | | |
| **Required Actions:** None. | | |
| 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:<br>a. Developed by an individual meeting LTSS service coordination requirements with member | **Suggested Documents:**<br>• Member onboarding policies and procedures<br>• Care Coordination and/or Care Management policies and procedures<br>• Sample care plans (one each) for the following:<br>– Member receiving LTSS with care plan **developed** during the CY 2022 review period;<br>– Member receiving LTSS with care plan **reviewed/revised** during the CY 2022 review period;<br>– Member receiving ICC services with care plan **developed** during the CY 2022 review period; and | ☐ Met<br>☒ Partially Met<br>☐ Not Met |

| Standard III—Coordination and Continuity of Care (42 CFR §438.208) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| participation, and in consultation with any providers caring for the member.<br>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).<br>c. Approved by the CCO in a timely manner (if such approval is required by the CCO).<br>d. Be developed in accordance with OHA quality assessment and performance improvement utilization review standards.<br>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.<br>*42 CFR §438.208(c)(3)*<br>*Contract: Exhibit B Part 4 (2)(g)(1)*<br>*OAR 410-141-3870 (15)* | – Member receiving ICC services with care plan **reviewed/revised** during the CY 2022 review period. **Additional examples may be requested during the onsite.*<br>• Sample screenshots, dashboards, or spreadsheets to show tracking to ensure the reassessments are completed within the time frame<br>*HSAG will also use the results of the care coordination file review<br>**Documents Submitted for Desk Review:**<br>• EOCCO CM Training Manual draft 8 (1).docx<br>• EOCCO Care Coordination Policy.pdf<br>• EOCCO Special Healthcare Needs Policy.pdf<br>• ICC Sample 1.pdf<br>• ICC Sample 2.pdf<br>• ICC Sample 3.pdf<br>• ICC Sample 4.pdf<br>• ICC Tracking Reassessments spreadsheet sample.xlsx<br>• ICC Reassessment.pdf<br>• CC Reassessment.pdf<br>• Care Plan 90 day goal check.pdf<br>• BH Overdue Goals Report 4.22.22.xlsx<br>• Collective BH Trigger Notifications- Sample October 2022.pdf<br>• BH ICC Plan Sample_LTSS.pdf | |

| Standard III—Coordination and Continuity of Care (42 CFR §438.208) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | • BH ICC Plan example_LTSS with care plan reviewed-revised.pdf<br>• BH ICC Plan Sample_CP reviewed-revised.pdf<br>• BH ICC Plan Sample.pdf<br>• BH ED Report 10.23.2022_ Line 69_73_118 ED Trigger Reassess for ICC members.xlsx<br>• CM Manual.pdf | |
| **HSAG Findings:** The *Care Coordination* policy stated that the CCO is to develop a written care plan employing an intensive care coordinator with members' participation and in consultation with any specialists caring for the members. The policy stated that the plan is to be revised as needed or at a member's instigation, and revisions are to be made at least every three months for members receiving ICC services and annually for other members if approval is required. However, the requirement stipulates that an assessment is required at the specified frequency regardless of whether the CCO requires approval. The *Special Health Care Needs* policy stated that for all members, a treatment plan is to be developed with members' or their representative's participation and is evaluated and revised as necessary but at least every 12 months. As discussed in element 7, the CM Training manual stated that the ICC assessment has suggested goals that will assist the care manager in building the care plan. During the site visit, the CCO asserted that assessments and treatment are completed within the specified time frames for members enrolled in case management. The CCO record review demonstrated that members were assessed based on their level of care management and care coordination needed. Members with SHCN were provided with a comprehensive assessment that evaluated their health and social needs. However, the CCO did not consistently demonstrate documentation of member involvement in developing the treatment plan. Additionally, reviews of the subcontracted dental care coordinating entities demonstrated the care coordination conducted. However, the CCOs lacked processes and evidence to assess members' needs for care coordination, treatment/care plan development, and reassessments. It should be noted that the LTSS requirements in the element are not applicable because the CCO is not directly responsible for coordinating LTSS. The CCO also provided evidence of monitoring assessment completion and mechanisms within the treatment plan to ensure timely completion. This requirement was *Partially Met*. | | |
| **Required Actions:** The CCO must ensure its policies and processes align with federal requirements and the upcoming changes to OARs, effective February 2024, and 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.<br>*42 CFR § 438.208(c)(4)*<br>*Contract: Exhibit B Part 4 (2)(g)(2)*<br>*OAR 410-141-3870 (19)* | **Suggested Documents:**<br>• Policies and procedures on direct access for SHCN members<br>• Materials informing SHCN members about direct access to specialists and the approval process<br>• Samples documentation showing members being granted direct access<br>**Documents Submitted for Desk Review**<br>• EOCCO Care Coordination Policy.pdf<br>• EOCCO Special Healthcare Needs Policy.pdf<br>• ICC Sample 3.pdf<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>– Pg. 22,29<br>• BH ICM Case Sample_Direct access Specialty Service, IOP, SCA for member SHCN.pdf<br>• BH ICC Case Sample_Direct Access Specialist_Neuropsych.pdf<br>• BH Case Sample_Preg Direct Access to SUD Res.pdf<br>• Case Sample 2 BH ICM Wraparound.pdf<br>• CM Manual.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met |
| **HSAG Findings:** This requirement was *Met*. | | |
| **Required Actions:** None. | | |

| Results for Standard III—Coordination and Continuity of Care | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Total** | Met | = | 6 | X | 1.0 | = | 6.0 |
| | Partially Met | = | 3 | X | 0.5 | = | 1.5 |
| | Not Met | = | 0 | X | 0.0 | = | 0.0 |
| **Total Applicable** | | = | 9 | **Total Score** | | = | 7.5 |

| | | |
|---|---|---|
| **Total Score ÷ Total Applicable** | = | **83.3%** |

# 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:<br>a. Specify the amount, duration, and scope of each service that the CCO is required to offer.<br>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.<br>i. Services may not be less than the amount, duration, and scope for the same services delivered to FFS Medicaid members.<br>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).<br>*42 CFR § 438.210(a)(2);(3)(i)*<br>*Contract: Exhibit B Part 2(2)(b)*<br>*OAR 410-141-3835(6)* | **Suggested Documents:**<br>• Coverage and authorization policies and procedures<br>• Utilization management (UM) plan/utilization review (UR) policies and procedures<br>• Service Authorization Handbook<br>• Plan documents outlining the services defined in the contract<br>• Member materials, such as the member handbook and benefits grid<br>**Documents Submitted for Desk Review:**<br>• EOCCO Service Authorization/Referral Request Policy.pdf<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• EOCCO Covered and Non-Covered Service Policy.pdf<br>• EOCCO Participating Provider Agreement.docx<br>• EOCCO EPSDT Policy.pdf<br>• EOCCO Behavioral Health Medication Management Services Policy.pdf<br>• EOCCO Notice of Adverse Benefit Determination Policy.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard IV—Coverage and Authorization of Services (42 CFR §438.210) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | • EOCCO Service Authorization-Referral Request Policy.pdf<br>• EOCCO Website (Your Benefits Tab by age group): EOCCO Benefits for 19-63 year olds | |
| **HSAG Findings:** This requirement was *Met.* | | |
| **Required Actions:** None. | | |
| 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.<br>*42 CFR § 438.210(a)(3)(ii)*<br>*Contract: Exhibit B Part 2(2)(a-b)*<br>*OAR 410-141-3835(7)* | **Suggested Documents:**<br>• Coverage and authorization policies and procedures<br>• Service Authorization Handbook<br>• UM plan/UR policies and procedures<br>• Plan documents outlining process for determining service denials<br>• Coverage guidelines/criteria<br>**Documents Submitted for Desk Review:**<br>• EOCCO Service Authorization/Referral Request Policy.pdf<br>• EOCCO UM Medical Necessity Policy.pdf<br>• EOCCO Covered and Non-Covered Services Policy.pdf<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• Current EOCCO Provider Manual 10.5.2022.pdf<br>• EOCCO Notice of Adverse Benefit Determination Policy.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard IV—Coverage and Authorization of Services (42 CFR §438.210) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | • Current EOCCO Provider Manual 10.5.2022.pdf<br>• EOCCO Physical and Oral Health Clinical Practice Guidelines.pdf<br>• eocco_bhclinicalpracticeguidelines.pdf<br>• Referral and Auth Guidelines.pdf | |
| **HSAG Findings:** This requirement was *Met*. | | |
| **Required Actions:** None. | | |
| 3. The CCO may place appropriate limits on services–<br>a. On the basis of criteria applied under the State plan (such as medical necessity).<br>b. For the purpose of utilization control, provided that:<br>i. The services furnished can reasonably achieve their purpose.<br>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.<br>iii. Family planning services are provided in a manner that enables the member to choose the method of family planning.<br>*42 CFR § 438.210(a)(4)*<br>*Contract: Exhibit B Part 2(3)(b)(3)*<br>*OAR 410-141-3835(9)* | **Suggested Documents:**<br>• Coverage and authorization policies and procedures<br>• Service Authorization Handbook<br>• UM plan/UR policies and procedures<br>• Plan documents outlining processes for determining quantitative and non-quantitative service limits<br>• Coverage guidelines/criteria, including pharmacy<br>• Member materials, such as member handbook<br>**Documents Submitted for Desk Review:**<br>• EOCCO UM Medical Necessity Policy.pdf<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• Current EOCCO Provider Manual 10.5.2022.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard IV—Coverage and Authorization of Services (42 CFR §438.210) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | • EOCCO Covered and Non-Covered Services Policy.pdf<br>• EOCCO Participating Provider Agreement.pdf<br>• EOCCO Initial Health Risk Assessment Policy.pdf<br>• EOCCO Special Health Care Needs Policy.pdf<br>• EOCCO Medical Management Program and Clinical Decisions Policy.pdf<br>• EOCCO Non-Participating Provider Referral and Service Authorization Request Policy.pdf<br>• EOCCO Service Authorization-Referral Request Policy.pdf<br>• EOCCO UM Medical Necessity Policy.pdf<br>• Case Sample 1 BH SUD Detox Auth Approval.pdf | |
| **HSAG Findings:** This requirement was *Met.* | | |
| **Required Actions:** None. | | |
| 4. The CCO specifies what constitutes medically necessary covered services and administers the services in a manner that:<br>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). | **Suggested Documents:**<br>• Coverage and authorization policies and procedures<br>• Service Authorization Handbook<br>• UM plan/UR policies and procedures<br>• Medical necessity criteria utilized (e.g., InterQual, MCG) | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard IV—Coverage and Authorization of Services (42 CFR §438.210) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| b. Takes into account and addresses the following:<br>i. The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability.<br>ii. The ability for a member to achieve age-appropriate growth and development.<br>iii. The ability for a member to attain, maintain, or regain functional capacity.<br>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.<br>*42 CFR § 438.210(a)(5)*<br>*Contract: Exhibit B Part 2(2)(b)* | **Documents Submitted for Desk Review:**<br>• EOCCO Covered and Non-Covered Services Policy.pdf<br>• EOCCO Clinical Practice and Coverage Guidelines Policy.pdf- Pg 1-2 (sections II. A. and III. C.).<br>• EOCCO Medical Management Program and Clinical Decisions Policy.pdf- Pg 3 (section III B 2).<br>• EOCCO Participating Provider Agreement.pdf (pgs. 8, 11).<br>• EOCCO Special Health Care Needs Policy.pdf (pg. 3, part B (5), and C)<br>• EOCCO Care Coordination Policy.pdf-(pg 7, parts 6 and 7).<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• EOCCO UM Medical Necessity Policy.pdf (pages 1-3)<br>• Current EOCCO Provider Manual 10.5.2021.pdf- Pg. 44<br>• Case Sample 1 BH SUD Detox Auth Approval.pdf | |
| **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.<br>a. The **CCO/subcontractor's policies and procedures** must <u>also</u> comply with prior authorization requirements outlined in Contract: Exhibit B Part 2(3)(b).<br>*42 CFR § 438.210(b)(1)*<br>*Contract: Exhibit B Part 2(3)(a)*<br>*OAR 410-141-3835(10)(f)(C)* | **Suggested Documents:**<br>• UM plan/UR policies and procedures outlining procedures Coverage and authorization policies and procedures<br>• Service and Authorization Handbook<br>• Audit results from delegation oversight of policies and procedures<br>**CCO should be prepared to provide copies of delegated entities' policies and procedures upon request*<br>**Documents Submitted for Desk Review:**<br>• EOCCO Service Authorization/Referral Request Policy.pdf<br>• EOCCO UM Medical Necessity Policy.pdf-Pg 3-4 (section III, parts I and L).<br>• EOCCO Medical Management Program and Clinical Decisions Policy.pdf<br>• EOCCO Subcontractor Oversight and Monitoring Policy-No-Watermark (2).pdf<br>• Current EOCCO Provider Manual 10.5.2021.pdf | ☐ Met<br>☒ Partially Met<br>☐ Not Met |
| **HSAG Findings:** The *UM Medical Necessity* and *Medical Management Program and Clinical Decisions* policies address processing service authorization requests.<br>The reviewer verified compliance with prior authorization requirements that are outlined in Contract Exhibit B Part 2(3)(b), as follows:<br>• Members' right to refer themselves without prior authorization for behavioral health services was included in the *Service Authorization-Referral Request* policy. | | |

| Standard IV—Coverage and Authorization of Services (42 CFR §438.210) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| • Members' rights to obtain medication-assisted treatment (MAT) without prior authorization was included within the *Access to Substance Use Disorder* policy demonstrated during the site visit.<br>• Members' right to obtain outpatient behavioral health services from a network provider without prior authorization (excluding exceptions) was included within the *Service Authorization-Referral Request* policy.<br>• Members' right to refer themselves to a traditional health worker, health risk screening for ICC, ICC services, and covered family planning services from out-of-network providers was included between the *Access to Care, Traditional Health Care Worker Integration*, and *Care Coordination* policies demonstrated during the site visit.<br>• Members' right to receive a sexual abuse exam without prior authorization was included within the *Referral and Authorization Guidelines.*<br>During the site visit, the CCO provided its *Annual Utilization Management Delegation Report Review*, which demonstrated that the CCO reviews policies and procedures applicable to delegated functions. However, the CCO did not submit evidence ensuring that its subcontractors have written policies and procedures they followed addressing the processing of requests for initial and continuing authorization of services. These service requests include the authorization time frame specifications outlined in element 11. Moreover, interviews with dental subcontractors confirmed no such policies and procedures were in place. This requirement was *Partially Met.* | | |
| **Required Actions:** The CCO must ensure all subcontractors delegated the responsibility of making coverage decisions have policies and procedures in place for initial and continuing authorization of services, including authorization time frame specifications that are outlined in element 11. | | |
| 6. The CCO has and follows written policies and procedures that include mechanisms to ensure consistent application of review criteria for authorization decisions.<br>*42 CFR §438.210(b)(2)(i)*<br>*Contract: Exhibit B Part 2(3)(b)(1)*<br>*OAR 410-141-3835(10)(f)* | **Suggested Documents:**<br>• UM plan/UR policies and procedures<br>• Coverage and authorization policies and procedures<br>• Coverage guidelines/criteria<br>• Service authorization handbook<br>• Results of inter-rater reliability (IRR) activities<br>• Committee meeting minutes where IRR results are reviewed | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard IV—Coverage and Authorization of Services (42 CFR §438.210) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | **Documents Submitted for Desk Review:**<br>• EOCCO UM Medical Necessity Policy.pdf- Pgs. 1-5 (Section III.)<br>• EOCCO Clinical Practice and Coverage Guidelines Policy.pdf- Pg 1 (sections I and II), Pgs. 2-3 (section III parts C-F).<br>• 2022 Interator Reliability Testing Summary.docx<br>• EOCCO Medical Management Program and Clinical Decisions Policy.pdf<br>• BH Auth Case Sample Hold_Acute_DC plan with County.pdf<br>• Case Sample 2 BH NOABD.pdf<br>• Current EOCCO Provider Manual 10.5.2021.pdf<br>• EOCCO Service Authorization-Referral Request Policy.pdf- I ; III. A. | |
| **HSAG Findings:** This requirement was *Met.* | | |
| **Required Actions:** None. | | |
| 7. The CCO has and follows written policies and procedures to consult with the requesting provider for medical services when appropriate.<br>*42 CFR §438.210(b)(2)(ii)*<br>*Contract: Exhibit B Part 2(3)(a)*<br>*OAR 410-141-3835(10)(f)(A)* | **Suggested Documents:**<br>• UM plan/UR policies and procedures Coverage and authorization policies and procedures<br>• Service Authorization Handbook<br>• Three examples of peer-to-peer consults<br>**Documents Submitted for Desk Review:**<br>• P2P Sample 2, Pg. 2 | ☐ Met<br>☒ Partially Met<br>☐ Not Met |

| Standard IV—Coverage and Authorization of Services (42 CFR §438.210) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | • Case Sample 2 BH NOABD.pdf<br>• Current EOCCO Provider Manual 10.5.2021.pdf<br>• EOCCO Medical Management Program and Clinical Decisions Policy.pdf- III. A. 3. ; III. B. 3. a.<br>• EOCCO Service Authorization-Referral Request Policy.pdf- I ; III. A. | |
| **HSAG Findings:** The *Medical Management Program and Clinical Decisions* and *Service Authorization-Referral Request* policies specified reaching out to providers when additional information is necessary to evaluate prior authorization requests.<br>The CCO also submitted a P2P [peer-to-peer] Sample 2 document, which included case notes for a denial that prompted the treating provider to request a peer-to-peer phone call. The CCO upheld the denial based on the phone call. Another sample, Case Sample 2 BH [behavioral health] NOABD [notice of adverse benefit determination], showed that the CCO overturned a denial following a peer-to-peer phone call.<br>During the site visit, the CCO confirmed using peer-to-peer consultations after an NOABD had been issued. Further, the CCO reported reversing denial decisions based upon peer-to-peer conversations. This was the CCO's preferred approach rather than informing the requesting provider of its denial rationale and assisting the provider in deciding to appeal the decision. This requirement was *Partially Met*. | | |
| **Required Actions:** The CCO must ensure its process for consulting with the requesting provider occurs prior to the authorization decision and issuance of the NOABD when the CCO believes additional information is required to make a determination. The CCO also must ensure peer-to-peer consultations are conducted informing requesting providers of the reason for the adverse benefit determination and provide the information needed for the requesting provider to determine whether or not to appeal the decision. In addition, the CCO must ensure its process does not include reversing adverse benefit determinations and aligns with State and federal regulations requiring that the CCO treat provider requests for redetermination as provider-initiated appeals. | | |
| 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.<br>*42 CFR §438.210(b)(3)* | **Suggested Documents:**<br>• Coverage and authorization policies and procedures<br>• Service Authorization Handbook<br>• UM plan/UR policies and procedures | ☐ Met<br>☒ Partially Met<br>☐ Not Met |

| Standard IV—Coverage and Authorization of Services (42 CFR §438.210) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| *Contract: Exhibit B Part 2(3)(b)(2)* | • Policies and procedures outlining service authorization denials<br>• Job descriptions/minimum qualifications for UM decision makers<br>*HSAG will also use the results of the service authorization denial file review<br><br>**Documents Submitted for Desk Review:**<br><br>• EOCCO Service Authorization-Referral Request Policy.pdf<br>• EOCCO Medical Management Program and Clinical Decisions Policy.pdf<br>• Case Sample 2 BH NOABD.pdf<br>• Current EOCCO Provider Manual 10.5.2021.pdf | |
| **HSAG Findings:** The *Medical Management Program and Clinical Decisions* policy stated that all services requiring medical necessity review are initially assessed by care coordinators or prior authorization coordinators, and, if needed, additional review is conducted by the medical director, chief medical officer, or the president of the health plan. The policy also stated that the care coordinator reviews all medical requests "within the scope of his/her expertise against clinical decision support tools."<br>Interviews conducted with the CCO and subcontractors during the site visit and file reviews revealed "system" denials. These denials occurred when:<br>• Information was requested from the provider by an analyst and/or registered nurse and was not received.<br>• Registered nurses performed administrative denials when the services requested were considered exclusions or below the funded line and no other conditions were noted within the medical record.<br>However, the "Comorbidity Rule" 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: | | |

| Standard IV—Coverage and Authorization of Services (42 CFR §438.210) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| *(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:*<br>*(A) The member has a funded condition for which documented clinical evidence shows that the funded treatments are not working or are contraindicated; and*<br>*(B) The member concurrently has a medically related unfunded condition that is causing or exacerbating the funded condition; and*<br>*(C) Treating the unfunded medically related condition would significantly improve the outcome of treating the funded condition.*<br>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. As such, before a denial decision is issued, the request for unfunded condition-related services must also be reviewed as described in the CCO contract, Exhibit B Part 2(3)(b)(2). Specifically, that provision states, "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 in treating the Member's physical, mental, Oral Health condition or disease, as applicable." In addition, the CCO may not permit "system" denials for not receiving requested information prior to a review by an individual with appropriate expertise in treating the member's condition. 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 member's 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:<br>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 methods to obtain the necessary information during the 14-day period.* | **Suggested Documents:**<br>• Coverage and authorization policies and procedures<br>• UM plan/UR policies and procedures<br>• Service Authorization Handbook<br>• Service authorization turn-around-time tracking<br>• Extension notice template | ☐ Met<br>☒ Partially Met<br>☐ Not Met |

| Standard IV—Coverage and Authorization of Services (42 CFR §438.210) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| 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.<br>c. The time frame for making standard or expedited authorization decisions may be extended by up to **14 additional calendar days** if:<br>i. The member or the provider requests an extension, or<br>ii. The CCO justifies (to the State upon request) a need for additional information and how the extension is in the member's interest.<br>iii. If the CCO extends the time frame for standard or expedited authorization decisions, it must:<br>– Give the member written notice of the reason for the extension (no later than the date the authorization time frame expires).<br>– Inform the member of the right to file a grievance if he or she disagrees with that decision.<br>– Issue and carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.<br>*42 CFR §438.210(d)(1-2)* | • Three examples of an extensions notice and corresponding determination notice<br>*HSAG will also use the results of the service authorization file review<br>**Documents Submitted for Desk Review:**<br>• EOCCO Service Authorization-Referral Request Policy.pdf<br>• EOCCO Delay Letter Template.docx<br>• Medicaid Expedited Timeline for Sending a Delay Letter for Request Addtl Info.pdf<br>• Medicaid Standard Timeline for Sending a Delay Letter for Request Addtl Info(1).pdf<br>• Extension Notice Sample 1.pdf- Pgs. 1 & 6<br>• BH Auth Case Sample Hold_Acute_DC plan with County.pdf- Pg. 5<br>• Current EOCCO Provider Manual 10.5.2021.pdf<br>• Case Sample 1 BH SUD Detox Auth Approval.pdf<br>• Case Sample 3 BH NOABD.pdf | |

| Standard IV—Coverage and Authorization of Services (42 CFR §438.210) | | |
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| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| *42 CFR §438.404(c)(4)*<br>*Contract: Exhibit B Part 2(3)(b)(11);(12)*<br>*OAR 410-141-3835(10)(a)(A)*<br>*OAR 410-141-3835(10)(a)(B)(i)*<br>*OAR 410-141-3835(10)(g)(A)* | | |

**HSAG Findings:** The *Service Authorization-Referral Request* policy addressed the required time frames for making standard and expedited coverage decisions. However, the policy did not address the CCO requirement to make three attempts using two methods to obtain information. Likewise, the policy did not address the CCO requirement to inform the member of his/her right to file a grievance if he/she disagreed with a time frame extension. However, the Government Prior Authorization and RN Care Coordinator Training Manual presented during the site visit did include the requirement of the CCO to make three attempts using two different methods to obtain information. The *Notice of Adverse Benefit Determination* policy, submitted with element 10, included the provision to inform the member of the right to file a grievance if he or she disagreed with the decision. This also included the provision to make reasonable attempts to provide oral notice of the decision's rationale to extend the time frame. This provision included an obligation to inform the member of the right to file a grievance if he/she disagreed with the extension. However, the Delay Letter Template and Extension Notice Sample 1 document submitted did not include the member's right to grieve the extension—this omission also was noted during file reviews.

During the site visit, the CCO also demonstrated that it was tracking prior authorization decisions made by the CCO and its subcontractors. This requirement was *Partially Met.*

**Required Actions:** The CCO must revise its *Service Authorization-Referral Request* policy to include the requirements that the CCO and its subcontractors make three attempts using two different methods to obtain information. In addition, the CCO must update its Delay Letter Template to include the member's right to grieve the extension.

**Recommendations:** HSAG recommends that the CCO include these provisions to:

- Make reasonable attempts to provide oral notice of the decision's reasoning extending the authorization time frame.
- Inform the member of the right to file a grievance. That is, if he or she disagrees with the decision to extend the authorization time frame within its *Service and Authorization-Referral Request* policy, the member may file a grievance.

These recommendations are given to ensure consistency among policies and support compliance with the requirements, noting that the policy submitted did not include all the required elements.

| 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).<br>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:<br>i. For standard service authorization decisions that deny or limit services, within 14 calendar days of the request for authorization.<br>ii. For expedited service authorization decisions, within 72 hours of the request for authorization.<br>iii. For service authorization decisions not reached within the required time frames specified in §438.210(d), on the date these time frames expire.<br>*42 CFR §438.210(c);(d)*<br>*Contract: Exhibit B Part 2(3)(b)(11);(17);(18)*<br>*OAR 410-141-3835(10)(d);(e)* | **Suggested Documents:**<br>• Coverage and authorization policies and procedures<br>• UM plan/UR policies and procedures<br>• Service Authorization Handbook<br>• NOABD turn-around-time tracking<br>• NOABD letter template<br>• Three examples of NOABD sent to a member for service authorizations not reached within the required timeframes<br>*HSAG will also use the results of the service authorization and denial file review<br>**Documents Submitted for Desk Review:**<br>• EOCCO Notice of Adverse Benefit Policy.pdf<br>• Current EOCCO Provider Manual 10.5.2022.pdf<br>• NOABD Sample 1.pdf- Pg. 3<br>• EOCCO Service Authorization-Referral Request Policy.pdf- III. A. 1. b. ; III. B. 3. ; III. B. 5<br>• Case Sample 1 BH Eating Disorder NOABD.pdf | ☒ Met<br>☐ Partially Met<br>☐ 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** |
| 11. Policies and procedures for processing authorization requests specify time frames for the following:<br>a. Date and time stamping prior authorization requests when received.<br>b. Determining within a specific number of days from receipt whether a prior authorization request is valid or non-valid.<br>c. The specific number of days allowed for follow-up on pended prior authorization requests to obtain additional information.<br>d. The specific number of days following receipt of the additional information that an approval or denial shall be issued.<br>e. Providing services after office hours and on weekends that require prior authorization.<br><br>*42 CFR §438.210(b)(1)*<br>*OAR 410-141-3835(10)(f)(C)* | **Suggested Documents:**<br>• Coverage and authorization policies and procedures<br>• UM plan/UR policies and procedures<br>**Documents Submitted for Desk Review:**<br>• Weekend Processing Prior Auth.pdf<br>• EOCCO Service Authorizations/Referral Request Policy.pdf<br>• PA Sample 3.pdf- Pgs. 1 & 10<br>• PA Sample 4.pdf- Pgs. 1 & 16<br>• BH Auth Case Sample Hold_Acute_DC plan with County.pdf- Pg. 5<br>• Current EOCCO Provider Manual 10.5.2021.pdf- Pg. 41<br>• EOCCO Medical Management Program and Clinical Decisions Policy.pdf III. B. ; III. B. 3.<br>• EOCCO NEMT Covered Services Policy.pdf- III. G. 1<br>• Case Sample 3 BH NOABD.pdf<br>• Case Sample 1 BH SUD Detox Auth Approval.pdf<br>• 2022 On Call UM Coverage Calendar for After Hours.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met |
| **HSAG Findings:** The *Service Authorization-Referral Request* policy included the provision that the CCO is to date and time stamp prior authorization requests for drugs only, not all service requests. The *Medical Management Program and Clinical Decisions* policy also did not address the date and time stamp requirements. However, the Medicaid Loading of Outpatient Requests process document (presented during the | | |

| Standard IV—Coverage and Authorization of Services (42 CFR §438.210) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| site visit) included a process to date and time stamp all requests. The *Service Authorization-Referral Request* policy also did not specify time frames for:<br>• Determining prior authorization request validity;<br>• Following up on pending prior authorization requests to obtain additional information;<br>• Making approval or denial decisions following receipt of additional information; or<br>• Providing services after office hours or on weekends that require prior authorization.<br>However, the Denial Delay Letter workflow document (also presented during the site visit) included the CCO's process for sending an extension letter within 24 hours when additional information is needed, and holding the authorization for 10 days while the CCO waits for additional information. The Weekend Prior Auth document included guidelines for identifying missed and unindexed government rushes and pharmacy faxes only, and the 2022 On Call UM Coverage Calendar for After Hours document pertained to the Greater Oregon Behavioral Health Inc. subcontractor only. However, the Government Prior Authorization and RN Care Coordinator Training Manual included the CCO's weekend and holiday coverage process, and the CCO presented its holiday and weekend coverage calendar that applied to all UM staff. This requirement was *Met*. | | |
| **Required Actions:** None. | | |
| **Recommendations:** HSAG recommends that the CCO update its *Service Authorization-Referral Request* policy to include the specified requirements of this element and/or include a reference within this policy to the various policies and workflow documents addressing the requirements. | | |
| 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.<br><br>**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.*<br><br>*42 CFR §438.404(c)*<br>*Contract: Exhibit I(3)(b)(2)*<br>*OAR 410-141-3875(1)(C)* | **Suggested Documents:**<br>• Claims denial of payment policies and procedures<br>• Plan documents outlining requirement to provide NOABD at the time of any denial affecting the claim<br>• Workflow for payment denial on a claim to trigger NOABD<br>• Three examples of NOABD sent to a member for the denial of payment on a claim | ☐ Met<br>☒ Partially Met<br>☐ Not Met |

| Standard IV—Coverage and Authorization of Services (42 CFR §438.210) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | • NOABD turn-around-time tracking<br>• Denial of claims payment NOABD letter template<br>*HSAG will also use the results of the service authorization file review<br>**Documents Submitted for Desk Review:**<br>• Case Sample 4 BH NOABD.pdf<br>• Current EOCCO Provider Manual 10.5.2021.pdf- Pg. 45<br>• EOCCO Notice of Adverse Benefit Determination Policy.pdf- II. A. ; II. E. ; III. C. 1. a. ; III. D. 2. c.<br>• TAT UM Dashboard Report 2022.pdf | |
| **HSAG Findings:** The *Notice of Adverse Benefit Determination* policy stated that the CCO is to mail the Notice of Action for Denial of Payment Affecting a Clean Claim in "as few as five calendar days" when the CCO has denied payment for a claim.<br>However, during the site visit, the CCO reported that it had not implemented its process for sending NOABDs for claim denials in calendar year (CY) 2022. The CCO reported it had implemented its system for CY 2023 and described its current process for issuing claims NOABDs, which included the CCO's process for determining clean claims. This requirement was *Partially Met.* | | |
| **Required Actions:** There are no additional required actions for this finding because the CCO had implemented its process for sending claim denial NOABDs in CY 2023. | | |
| 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:<br>a. The CCO gives notice on or before the date of action if: | **Suggested Documents:**<br>• Coverage and authorization policies and procedures<br>• Service Authorization Handbook<br>• UM plan/UR policies and procedures<br>• Advance NOABD letter template | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard IV—Coverage and Authorization of Services (42 CFR §438.210) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| i. The agency has factual information confirming the death of a member.<br>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.<br>iii. The member has been admitted to an institution where he/she is ineligible under the plan for further services.<br>iv. The member's whereabouts are unknown, and the post office returns agency mail directed to him/her indicating no forwarding address.<br>v. The agency establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, State, territory, or commonwealth.<br>vi. A change in the level of medical care is prescribed by the member's physician.<br>vii. The notice involves an adverse determination made with regard to the preadmission screening requirements.<br>b. If probable member fraud has been verified, the CCO gives notice five (5) calendar days before the date of action.<br>*42 CFR §438.404(c); §431.211; §431.213; §431.214*<br>*Contract: Exhibit I(3)(b)(1)*<br>*OAR 410-141-3885(5);(6)* | • NOABD turn-around-time tracking for previously authorized services<br>• Three examples of an NOABD sent to a member for the termination, suspension, or reduction of a previously authorized service<br>• Three examples of an NOABD sent to a member due to probable fraud<br>*HSAG will also use the results of the service authorization file review<br>**Documents Submitted for Desk Review:**<br>• EOCCO Notice of Adverse Benefit Determination Policy.pdf<br>• EOCCO Service Authorization-Referral Request Policy.pdf- III. C.<br>*HSAG will also use the results of the service authorization file review | |
| **HSAG Findings:** The *Notice of Adverse Benefit Determination* policy addressed the requirements of this element. During the site visit, the CCO reported that it did not deny or reduce services that had been previously approved. The CCO also confirmed that contracted benefits do | | |

| Standard IV—Coverage and Authorization of Services (42 CFR §438.210) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| not include long-term services (e.g., LTSS and meal plans) that would be subject to termination or modification prior to the end of the authorization period. This requirement was *Met.* | | |
| **Required Actions:** None. | | |
| **Recommendations:** HSAG recommends that the CCO update its policy to reflect its current process, which includes upholding prior authorization decisions and not terminating or modifying services prior to the end of the authorization period. | | |
| 14. The notice of adverse benefit determination must be in writing and meet the language and format requirements of 42 CFR §438.10(c).<br>*42 CFR §438.404(a)*<br>*Contract: Exhibit I(3)(a)(1)*<br>*OAR 410-141-3835(10)(e)* | **Suggested Documents:**<br>• Coverage and authorization policies and procedures<br>• Service Authorization Handbook<br>• NOABD letter template<br>**Documents Submitted for Desk Review:**<br>• EOCCO NOABD template FINAL APPROVED 12.22.2022.pdf- Pg. 6-8<br>• Case Sample 4 BH NOABD.pdf<br>• EOCCO Notice of Adverse Benefit Determination Policy: III. B. | ☐ Met<br>☒ Partially Met<br>☐ Not Met |
| **HSAG Findings:** The *Notice of Adverse Benefit Determination* policy stated that the NOABD would be "Provided using easily understood language and format. OHA defines "easily understood" as sixth-grade reading level or lower using the Flesch-Kincaid readability scale. EOCCO uses a minimum 12-point font or large print (18 point); Includes a language access statement which, at a minimum, is translated to the prevalent languages in EOCCO's service area; Includes taglines in large print (18 point) and prevalent non-English language describing how to request auxiliary aids and services, including written translation or oral interpretation and toll-free and TTY/TDD customer service number, and availability of materials in alternative formats provided at no cost to the member."<br>File reviews for eviCore, AllMed, and Oregon Dental Services revealed readability above the sixth-grade reading level and CCO NOABDs with language access tag lines less than 18-point font. This requirement was *Partially Met.* | | |
| **Required Actions:** The CCO must ensure all NOABDs sent to members by the CCO and its subcontractors meet the language and readability requirements specified in this element. | | |

| Standard IV—Coverage and Authorization of Services (42 CFR §438.210) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| **Recommendations:** HSAG recommends that the CCO implement processes to monitor NOABDs generated internally regularly and by subcontractors to ensure notices meet the language and readability requirements. | | |
| 15. The notice of adverse benefit determination explains the following:<br>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;<br>b. CCO contact information including name, address, and telephone number;<br>c. Date of the notice;<br>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;<br>e. Member's name, date of birth, address, and OHP ID number;<br>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;<br>g. Date the service was requested by the provider or member;<br>h. Name of the provider who requested the service; | **Suggested Documents:**<br>• Coverage and authorization policies and procedures<br>• Service Authorization Handbook<br>• NOABD letter template<br>*HSAG will also use the results of the service authorization file review<br>**Documents Submitted for Desk Review:**<br>• EOCCO Notice of Adverse Benefit Determination Policy.pdf- Sec. III. B. 3.<br>• EOCCO NOABD template FINAL APPROVED 12.22.2022.df<br>• NOABD Sample 4.pdf- Pgs. 2-21 | ☐ Met<br>☒ Partially Met<br>☐ Not Met |

| Standard IV—Coverage and Authorization of Services (42 CFR §438.210) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| i. Effective date of the adverse benefit determination if different from the date of the NOABD;<br>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;<br>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;<br>l. Clear and thorough explanation of the specific reasons for the adverse benefit determination;<br>m. A reference to the specific sections of the statutes and administrative rules to the highest level of specificity for each reason and specific circumstances identified in the NOABD;<br>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;<br>o. The member's or the provider's right to request a contested case hearing with OHA only after CCO's | | |

| Standard IV—Coverage and Authorization of Services (42 CFR §438.210) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| 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;<br>p. The circumstances under which an expedited appeal resolution and an expedited contested case hearing are available and how to request;<br>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;<br>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<br>s. Copies of the appropriate forms as listed in OAR 410-141-3885.<br>*42 CFR §438.404(b)*<br>*Contract: Exhibit I(3)(a)(2)*<br>*OAR 410-141-3835(10)(e)* | | |
| **HSAG Findings:** The *Notice of Adverse Benefit Determination* policy addressed all the requirements of this element. The NOABD template FINAL APPROVED 12.22.2022 submitted by the CCO included all the stated requirements.<br>However, file reviews of NOABDs from the CCO and its subcontractors revealed the following omissions and/or misalignments with the CFR requirements:<br>• Advising members to have their provider ask for authorization request rather than appeal the decision.<br>• Including unclear reasons for the denial (e.g., communicating that the authorization was denied due to lack of documentation, but also including a statement that records were reviewed for another condition).<br>• Including OAR citations that were specific to the health plan having policies and procedures for authorizing services rather than specific reasons for the denial. | | |

| Standard IV—Coverage and Authorization of Services (42 CFR §438.210) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| • Informing the member that appeals may be expedited "If your [the] appeal qualifies…." However, it did not provide circumstances warranting expedited appeals or the member's ability to grieve the CCO's denial of an expedited appeal.<br>The reviewer also noted not all notices included diagnosis and procedure codes submitted with the authorization request. However, written notice requirements provided in the template from or at the direction of OHA will not be captured in the CY 2023 compliance review scoring. Furthermore, the finding will be limited to content that was not provided by or at the direction of OHA. This requirement was *Partially Met*. | | |
| **Required Actions:** The CCO must ensure all NOABDs sent by the CCO and its subcontractors include the required content. | | |
| **Recommendations:** HSAG recommends that the CCO review the most recent versions of its templates to ensure that minimum State and federal requirements are captured, and any omissions in the template should be discussed with OHA and will be assessed during this standard's subsequent compliance review. 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 its subcontractors to ensure that notices contain appropriate content and clearly communicate information to members. | | |
| 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:<br>a. The sixty (60) days' time limit for filing an Appeal;<br>b. The toll-free numbers that the Member can use to file an Appeal by phone;<br>c. The availability of assistance in the filing process;<br>d. The process to request a Contested Case Hearing after an Appeal;<br>e. The rules that govern representation at the Contested Case Hearing; and<br>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. | **Suggested Documents:**<br>• Appeal policies and procedures<br>• Member materials, such as the member handbook<br>• NOABD notices<br>*HSAG will also review compliance through file reviews.<br>**Documents Submitted for Desk Review:**<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• NOABD Sample 4.pdf- Pg. 6, 11, 15<br>• EOCCO Notice of Adverse Benefit Determination.pdf- Sec. III. B. 3. n-o<br>• Current EOCCO Provider Manual 10.5.2021.pdf Pg. 45 | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard IV—Coverage and Authorization of Services (42 CFR §438.210) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| *Contract: Exhibit I (4)(a)(4)* | • EOCCO Medicaid Member Grievances and Appeals Policy.pdf II. C. ; III. A. 1. ; III. B. 3. ; III. I. 1. o.<br>• EOCCO OHA Contested Case Hearings Policy.pdf II. B. C. D. | |
| **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.<br>*42 CFR §438.210(e)*<br>*Contract: Exhibit B Part 2(2)(d)*<br>*OAR 410-141-3835(9)(d)* | **Suggested Documents:**<br>• UM plan/UR policies and procedures<br>• UM staff messaging/training materials<br>**Documents Submitted for Desk Review:**<br>• 2022 EOCCO Interator Reliability Testing Summary.pdf<br>• EOCCO Medical Management Program and Clinical Decisions Policy.pdf- Sec. III. F.<br>• eviCore Contract.pdf Article 3.2<br>• Magellan Rx Contract.pdf<br>• EOCCO Service Authorization-Referral Request Policy.pdf<br>• code_of_conduct.pdf<br>• Current EOCCO Provider Manual 10.5.2021: Pg. 45<br>• EOCCO Medicaid Member Grievances and Appeals Policy.pdf- III. G. 5. | ☒ Met<br>☐ Partially Met<br>☐ 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** |
| 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.<br>*42 CFR §438.210(d)(3)*<br>*42 U.S. Code §1396r-8(d)(5)*<br>*Contract: Exhibit B Part 2(3)(b)(13)*<br>*OAR 410-141-3835(10)(b)* | **Suggested Documents:**<br>• Coverage and authorization policies and procedures<br>• Service Authorization Handbook<br>• UM plan/UR policies and procedures<br>• Pharmacy authorization turn-around-time tracking<br>*HSAG will also use the results of the prior authorization and denial file review<br>**Documents Submitted for Desk Review:**<br>• PAD Auth Sample.pdf<br>• EOCCO Service Authorization-Referral Request Policy.pdf Sec. III. B. 3.<br>• EOCCO Notice of Adverse Benefit Determination Policy.pdf Sec. III. E | ☐ Met<br>☒ Partially Met<br>☐ Not Met |
| **HSAG Findings:** The *Service Authorization-Referral Request* and *Notice of Adverse Benefit Determination* policies addressed the requirements of this element. The CCO submitted a sample pharmacy authorization and the Magellan Rx-Q42022 Moda Determination TAT Medicaid tracking spreadsheet that demonstrated a turnaround-time performance standard of 14 days, which did not align with the CCO's policy or the OAR that requires a response within 24 hours and a decision within 72 hours. In addition, the tracking spreadsheet did not demonstrate monitoring of responses within 24 hours. File reviews also demonstrated decision time frames greater than 72 hours.<br>During the site visit, the CCO reported that it had discovered its subcontractor was using the wrong time frames for making pharmacy decisions and the CCO corrected the issue for CY 2023, which was demonstrated through reporting dashboards. However, the CCO did not demonstrate monitoring for the 24-hour response time frame. This requirement was *Partially Met*. | | |
| **Required Actions:** The CCO must demonstrate monitoring its pharmacy subcontractor's 24-hour response time frames. | | |

| Results for Standard IV—Coverage and Authorization of Services | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Total** | Met | = | 10 | X | 1.0 | = | 10.0 |
| | Partially Met | = | 8 | X | 0.5 | = | 4.0 |
| | Not Met | = | 0 | X | 0.0 | = | 0.0 |
| **Total Applicable** | | = | 18 | **Total Score** | | = | 14.0 |

| | | |
|---|---|---|
| **Total Score ÷ Total Applicable** | = | **77.8%** |

# 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:<br>a. Communicates these policies and procedures to employees and participating providers; and<br>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.<br>*42 CFR §438.100(a)(1) and (2)*<br>*Contract: Exhibit B Part 3 (2)*<br>*OAR 410-141-3590 (1)* | • Documents Submitted for Desk Review:<br>• EOCCO Members- Rights and Responsibilities Policy.pdf<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf. Pg 71<br>• Current EOCCO Provider Manual 10.5.2022.pdf - Pg 19-20<br>• EOCCO NOPP Website URL: EOCCO Notice of privacy practices<br>• EOCCO QIC October 24_Meeting Minutes.docx-<br>• EOCCO Participating Provider Agreement.pdf- Pg 6, 11, 16<br>• SAMPLE NEMT BPA_2022 _.pdf- Pg. 18<br>• 9/5 – Training Documentation | ☒ Met<br>☐ Partially Met<br>☐ 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:<br>a. Be treated with respect and with due consideration for his or her dignity and privacy.<br>b. Receive information in accordance with information requirements (42 CFR §438.10). | **Documents Submitted for Desk Review:**<br>• EOCCO Revised Ride Guide 08.2022_Compiled.pdf- Pg. 12<br>• EOCCO Members- Rights and Responsibilities Policy.pdf - III. A. 1., 2., 10, 12, 14, 15, 17, 36 ; III. A. | ☐ Met<br>☒ Partially Met<br>☐ Not Met |

| Standard VII—Member Rights and Protections (42 CFR §438.100) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| 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.<br>d. Participate in decisions regarding his or her healthcare, including the right to refuse treatment, including:<br>i. Being actively involved in the development of treatment plans and have family involved in such treatment planning.<br>ii. Having the opportunity to execute a statement of wishes, including the right to accept or refuse medical, surgical, or behavioral health treatment<br>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.<br>e. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.<br>f. Request and receive a copy of his or her medical records and request that they be amended or corrected.<br>g. Be furnished with health care services in accordance with § 438.206 through 438.210.<br>h. Choose their own health professional from available participating providers and facilities to the extent possible and appropriate.<br>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 | • EOCCO Member Request for Material Translation and Alternative Formats Policy.pdf<br>• EOCCO Access Plan Policy.pdf<br>• EOCCO Individual Request for Amendment of Protected Health Information Policy.pdf Pg. 1 and 2.<br>• Current EOCCO Provider Manual 10.5.2022 Pg.19-20<br>• 2022 EOCCO Member Handbook_Compiled_04132023 -Pg 71, 80<br>• EOCCO NOPP Website URL: EOCCO Notice of privacy practices<br>• EOCCO Participating Provider Agreement.pdf - Pg 6, 11, 16<br>• EOCCO Use of Seclusion and Restraint policy.pdf<br>• EOCCO Nondiscrimination Statement.pdf-Entire Notice<br>• pcp_change_eng.pdf<br>• EOCCO Care Coordination Policy.pdf<br>• EOCCO Service Authorization-Referral Request Policy.pdf<br>• EOCCO Care Coordination Policy.pdf<br>• EOCCO QIC April 2022_Meeting Minutes.docx | |

| Standard VII—Member Rights and Protections (42 CFR §438.100) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| Contractor, OHA, the Bureau of Labor and Industries, or the Office of Civil Rights.<br>*42 CFR §438.100(b)(2-3)*<br>*Contract Exhibit B Part 3 (2)*<br>*OAR 410-141-3590 (2)* | • EOCCO QIC October 24_Meeting Minutes.docx | |
| **HSAG Findings:** The *EOCCO Members' Rights and Responsibilities Policy* provided a list of member rights that aligned most of the required elements. However, the policy did not include the right of a member to be treated with due consideration for his or her privacy. The CCO's member handbook mirrored the rights listed in the policy and included the member's right to be given due consideration for his or her privacy. Neither the provider manual nor the sample participating provider agreement template included the right of members to report discrimination by contacting the CCO, Bureau of Labor and Industries, or the Office of Civil Rights, in addition to OHA. During the site visit, HSAG reviewed the findings and requested clarification regarding the omission of these elements from its policy and provider manual. The CCO reported that while these elements were not documented within its member rights policy, the CCO included a section on confidentiality within the *EOCCO Medicaid Member Grievances and Appeals Policy.* However, this policy was limited to the treatment of personal health information (PHI) related to grievances and appeals. This requirement was *Partially Met*. | | |
| **Required Actions:** The CCO must update its policy to include the member's right to be treated with due consideration for his or her privacy. | | |
| **Recommendation:** The CCO should update its provider manual and provider agreements to include the member's right to report a complaint of discrimination by contacting the CCO, Bureau of Labor and Industries, or the Office of Civil Rights, in addition to OHA. Further, its update should include the information necessary to file a discrimination claim to ensure that all member rights listed in the requirement are present and compliant across relevant policies and materials. | | |
| 3. The CCO ensures that each member is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the CCO, its network providers, or the State treats the member.<br>*42 CFR §438.100(c)*<br>*Contract: Exhibit B Part 3 (2)(o)* | **Documents Submitted for Desk Review:**<br>• EOCCO Advance Directive Policy.pdf- III. E. 3.<br>• EOCCO Medicaid Member Grievances and Appeals Policy.pdf I. Paragraph 1<br>• EOCCO Medicaid Member Non-Discrimination Policy.pdf I.<br>• EOCCO Revised Ride Guide 08.2022_Compiled.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard VII—Member Rights and Protections (42 CFR §438.100) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | • Current EOCCO Provider Manual 10.5.2022.pdf- Pg 19-20<br>• EOCCO Members- Rights and Responsibilities Policy.pdf- Pg 2 | |
| **HSAG Findings:** While this element is not specifically addressed within the *Members' Rights and Responsibilities* policy, the CCO's policy does correctly list all members' rights and identifies how it actively monitors for compliance. Additionally, the *Advance Directive* policy and *EOCCO Medicaid Member Grievances and Appeals* policy noted that the plan and its providers may not treat a member adversely for exercising his or her rights. The member handbook stated that a member is free to exercise his/her rights and that exercising those rights does not adversely affect his/her treatment. Additionally, while the sample provider agreement stated that providers cannot penalize a member in any way due to a member exercising his or her rights, a statement affirming this requirement was missing from the provider manual. This requirement was *Met*. | | |
| **Required Actions:** None. | | |
| **Recommendation:** HSAG recommends updating the *Members' Rights and Responsibilities* policy and provider manual to include a statement that the member is free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the CCO, its network providers, or the State treats the member to ensure that staff and providers understand the full scope of the right. | | |
| 4. The CCO has written policies regarding compliance with other federal and State laws and must:<br>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.<br>b. Provide 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. | **Documents Submitted for Desk Review:**<br>• *EOCCO Nondiscrimination Statement*.pdf<br>• EOCCO Medicaid Member Grievances and Appeals Policy.pdf- III. I. 1. o. x<br>• EOCCO Medicaid Member Non-Discrimination Policy.pdf I. ; III. A ; III. C<br>• EOCCO Member Services and Outreach Communication Policy.pdf: III. A. 7.<br>• Sample NEMT BPA_2022.pdf- Pg. 70<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf- Pg 80 | ☐ Met<br>☒ Partially Met<br>☐ Not Met |

| Standard VII—Member Rights and Protections (42 CFR §438.100) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| 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.<br>*42 CFR §438.100(a)(2);(d)*<br>*Contract: Exhibit B Part 3 (2)(b-d)* | • EOCCO Revised Ride Guide 08.2022_Compiled.pdf- Pg 2, 13, 23<br>• EOCCO Website: EOCCO Nondiscrimination notice<br>• REV2-0788-EOCCO-Postcard Annual Notice_FINAL_Print.pdf | |
| **HSAG Findings:** The *Medicaid Member Non-Discrimination* policy articulated the CCO's commitment to ensure each member's civil rights are protected and documented both the regulatory requirements and its process for communicating non-discrimination information to any member through its member handbook, welcome packet, appeals and grievances notices, communications, and the CCO's website. The policy contained options for submitting grievances related to discrimination to EOCCO, OHA, the Bureau of Labor and Industries (BOLI), and the Office of Civil Rights (OCR). These options were also present in the CCO's *Medicaid Member Grievances and Appeals* policy. While the provider manual stated that each member had the right to be treated fairly and file a complaint of discrimination, the provider manual did not address equal access for males and females under 18 years of age (i.e., 4b) or member civil rights (i.e., 4c). This information was also absent from the participating provider agreement and provider training materials submitted prior to the site visit. During the site visit, HSAG confirmed that the training documents previously provided reflected the primary mechanisms for educating providers on the CCO's non-discrimination policies. The CCO also noted that all policies are posted and available in its online provider portal and required providers to complete a global attestation affirming their review. However, the global attestation form did not include documentation of providers' receipt/review of the CCO's non-discrimination policy nor did its training address these elements. Meeting minutes from the CCO's Quality Improvement Committee (QIC) showed review of grievances related to discrimination. This requirement was *Partially Met*. | | |
| **Required Actions:** The CCO must ensure its contracted providers are informed of its non-discrimination policies and procedures. Based on current documentation, this includes updates to the CCO's provider manual and training materials to ensure elements 4b and 4c are included in the documentation. | | |

| 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:<br>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.<br>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:<br>i. Clarify the difference between institution-wide conscientious objections and those raised by individual physicians.<br>ii. Identify the State legal authority permitting such objection.<br>iii. Describe the range of medical conditions or procedures affected by the conscientious objection.<br>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.<br>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 | **Documents Submitted for Desk Review:**<br>• EOCCO Advance Directive Policy.pdf<br>• EOCCO Website (bottom of page): General resources (eocco.com)<br>• Advance Directive Policy summary on website: 2022_EOCCO-Advance-Directive-Summary.pdf<br>• 2022 Advance Directive Training Tracker.xlsx<br>• Consumer Caucus Meeting Minutes 9.28.2022.docx- Pg. 1-2<br>• EOCCO Website: State of Oregon Advance Directive Form (eocco.com) | ☐ Met<br>☒ Partially Met<br>☐ Not Met |

| Standard VII—Member Rights and Protections (42 CFR §438.100) | | |
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| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| ensure that the information is given to the individual directly at the appropriate time<br>e. Provisions for documenting in a prominent part of the member's medical record whether or not the member has executed an advance directive.<br>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.<br>g. Provisions for ensuring compliance with State laws regarding advance directives.<br>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.<br>i. Provisions for the education of staff concerning its policies and procedures on advance directives.<br>j. Provisions for community education regarding advance directives that include:<br>i. What constitutes an advance directive.<br>ii. Emphasis that an advance directive is designed to enhance an incapacitated individual's control over medical treatment.<br>iii. Description of applicable State law concerning advance directives.<br>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.<br>*42 CFR §438.3(j)*<br>*42 CFR §422.128*<br>*Contract: Exhibit E (14)* | | |

**HSAG Findings:** The CCO's *EOCCO Advance Directive* policy stated the member's right to create an advance directive, appoint an individual to speak for him/her when he/she is incapacitated, and to accept or reject health care. The policy stated that:

- The CCO would not refuse to implement a member's advance directive, even as a matter of conscience.
- The CCO and its participating providers were responsible for providing information.
- Physical and behavioral health providers were expected to prominently display the existence of an advance directive for members within their clinical records.
- Members were not required to have an advance directive, and that provision of care would not be contingent on whether or not a member had executed an advance directive.
- CCO staff are educated upon hire and updated as necessary regarding advance directives, including the provision of written information via the member handbook, website, and other written information.
- The CCO provided community education via its written materials as well as its website, which contained information on the CCO's policies as well as registration options for a quarterly community education webinar.
- Members may file grievances related to advance directives with OHA.
- Information regarding advance directives were provided to members upon enrollment via the member handbook and via the website.

The policy also documented provisions for providing advance directive information to each member's families or surrogates if the member were incapacitated at the time of initial enrollment. Further, the policy required the provision of advance directive information to the member once he/she was no longer incapacitated. The policy stated that a member would be given notification of changes in State laws regarding advance directives within 90 days of changes, yet no process for doing so (e.g., member mailing, etc.) was documented. During the site visit, CCO staff noted that communication of changes to State laws regarding advance directives would be communicated via its website, and provided a notification copy.

Additionally, while the policy stated that the CCO would conduct reviews of subcontractor and participating providers' advance directive policies and procedures, the policy did not specify the applicable providers (i.e., hospitals, critical access hospitals, skilled nursing facilities [SNFs], nursing facilities, home health agencies, providers of home health/personal care, hospices, and religious nonmedical health care institutions) required to comply with the 42 CFR 489.102 requirement to maintain advance directive policies and procedures. The policy also

| Standard VII—Member Rights and Protections (42 CFR §438.100) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| stated that providers were required to supply information about advance directives but did not state that providers were required to honor advance directives. During the site visit, the CCO stated that all providers received training and information on advance directives, including the provider manual. However, the CCO confirmed that required institutional providers (e.g., hospitals, SNFs, etc.) do not receive the provider manual or training on advance directives. Additionally, the CCO confirmed that there are currently no processes in place to verify and/or hold required providers to these requirements. In follow-up to the site visit, the CCO provided copies of its participating provider agreement, a sample hospital's advance directives policy, and a copy of training and training notices.<br>The CCO's member handbook informed each member of his/her rights to create an advance directive or other document describing his/her end-of-life wishes. The handbook further informed the member of his/her right to appoint an individual to speak for him/her in case of incapacitation, and to accept or reject health care. The member handbook provided information on advance directives as well an option to contact the CCO for additional information. The handbook further stated that the member was not required to complete an advance directive, nor would the presence or absence of one affect his/her care or treatment. Each member was informed of how to file a grievance related to advance directives. However, while the handbook supplied information on where to file a grievance related to advance directives, neither the CCO's policy nor its member handbook listed the specific entity referenced in OHA's model member handbook (i.e., Health Licensing Office).<br>The CCO's provider manual stated the right of every adult member to create a statement of treatment wishes, including the right to accept or refuse treatment, appoint a spokesperson, and create an advance directive or other document describing his/her end-of-life care wishes. It was not apparent from the documentation how 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 non-medical health care institutions) were made aware of the requirement to either maintain written policies and procedures concerning advance directives or comply with EOCCO's policies. Additionally, neither the provider agreement nor the provider manual stated that the decision to provide care to a member must not be conditioned on whether the member has executed an advance directive and that a member may not be discriminated against based on whether he/she has executed an advance directive. This requirement was *Partially Met*. | | |
| **Required Actions:** EOCCO must make the following updates to its policies, procedures, member-facing materials, and provider-facing materials:<br>• Update its *Advance Directive* policy to:<br>– Specify the 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) required to comply with the requirement of 42 CFR 489.102 to maintain advance directive policies and procedures.<br>– Include the requirement for providers to honor member advance directives. | | |

| Standard VII—Member Rights and Protections (42 CFR §438.100) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| • Ensure provider-facing materials:<br>– Inform providers of their obligation to honor member advance directives.<br>– Inform providers of their obligations to provide advance directive information to family members or surrogate when a member is incapacitated and provide information to the member once he or she is no longer incapacitated.<br>– State that the decision to provide care to a member is not conditioned on whether the member has executed an advance directive, and that a member may not be discriminated against based on whether he/she has executed an advance directive. | | |
| **Recommendations:** HSAG recommends, as a best practice, that the CCO update the *EOCCO Advance Directive* policy and procedure to include how the CCO informs members of advance directive law and policy changes within 90 days other than through the annual member handbook. HSAG also recommends using the OHA Model Member Handbook as the basis for future iterations of the CCO's member handbook, including identifying the correct OHA offices for filing complaints related to advance directives. Finally, HSAG recommends the CCO update its policy to include the specific entity referenced in OHA's model member handbook (i.e., Health Licensing Office) for receiving and processing grievances associated with advanced directives. | | |

| Standard VII—Member Rights and Protections | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Total** | Met | = | 2 | X | 1.0 | = | 2.0 |
| | Partially Met | = | 3 | X | 0.5 | = | 1.5 |
| | Not Met | = | 0 | X | 0.0 | = | 0.0 |
| **Total Applicable** | | = | 5 | **Total Score** | | = | 3.5 |

| | | |
|---|---|---|
| **Total Score ÷ Total Applicable** | = | **70.0%** |

# 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:<br>a. Discourage a member from using any aspect of the grievance, appeal, or hearing process.<br>b. Encourage any member to withdraw a grievance, appeal, or contested case hearing request already filed.<br>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.<br>d. Take punitive action against a provider who requests an expedited resolution or supports a member's grievance or appeal.<br>*42 CFR §438.400(a)(3) and (b)*<br>*Contract: Exhibit I*<br>*OAR 410-141-3875 (10)*<br>*OAR 410-141-3895 (2)* | **Suggested Documents:**<br>• Grievance and appeal policies and procedures<br>• Reports<br>• (Throughout this standard, HSAG will use results from grievance and appeal record reviews to score the related requirements.)<br>**Documents Submitted for Desk Review:**<br>• EOCCO Medicaid Member Grievances and Appeals Policy.pdf<br>• EOCCO Revised Ride Guide 08.2022_Compiled.pdf<br>• Sample NEMT BPA_2022.pdf<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• Current EOCCO Provider Manual 10.5.2022.pdf<br>• OHA Appeal_Hearing Form_(English)_he3302.pdf<br>• OHA_Hearing Rights (English)_he3030.pdf<br>• EOCCO Complaint form.pdf<br>• New Hire Training-Medical Medicaid(3.20.23).1pptx.pptx | ☒ Met<br>☐ Partially Met<br>☐ 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. | | |
| 2. The CCO defines "adverse benefit determination" as:<br>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.<br>b. The reduction, suspension, or termination of a previously authorized service.<br>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.*<br>d. The failure to provide services in a timely manner, as defined by the State.<br>e. The failure to act within the time frames defined by the State for standard resolution of grievances and appeals.<br>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:<br>i. The service or type of provider (in terms of training, expertise, and specialization) is not available within the CCO's network.<br>ii. The provider is not part of the network, but is the main source of a service to the beneficiary – provided that: | **Suggested Documents:**<br>• Policies and procedures that address denials/adverse benefit determination<br>• Staff training materials<br>• Member handbook<br>• Provider materials, such as provider manual<br>**Documents Submitted for Desk Review:**<br>• EOCCO Medicaid Member Grievances and Appeals Policy.pdf<br>• EOCCO Notice of Adverse Benefit Determination Policy.pdf<br>• EOCCO OHA Contested Case Hearings Policy.pdf<br>• EOCCO Revised Ride Guide 08.2022_Compiled.pdf<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• Current EOCCO Provider Manual 10.5.2022.pdf<br>• New Hire Training-Medical Medicaid(3.20.23).1pptx.pptx | ☐ Met<br>☒ Partially Met<br>☐ Not Met |

| Standard X—Grievance and Appeal Systems (42 CFR §438.228) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| – The provider is given the opportunity to become a participating provider under the same requirements for participation in the CCO's network as other providers of that type.<br>– 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.<br>g. The denial of a member's request to dispute a member's financial liability (cost-sharing, copayments, premiums, deductibles, coinsurance, or other).<br>*42 CFR §438.400(b)*<br>*42 CFR §438.52(b)(2)(ii)*<br>*Contract: Exhibit A*<br>*OAR 410-141-3875 (1)(b)* | | |
| **HSAG Findings:** The *Medicaid Member Grievances and Appeal* and *Notice of Adverse Benefit Determination* policies included the appropriate definition of an "adverse benefit determination." The *Contested Case Hearings* policy also defined an adverse benefit determination but did not address elements (e) through (g). Members and providers are informed of the circumstances regarding denials within the member handbook and provider manual. This requirement was *Partially Met*. | | |
| **Required Actions:** The CCO must revise its *Contested Case Hearings* policy to address components (e) through (g). | | |
| 3. The CCO defines "appeal" as a review by the CCO of an adverse benefit determination.<br>*42 CFR §438.400(b)*<br>*Contract: Exhibit A*<br>*OAR 410-141-3875 (1)(a)* | **Suggested Documents:**<br>• Grievance and appeals policies and procedures<br>• Staff training materials<br>• Member handbook<br>• Provider materials, such as provider manual | ☒ Met<br>☐ Partially Met<br>☐ 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:**<br>• EOCCO Medicaid Member Grievances and Appeals Policy.pdf<br>• EOCCO Revised Ride Guide 08.2022_Compiled.pdf<br>• EOCCO Medicaid Member Grievances and Appeals Policy.pdf<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• Current EOCCO Provider Manual 10.5.2022.pdf | |
| **HSAG Findings:** This requirement was *Met*. | | |
| **Required Actions:** None. | | |
| 4. The CCO defines "grievance" as an expression of dissatisfaction about any matter other than an adverse benefit determination.<br>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.<br>*42 CFR §438.400(b)*<br>*Contract: Exhibit A*<br>*OAR 410-141-3875 (1)(f)* | **Suggested Documents:**<br>• Grievance and appeal policies and procedures<br>• Staff training materials<br>• Member handbook<br>• Provider materials, such as provider manual<br>**Documents Submitted for Desk Review:**<br>• EOCCO Revised Ride Guide 08.2022_Compiled.pdf<br>• Sample NEMT BPA_2022.pdf<br>• EOCCO Medicaid Member Grievances and Appeals Policy.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard X—Grievance and Appeal Systems (42 CFR §438.228) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | • 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• Current EOCCO Provider Manual 10.5.2022.pdf<br>• New Hire Training-Medical Medicaid(3.20.23).1pptx.pptx | |
| **HSAG Findings:** This requirement was *Met*. | | |
| **Required Actions:** None. | | |
| 5. The CCO has provisions for who may file:<br>a. A member may file a grievance (with the State or the CCO), a CCO-level appeal, and may request a contested case hearing.<br>b. With the member's written consent, a provider or authorized representative may file a grievance (with the State or the CCO), an CCO-level appeal, and may request a contested case hearing on behalf of a member.<br>*42 CFR §438.402(c)*<br>*Contract: Exhibit I (1)(c)*<br>*Contract: Exhibit I (1)(c)*<br>*OAR 410-141-3880 (1)* | **Suggested Documents:**<br>• Grievance and appeal policies and procedures<br>• Member handbook<br>• Provider materials, such as provider manual<br>• Staff training materials<br>**Documents Submitted for Desk Review:**<br>• EOCCO Medicaid Member Grievances and Appeals Policy.pdf<br>• EOCCO Revised Ride Guide 08.2022_Compiled.pdf<br>• Sample NEMT BPA_2022.pdf<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• Current EOCCO Provider Manual 10.5.2022.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard X—Grievance and Appeal Systems (42 CFR §438.228) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | • OHA Appeal_Hearing Form_(English)_he3302.pdf<br>• OHA_Hearing Rights (English)_he3030.pdf<br>• EOCCO Complaint form.pdf<br>• New Hire Training-Medical Medicaid(3.20.23).1pptx.pptx<br>• EOCCO letter Grievance Ack Consent needed.docx<br>• EOCCO letter Appeal Ack Consent needed.docx | |
| **HSAG Findings:** This requirement was *Met*. | | |
| **Required Actions:** None. | | |
| 6. The CCO must:<br>a. Allow members to file a grievance at any time.<br>*42 CFR §438.402(c)(2)(i)*<br>*Contract: Exhibit I (1)(d)(1)*<br>*OAR 410-141-3880 (1)* | **Suggested Documents:**<br>• Grievance and appeal policies and procedures<br>• Member handbook<br>• Provider materials, such as provider manual<br>• Staff training materials<br>**Documents Submitted for Desk Review:**<br>• EOCCO Medicaid Member Grievances and Appeals Policy.pdf<br>• EOCCO Revised Ride Guide 08.2022_Compiled.pdf<br>• Sample NEMT BPA_2022.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard X—Grievance and Appeal Systems (42 CFR §438.228) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | • 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• Current EOCCO Provider Manual 10.5.2022.pdf<br>• EOCCO Complaint form.pdf<br>• New Hire Training-Medical Medicaid(3.20.23).1pptx.pptx | |
| **HSAG Findings:** The *Medicaid Member Grievances and Appeal* policy stated that grievances can be filed at any time by the member or their authorized representative. The member handbook and provider manual also complied with this requirement. The provider manual informed providers that they are encouraged to resolve complaints brought to them by their patients. However, the providers are directed to "inform the member that EOCCO has a formal complaint procedure." The intention is to direct members to contact the CCO if they would like to file a grievance. Hence, all statements in member and provider communications should clarify that when filing a grievance, the grievance is not designated as being formal nor informal, and that all grievances received from members will be handled similarly. This requirement was *Met*. | | |
| **Required Actions:** None. | | |
| **Recommendations:** HSAG recommends that the CCO revise the provider manual to remove the word "formal" when referencing the grievance/complaint procedure. | | |
| 7. The CCO must:<br>a. Accept grievances orally or in writing.<br><br>*42 CFR §438.402(c)(3)(i)*<br>*Contract: Exhibit I (e)(2)*<br>*OAR 410-141-3880 (1)* | **Suggested Documents:**<br>• Grievance and appeal policies and procedures<br>• Member handbook<br>• Provider materials, such as provider manual<br>• Grievances and appeals turn-around-time tracking<br>• Staff training materials<br>*HSAG will also assess compliance through file reviews. | ☒ Met<br>☐ Partially Met<br>☐ 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:**<br>• EOCCO Medicaid Member Grievances and Appeals Policy.pdf<br>• EOCCO NEMT Policy.pdf<br>• EOCCO Revised Ride Guide 08.2022_Compiled.pdf<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• Current EOCCO Provider Manual 10.5.2022.pdf<br>• EOCCO Complaint form<br>• New Hire Training-Medical Medicaid (3.20.23).1pptx.pptx | |
| **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:<br>a. An explanation of the decision; or<br>b. Informing the member that a decision will be made within 30 calendar days from the date of the CCO's receipt of the grievance and the reason additional time is necessary.<br>**The CCO may provide its decision related to oral grievances orally but must also respond to oral grievances in writing.*<br>*42 CFR §438.406(b)(1)*<br>*Contract: Exhibit I (2)(f)(1)*<br>*OAR 410-141-3880(2)* | **Suggested Documents:**<br>• Grievance and appeal policies and procedures<br>• Member handbook<br>• Provider materials, such as provider manual<br>• Grievances and appeals turn-around-time tracking<br>• Staff training materials<br>*HSAG will also assess compliance through file reviews. | ☐ Met<br>☒ Partially Met<br>☐ 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:**<br>• EOCCO Medicaid Member Grievances and Appeals Policy.pdf<br>• EOCCO Revised Ride Guide 08.2022_Compiled.pdf<br>• Ex 1 Ack Letter 04_21_22.pdf<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• Current EOCCO Provider Manual 10.5.2022.pdf<br>• EOCCO Letter -Grievance Ack Letter – delay.docx<br>• OHP Date Calculator 2014.xlsx<br>• Medicaid open cases report 12202022.xlsx | |
| **HSAG Findings:** The *Medicaid Member Grievances and Appeal* policy stated that the CCO is to send an acknowledgment letter within five business days of receipt of the grievance. The policy asserted that if a decision is made, the acknowledgment letter is to notify the member that a decision has been made and what the decision is. If a decision has not been made, the acknowledgment letter is to inform the member that the grievance has been received and is being investigated, that a delay is necessary to resolve the grievance, and that the member will receive a decision within 30 calendar days from the date of receipt of the grievance, and specifies the delay reason. The policy also stated that if more information is needed to investigate the grievance, the member is asked to complete an enclosed form. The member handbook and the provider manual informed members and providers of the grievance time frame and that the member will be informed if more information is needed to resolve the grievance.<br>The CCO also provided its open cases report demonstrating ongoing monitoring of all grievance letter time frames for EOCCO, ODS, and GOBHI. During the site visit, staff described how the document is used and color-coded based on when letters/decisions are due. The CCO also provided evidence of monitoring compliance with requirements for the CCO and its subcontractors via the EOCCO Performance Dashboard Master and the Grievance File Review furnished post-site visit. | | |

| Standard X—Grievance and Appeal Systems (42 CFR §438.228) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| The file review results demonstrated that the CCO and its subcontractors complied with sending grievance acknowledgment letters within five business days. None of the acknowledgment letters reviewed were resolved, and all of the letters informed members that the grievance would be resolved within 30 calendar days. However, the file reviews also showed that the CCO and two of three subcontractors responsible for managing grievances, including GOBHI and ODS, issued grievance acknowledgment letters that did not explain why additional time was needed to resolve the grievance. Additionally, it was found that GOBHI had the following statement in its grievance acknowledgment letters, "If you do not agree with us extending our time to work on your appeal, you have the right to file a complaint," which is not appropriate for a "grievance" acknowledgment letter. Advantage Dental Services (ADS), which was also responsible for managing member grievances, included the appropriate information in its acknowledgment letters. This requirement was *Partially Met*. | | |
| **Required Actions:** The CCO must ensure that its grievance acknowledgment letters include why additional time is necessary to resolve grievances beyond the standard five-business-day acknowledgment time frame. The reasons listed should be based on each grievance circumstance and not duplicate language included across all grievance acknowledgment letters. | | |
| **Recommendations:** EOCCO should ensure its subcontractor, GOBHI, revises the following statement, "If you do not agree with us extending our time to work on your appeal, you have the right to file a complaint," to refer to complaints versus appeals. | | |
| 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.<br>**The CCO may provide its decision related to oral grievances orally but must also respond to oral grievances in writing.*<br>*42 CFR §438.408 (b)(1)*<br>*Contract: Exhibit I (2)(f)(2)(a)*<br>*OAR 410-141-3880 (2)* | **Suggested Documents:**<br>• Grievance and appeal policies and procedures<br>• Member handbook<br>• Provider materials, such as provider manual<br>• Grievances and appeals turn-around-time tracking<br>• Staff training materials<br>*HSAG will also assess compliance through file reviews.<br>**Documents Submitted for Desk Review:**<br>• EOCCO Medicaid Member Grievances and Appeals Policy.pdf<br>• EOCCO Revised Ride Guide 08.2022.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard X—Grievance and Appeal Systems (42 CFR §438.228) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | • Ex 1 NEMT Resolution Letter.pdf<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• Current EOCCO Provider Manual 10.5.2022.pdf<br>• OHP Date Calulator 2014 xlsx<br>• Medicaid open cases report 12202022.xlsx<br>• EOCCO Letter- Grievance Resolution.docx | |
| **HSAG Findings:** This requirement was *Met*. | | |
| **Required Actions:** None. | | |
| 10. The grievance resolution notice must meet the following requirements:<br>a. The notice shall address each aspect of the member's grievance and explain the reason for CCO's decision.<br>b. The language in the notice shall be sufficiently clear that a layperson could understand the disposition of the grievance.<br>i. The notice must be in a format and language that may be easily understood by the member.<br>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 telephone. Such telephone numbers shall be included in the notice and are as follows:<br>i. For CSU: 800-273-0557, and<br>ii. For OHA's Ombudsperson: 503-947-2346 or toll free at 877-642-0450. | **Suggested Documents:**<br>• Grievance policies and procedures<br>• Grievance resolution notice template<br>*HSAG will also assess compliance through file reviews.<br>**Documents Submitted for Desk Review:**<br>• EOCCO Medicaid Member Grievances and Appeals Policy.pdf- III. I. 1. a.-i.<br>• EOCCO Revised Ride Guide 08.2022.pdf<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>– Pg.75-79<br>• EOCCO Letter grievance resolution.docx | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard X—Grievance and Appeal Systems (42 CFR §438.228) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| *42 CFR §438.408 (d)(1)*<br>*Contract: Exhibit I (2)(f)(2)*<br>*OAR 410-141-3880 (4)* | | |
| **HSAG Findings:** The *Medicaid Member Grievances and Appeal* policy stated that grievance resolution letters are to be written to be understood by laypersons in the member's preferred language. It further stated the CCO works to accommodate members with disabilities or limited English proficiency and attaches language access taglines to the letters in prevalent non-English languages. The policy also stated that the resolution letter advises members that they can file a grievance with the OHA Ombudsman or the CSU and provides their telephone numbers. The record reviews identified that the records included the required content. However, the resolution letters for the CCO's subcontractor, ADS, were in a font size that was too small—an 11-point font size instead of the required 12-point font for grievance notices. The record review demonstrated that the CCO and its subcontractors used various versions of the language access statement, and some versions did not contain the required 18-point font size. This requirement was not met for the 2023 review. However, at OHA's direction, written notice requirements provided in the template from or at the direction of OHA will not be captured in the 2023 compliance review scoring. 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 subsequent compliance review for this standard. The CCO should also ensure that it implements the appropriate version of the template at the CCO and subcontractor levels. | | |
| 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.<br>*42 CFR §438.406(a)*<br>*Contract: Exhibit I (1)(e)(5)*<br>*OAR 410-141-3875(9)* | **Suggested Documents:**<br>• Grievance and appeals policies and procedures<br>• Member handbook<br>• Provider materials, such as provider manual<br>*HSAG will also assess compliance through file reviews. | ☒ Met<br>☐ Partially Met<br>☐ 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:**<br>• EOCCO Medicaid Member Grievances and Appeals Policy.pdf -III. B. 3.<br>• EOCCO Revised Ride Guide 08.2022.pdf Pg. 27<br>– 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>○ Pg.75-79<br>– OHA Appeal_Hearing Form_(English)_he3302OHA Hearing rights.docx<br>– EOCCO Complaint Form.pdf<br>– OHA_Hearing Rights (English)_he3030.pdf | |
| **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:<br>a. Were not involved in any previous level of review or decision-making nor a subordinate of any such individual.<br>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:<br>i. An appeal of a denial that is based on lack of medical necessity. | **Suggested Documents:**<br>• UR policies and procedures<br>• Grievance and appeals policies and procedures<br>*HSAG will also review compliance through file reviews.<br>**Documents Submitted for Desk Review:**<br>• EOCCO Revised Ride Guide 08.2022.pdf Pg. 28 | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard X—Grievance and Appeal Systems (42 CFR §438.228) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| ii. A grievance regarding the denial of expedited resolution of an appeal.<br>iii. A grievance or appeal that involves clinical issues.<br>c. Take into account all comments, documents, records, and other information submitted by the member or his or her representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.<br>*42 CFR §438.406(b)(2)*<br>*Contract: Exhibit I (1)(e)(8-9)*<br>*OAR 410-141-3875(5)(d)* | • EOCCO Medicaid Member Grievances and Appeals Policy.pdf- III. G. 5.<br>• Current EOCCO Provider Manual 10.5.2022.pdf- page 22-24<br>• OHA Appeal_Hearing Form_(English)_he3302.pdf | |
| **HSAG Findings:** This requirement was *Met*. | | |
| **Required Actions:** None. | | |
| 13. A member may file an appeal with the CCO within 60 calendar days from the date on the notice of adverse benefit determination.<br>*42 CFR §438.402(c)(2)(ii)*<br>*Contract: Exhibit I (1)(d)(2)*<br>*OAR 410-141-3890 (6)(b)* | **Suggested Documents:**<br>• Grievance and appeal policies and procedures<br>• Member handbook<br>• Provider materials, such as provider manual<br>• Training materials<br>*HSAG will also review compliance through file reviews.<br>**Documents Submitted for Desk Review:**<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf- Pg.75-79<br>• EOCCO Medicaid Member Grievances and Appeals Policy: III. A. | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard X—Grievance and Appeal Systems (42 CFR §438.228) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | • Current EOCCO Provider Manual 10.5.2022.pdf- page 22-24<br>• OHA Appeal_Hearing Form_(English)_he3302.docx<br>• EOCCO website, EOCCO member home<br>• New Hire Training- Medical Medicaid (3.20.23).1pptx<br>• OHP Date Calculator 2014.xlsx | |
| **HSAG Findings:** This requirement was *Met*. | | |
| **Required Actions:** None. | | |
| 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.<br><br>*42 CFR §438.402(c)(3)(ii); 438.406(b)(3)*<br>*Contract: Exhibit I (1)(e)*<br>*OAR 410-141-3890 (6)* | **Suggested Documents:**<br>• Member handbook<br>• Grievance and appeal policies and procedures<br>• Provider materials, such as provider manual<br>• Training materials<br>*HSAG will also review compliance through file reviews.<br><br>**Documents Submitted for Desk Review:**<br>• EOCCO Medicaid Member Grievances and Appeals Policy.pdf- III. B. 2 ; III. B. 4<br>• EOCCO Revised Ride Guide 08.2022.pdf<br>• 2022 EOCCO Member Handbook_ Compiled_04132023.pdf- Pg.75-79 | ☐ Met<br>☒ Partially Met<br>☐ Not Met |

| Standard X—Grievance and Appeal Systems (42 CFR §438.228) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | • Current EOCCO Provider Manual 10.5.2022.pdf- page 22-24<br>• OHA Appeal_Hearing Form_(English)_he3302.docx<br>• New Hire Training- Medical Medicaid (3.20.23).1pptx | |
| **HSAG Findings:** The *Medicaid Member Grievances and Appeal* policy stated that members may file appeals orally or in writing. The policy described the CCO's process to ensure oral appeal requests are documented appropriately by staff. During the site visit, the CCO was able to describe processes that demonstrated the CCO's ability to receive and adequately handle oral and written requests in the same manner. The member handbook informed members that they can file an appeal verbally or in writing. However, the provider manual informed providers that appeals must be in writing and followed up with a written appeal, which does not comply with the requirement. This requirement was *Partially Met*. | | |
| **Required Actions:** The CCO must revise the provider manual to remove the requirement that members must follow up an oral appeal with a written appeal. | | |
| 15. The CCO acknowledges receipt of each appeal in writing within the following timeframes:<br>a. For non-expedited/standard appeals: in writing within five business days of receipt, and<br>b. For all expedited appeals: orally and in writing within one business day of receipt.<br>*42 CFR §438.406(b)(1)*<br>*Contract: Exhibit I (4)(a)(1)* | **Suggested Documents:**<br>• Grievance and appeal policies and procedures<br>• Training materials<br>*HSAG will also review compliance through file reviews.<br>**Documents Submitted for Desk Review:**<br>• EOCCO Medicaid Member Grievances and Appeals Policy.pdf- III. D. 3.<br>• EOCCO Revised Ride Guide 08.2022.pdf Pg. 28 | ☐ Met<br>☒ Partially Met<br>☐ Not Met |

| Standard X—Grievance and Appeal Systems (42 CFR §438.228) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | • 2022 EOCCO Member Handbook_ Compiled_04132023.pdf- Pg.75-79<br>• Current EOCCO Provider Manual 10.5.2022.pdf- page 22-24<br>• OHP Date Calulator 2014.xlsx<br>• EOCCO letter appeal ack regular<br>• EOCCO Letter- Appeal Ack Expedited.docx | |
| **HSAG Findings:** The *Medicaid Member Grievances and Appeal* policy stated that the CCO is to acknowledge receipt of appeals in writing within five business days for standard appeals. It further states, for expedited appeals, the CCO is to acknowledge receipt within one business day, orally and in writing. The member handbook and provider manual addressed the standard appeal acknowledgment time frame. During the site visit, the CCO asserted that the daily open cases spreadsheet is used to monitor when requests come in and ensured they would be acknowledged appropriately. The record review demonstrated that the CCO's subcontractor, GOBHI, did not adhere to the acknowledgment time frame for standard appeals, and that the CCO did not adhere to the oral and written acknowledgment time frame for expedited appeals. This requirement was *Partially Met*. | | |
| **Required Actions:** The CCO and its subcontractors must adhere to acknowledgment time frames for standard and expedited appeals. | | |
| 16. The CCO's appeal process must provide:<br>a. That the CCO may have only one level of appeal for members (or providers acting on their behalf).<br>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.)<br>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 | **Suggested Documents:**<br>• Grievance and appeal policies and procedures<br>• Member handbook<br>• Provider materials, such as provider manual<br>*HSAG will also review compliance through file reviews.<br>**Documents Submitted for Desk Review:**<br>• EOCCO Subcontract Requirements Policy.pdf- III. G. | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard X—Grievance and Appeal Systems (42 CFR §438.228) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| 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.<br>d. That adjudication of appeals in a member grievance and appeals process may not be delegated to a subcontractor.<br>e. That included, as parties to the appeal, are:<br>i. The member and his or her representative;<br>ii. The provider acting on the behalf of a member, with written consent from the member;<br>iii. The CCO; and<br>iv. The legal representative of a deceased member's estate.<br>*42 CFR §438.402(b);438.406(b)(4-6)*<br>*Contract: Exhibit I (1)(e)(11)*<br>*OAR:410-141-3890(2);(7)*<br>*OAR 410-141-3875 (14)* | • EOCCO Medicaid Member Grievances and Appeals Policy.pdf- II. H. ; III. A. 1 ; III. B. 6 ; III. E. 2 ; III. F. 4 ; III. N. 3<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf- Pg.75-79<br>• Current EOCCO Provider Manual 10.5.2022.pdf- page 22-24<br>• EOCCO_ Appeal Resolution_ Narrative.docx<br>• OHA Appeal_Hearing Form_(English)_he3302.pdf | |
| **HSAG Findings:** The *Medicaid Member Grievances and Appeal* policy stated that the CCO appeals process is to comply with all components listed. During the site visit, the CCO demonstrated having only one level of appeal and being the final adjudicator of appeals. The record review demonstrated that the CCO did not follow the process discussed during the site visit. Likewise, the CCO failed to follow the process outlined in the Medicaid Member Grievances and Appeal policy for investigating and obtaining member consent when a provider submits an appeal request on a member's behalf. The policy and CCO staff asserted that if written consent is required but not provided, the CCO follows up with the member or the member's representative. However, documentation from the record review demonstrated that several appeals were dismissed immediately for no member consent. However, the CCO did not attempt to obtain the consent. CCO staff asserted during the record review that it has since trained staff to adhere to its process for obtaining the appropriate member consent. This requirement was *Met.* | | |
| **Required Actions:** None. | | |
| **Recommendations:** HSAG recommends that the CCO adhere to its appeals process, including its process for obtaining member consent for providers or other representatives on appeal requests. | | |

| Standard X—Grievance and Appeal Systems (42 CFR §438.228) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| 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:<br>a. The CCO ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal.<br>b. If the CCO denies a request for expedited resolution of an appeal, it must:<br>i. Transfer the appeal to the time frame for standard resolution.<br>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)<br>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.<br>*42 CFR §438.410*<br>*Contract: Exhibit I (4)(b)(3)*<br>*OAR 410-141-3895(2)(6)* | **Suggested Documents:**<br>• Grievance and appeal policies and procedures<br>• Member handbook<br>• Provider materials, such as provider manual<br>• Staff training materials<br>*HSAG will also review compliance through file reviews.<br>**Documents Submitted for Desk Review:**<br>• EOCCO Revised Ride Guide 08.2022.pdf Pg. 28<br>• EOCCO Medicaid Member Grievances and Appeals Policy.pdf- I. Paragraph 1 ; II. E. ; III. F. 6<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf- Pg.75-79<br>• Current EOCCO Provider Manual 10.5.2022.pdf- page 22-24<br>• OHA Appeal_Hearing Form_(English)_he3302.pdf<br>• EOCCO Letter - Appeal Ack Denied expediting.docx<br>• EOCCO website, EOCCO member home<br>• OHP Date Calulator 2014.xlsx<br>• medicaid open cases report 12202022.xlsx | ☐ Met<br>☒ Partially Met<br>☐ Not Met |

| Standard X—Grievance and Appeal Systems (42 CFR §438.228) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| **HSAG Findings:** The *Medicaid Member Grievances and Appeal* policy stated that the CCO is to maintain an expedited review process and complied with the requirements listed in this element. However, the record review demonstrated that the CCO did not handle all expedited requests expeditiously even when the CCO determined, or the provider indicated, 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. Additionally, the CCO's subcontractors, ODS and ADS, did not demonstrate reasonable efforts to give members prompt oral notice when requests for expedited appeal were denied for not meeting expedited criteria. This requirement was *Partially Met.* | | |
| **Required Actions:** The CCO and its subcontractors must ensure they maintain 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 and its subcontractors must also make reasonable efforts to give its members prompt oral notice when requests for expedited appeals are denied for not meeting expedited criteria. | | |
| 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:<br>a. For standard resolution of appeals, within 16 days from the day the CCO receives the appeal.<br>b. For expedited resolution, within 72 hours after the CCO receives the appeal.<br>c. For notice of expedited resolution, the CCO must make reasonable efforts to provide oral notice of resolution.<br>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.<br>*42 CFR §438.408(b)(2); (3); (d)(2)*<br>*Contract: Exhibit I (4)(b)*<br>*OAR 410-141-3890(3)* | **Suggested Documents:**<br>• Grievance and appeal policies and procedures<br>• Member handbook<br>• Provider materials, such as provider manual<br>• Staff training materials<br>*HSAG will also review compliance through file reviews<br>**Documents Submitted for Desk Review:**<br>• EOCCO Revised Ride Guide 08.2022.pdf- Pg. 28<br>• EOCCO Medicaid Member Grievances and Appeals Policy.pdf III. B. 7 ; III. D. 3. a. ; III. I. 1. a-c., f. | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard X—Grievance and Appeal Systems (42 CFR §438.228) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | • 2022 EOCCO Member Handbook_Compiled_04132023.pdf- Pg.75-79<br>• Current EOCCO Provider Manual 10.5.2022.pdf- page 22-24<br>• EOCCO_ Appeal Resolution_ Narrative.docx<br>• EOCCO Letter- Appeal Ack Expedited.docx<br>• OHA Appeal_Hearing Form_(English)_he3302.pdf<br>• New Hire Training- Medical Medicaid (3.20.23).1pptx<br>• OHP Date Calulator 2014.xlsx<br>• medicaid open cases report 12202022.xlsx | |
| **HSAG Findings:** The *Medicaid Member Grievances and Appeal* policy stated that the CCO is to comply with the time frame requirements outlined in this element and the written notice requirements in Section (d). Additionally, the member handbook and provider manual communicated the appropriate time frames for resolution. The record review demonstrated that the CCO met the time frames for resolution. However, the CCO did not adhere to the requirement outlined in Section (d), which states that the written notice must be "written in language that, at a minimum, meets the standards described 42 CFR §438.10." The record review demonstrated that the CCO and its subcontractors used various versions of the language access statement, and some versions do not contain the required 18-point font size. Although this requirement 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. 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 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. | | |

| Standard X—Grievance and Appeal Systems (42 CFR §438.228) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| 19. The CCO may extend the time frames for resolution of grievances or appeals by up to 14 calendar days if:<br>a. The member requests the extension; or<br>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.<br>c. If the CCO extends the time frames for resolution of grievances or appeals, it must—for any extension not requested by the member:<br>i. Make reasonable efforts to give the member prompt oral notice of the delay (including as necessary multiple calls at different times of day).<br>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.<br>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).<br>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.<br>*42 CFR §438.408(c)*<br>*Contract: Exhibit I (4)(b)(2-3)*<br>*OAR 410-141-3890 (3)(a);(b);(c)* | **Suggested Documents:**<br>• Grievance and appeal policies and procedures<br>• Member handbook<br>• Provider materials, such as provider manual<br>• Staff training materials<br>*HSAG will also review compliance through file reviews.<br>**Documents Submitted for Desk Review:**<br>• EOCCO Medicaid Member Grievances and Appeals Policy.pdf- III. D. 3. b.<br>• EOCCO Revised Ride Guide 08.2022.pdf- Pg. 28<br>• EOCCO Medicaid Member Grievances and Appeals Policy.pdf<br>• 2022 EOCCO Member Handbook_ Compiled_04132023.pdf- Pg.75-79<br>• Current EOCCO Provider Manual 10.5.2022.pdf- page 22-24<br>• EOCCO Letter- Appeal Ack- Regular Appeal.docx<br>• EOCCO Letter -Grievance Ack Letter – delay.docx<br>• OHP Date Calulator 2014.xlsx<br>• medicaid open cases report 12202022.xlsx | ☐ Met<br>☒ Partially Met<br>☐ Not Met |

| Standard X—Grievance and Appeal Systems (42 CFR §438.228) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| **HSAG Findings:** The *Medicaid Member Grievances and Appeal* policy featured the appropriate time frames and requirements for extensions, including the justification for additional information and reasonable efforts to provide notice of any delay. The member handbook and provider manual also communicated these requirements. However, the record review demonstrated that the CCO and its subcontractor, ADS, did not make reasonable efforts to give its members prompt oral notice of delays when extending the resolution time frame on standard and expedited appeals. This requirement was *Partially Met*. | | |
| **Required Actions:** The CCO and its subcontractors must demonstrate when extending time frames for resolution of grievances or appeals by up to 14 calendar days, that it makes reasonable efforts to give its members prompt oral notice of any delays (including, as necessary, multiple calls at different times of day). | | |
| 20. Appeal resolution notices must be in writing, meet the language and format requirements of §438.10, and must include:<br>a. The results of the resolution process and the date it was completed.<br>b. For appeals not resolved wholly in favor of the member:<br>i. How to request the continued services.<br>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.<br>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: | **Suggested Documents:**<br>• Notice of appeal resolution template<br>• Grievance and appeal policies and procedures<br>*HSAG will also review compliance through file reviews.<br>**Documents Submitted for Desk Review:**<br>• EOCCO Medicaid Member Grievances and Appeals Policy.pdf-: III. I.<br>• EOCCO Revised Ride Guide 08.2022.pdf- Pg. 29<br>• EOCCO OHA Contested Case Hearings Policy.pdf<br>• 2022 EOCCO Member Handbook_ Compiled_04132023.pdf- Pg.75-79<br>• Current EOCCO Provider Manual 10.5.2022.pdf- page 22-24 | ☐ Met<br>☒ Partially Met<br>☐ Not Met |

| Standard X—Grievance and Appeal Systems (42 CFR §438.228) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| https://www.oregon.gov/oha/HSD/OHP/Pages/Forms.aspx.<br>iv. Explanation to the member that an expedited Hearing will not be granted for post-service denials;<br>v. The right to continue to receive benefits pending a Contested Case Hearing and how to do so;<br>vi. Information explaining that if CCO's Adverse Benefit Determination is upheld in a Contested Case Hearing, the member may be liable for the cost of any continued benefits.<br><br>*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.*<br><br>*42 CFR §438.408(e)*<br>*Contract: Exhibit I (4)(b)(4)*<br>*OAR 410-141-3890 (11)* | • EOCCO_ Appeal Resolution_ Narrative.docx<br>• OHA_Hearing Rights (English)_he3030.pdf<br>• OHA Appeal_Hearing Form_(English)_he3302.pdf<br>• EOCCO website, EOCCO member home | |
| **HSAG Findings:** The *Medicaid Member Grievances and Appeal* policy stated that appeal resolution notices are to notify members of all components listed in this element except component (b)(iv). Additionally, the reviewer noticed the following required content was missing from the appeal resolution letters for either the CCO or its subcontractors:<br>• 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.<br>• The member's right to request a standard or expedited Contested Case Hearing with OHA within 120 days from the date of the CCO's Notice of Appeal Resolution and how to do so. This 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.<br>• Explanation to the member that an expedited hearing will not be granted for post-service denials.<br>The notice requirements were not met for the 2023 review. However, 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 2023 compliance review scoring. 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 revise its policy to include that for appeals not resolved wholly in favor of the member, the notices will explain to the member that an expedited hearing will not be granted for post-service denials. | | |
| **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. | | |
| 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.<br>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.<br>*42 CFR §438.408(f)(1)–(3)*<br>*Contract: Exhibit I (5)*<br>*OAR 410-141-3890 (7)*<br>*OAR 410-141-3900 (1)(b);(2)(a)* | **Suggested Documents:**<br>• Grievance and appeal policies and procedures<br>• Contested case hearing policies and procedures<br>• Member handbook<br>• Provider materials, such as provider manual<br>• Staff training materials<br>**Documents Submitted for Desk Review:**<br>• EOCCO OHA Contested Case Hearings Policy.pdf- II. C.<br>• EOCCO Revised Ride Guide 08.2022_Compiled.pdf- Pg. 25<br>• EOCCO Medicaid Member Grievances and Appeals Policy.pdf<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• Current EOCCO Provider Manual 10.5.2022.pdf<br>• EOCCO website, EOCCO member home | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard X—Grievance and Appeal Systems (42 CFR §438.228) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | • EOCCO_ Appeal Resolution_ Narrative.docx<br>• OHA_Hearing Rights (English)_he3030.pdf<br>• OHA Appeal_Hearing Form_(English)_he3302.pdf<br>• OHP Date Calulator 2014.xslx | |
| **HSAG Findings:** This requirement was *Met*. | | |
| **Required Actions:** None. | | |
| 22. The CCO provides for continuation of benefits/services while the CCO-level appeal and the Contested case hearing are pending if:<br>a. The member files in a timely manner* for continuation of benefits—defined as on or before the later of the following:<br>i. Within 10 days of the CCO mailing the notice of adverse benefit determination.<br>ii. The intended effective date of the proposed adverse benefit determination.<br>b. The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.<br>c. The services were ordered by an authorized provider.<br>d. The period covered by the original authorization has not expired.<br>e. The member requests an appeal within 60 days following the adverse benefit determination. | **Suggested Documents:**<br>• Grievance and appeal policies and procedures<br>• Staff training materials<br>*HSAG will also review compliance through file reviews.<br>**Documents Submitted for Desk Review:**<br>• EOCCO Revised Ride Guide 08.2022_Compiled.pdf<br>• EOCCO Medicaid Member Grievances and Appeals Policy.pdf II. C. ; III. A. 1.<br>• EOCCO OHA Contested Case Hearings Policy.pdf III. C. 2-4.<br>• OHA_Hearing Rights (English)_he3030.pdf<br>• OHA Appeal_Hearing Form_(English)_he3302.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard X—Grievance and Appeal Systems (42 CFR §438.228) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| *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.*<br>*Note: The provider may not request continuation of benefits on behalf of the member (page 27510, 2016 Federal Register).*<br>*42 CFR §438.420(a);(b)*<br>*Contract: Exhibit I (6)*<br>*OAR 410-141-3910 (1)* | | |
| **HSAG Findings:** This requirement was *Met*. | | |
| **Required Actions:** None. | | |
| 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:<br>a. The member withdraws the appeal or request for a contested case hearing.<br>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.<br>c. A contested case hearing officer issues a hearing decision adverse to the member.<br>*42 CFR §438.420(c)*<br>*Contract: Exhibit I (6)(c)*<br>*OAR 410-141-3910 (1)(d)* | **Suggested Documents:**<br>• Grievance and appeal policies and procedures<br>• Contested case hearing policies and procedures<br>**Documents Submitted for Desk Review:**<br>• EOCCO OHA Contested Case Hearings Policy.pdf III. C. 3.<br>• EOCCO Revised Ride Guide 08.2022.pdf<br>• EOCCO Medicaid Member Grievances and Appeals Policy.pdf<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• EOCCO website, EOCCO member home<br>• EOCCO_ Appeal Resolution_ Narrative.pdf<br>• OHA_Hearing Rights (English)_he3030.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard X—Grievance and Appeal Systems (42 CFR §438.228) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | • OHA Appeal_Hearing Form_(English)_he3302.pdf | |
| **HSAG Findings:** This requirement was *Met*. | | |
| **Required Actions:** None. | | |
| 24. Member responsibility for services furnished while the appeal or contested case hearing is pending:<br>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.<br>*42 CFR §438.420(d)*<br>*Contract: Exhibit I (6)(d)*<br>*OAR: 410-141-3910(1)(e)* | **Suggested Documents:**<br>• Grievance and appeal policies and procedures<br>• Contested case hearing policies and procedures<br>• Member handbook<br>**Documents Submitted for Desk Review:**<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• Current EOCCO Provider Manual 10.5.2022.pdf<br>• EOCCO OHA Contested Case Hearings Policy.pdf- III. D. 8. f.·<br>• EOCCO Revised Ride Guide 08.2022.pdf Pg. 31<br>• EOCCO Medicaid Member Grievances and Appeals Policy.pdf<br>• Oregon Health Authority Contested Case Hearing Policy.pdf<br>• OHA_Hearing Rights (English)_he3030.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard X—Grievance and Appeal Systems (42 CFR §438.228) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | • OHA Appeal_Hearing Form_(English)_he3302.pdf | |
| **HSAG Findings:** This requirement was *Met.* | | |
| **Required Actions:** None. | | |
| 25. Effectuation of reversed appeal resolutions:<br>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.<br>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.<br>*42 CFR §438.424*<br>*Contract: Exhibit I (7)*<br>*OAR: 410-141-3910(2)* | **Suggested Documents:**<br>• Grievance and appeal policies and procedures<br>• Contested case hearing policies and procedures<br>• Contested case tracking reports<br>*HSAG will also review compliance through file reviews.<br>**Documents Submitted for Desk Review:**<br>• EOCCO Medicaid Member Grievances and Appeals Policy.pdf- III. H.<br>• EOCCO OHA Contested Case Hearings Policy.pdf- III. D. 8. e.<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• EOCCO Revised Ride Guide 08.2022_Compiled.pdf | ☒ Met<br>☐ Partially Met<br>☐ 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** |
| 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:<br>a. A general description of the reason for the appeal or grievance and the supporting reasoning for its resolution;<br>b. The member's name and ID;<br>c. The date CCO received the grievance or appeal filed by the member, subcontractor, or provider;<br>d. The NOABD;<br>e. If filed in writing, the appeal or grievance;<br>f. If filed orally, documentation that the grievance or appeal was received orally;<br>g. Records of the review or investigation at each level of the appeal, grievance, or contested case hearing;<br>h. Notice of resolution of the grievance or appeal, including dates of resolution at each level;<br>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<br>j. All written decisions and copies of all correspondence with all parties to the grievance, appeal, or contested case hearing.<br>k. Resolution at each level of the appeal or grievance process, as applicable. | **Suggested Documents:**<br>• Grievance and appeal policies and procedures<br>• Grievance and appeal tracking reports<br>*HSAG will also review compliance through file reviews.<br>**Documents Submitted for Desk Review:**<br>• Sample NEMT BPA_2022: Pg. 15<br>• EOCCO Medicaid Member Grievances and Appeals Policy: III. M. 5.<br>• Medicaid Complaint Data Check Weekly 01-10 to 01-16.xlsx<br>• Medicaid Appeal Data Check weekly 01-10 to 01-16.xlsx | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard X—Grievance and Appeal Systems (42 CFR §438.228) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| l. Date of resolution at each level of the appeal or grievance process, as applicable.<br>*42 CFR §438.416*<br>*Contract: Exhibit I (9)(b)*<br>*OAR 410-141-3915* | | |
| **HSAG Findings:** This requirement was *Met.* | | |
| **Required Actions:** None. | | |
| 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:<br>a. The member's right to file grievances and appeals.<br>b. The requirements and time frames for filing grievances and appeals.<br>c. The right to a Contested case hearing after the CCO has made a decision on an appeal which is adverse to the member.<br>d. The availability of assistance in the filing processes.<br>e. The fact that, when requested by the member:<br>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.<br>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. | **Documents Submitted for Desk Review:**<br>• EOCCO Revised Ride Guide 08.2022.pdf Pg. 27-32<br>• EOCCO Participating Provider Agreement.docx<br>• Current EOCCO Provider Manual 10.5.2022.pdf<br>• Sample NEMT BPA_2022.pdf Pg. 26<br>• EOCCO Medicaid Member Grievances and Appeals Policy.pdf- III. O | ☐ Met<br>☒ Partially Met<br>☐ Not Met |

| Standard X—Grievance and Appeal Systems (42 CFR §438.228) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| h. Written notification of updates to these procedures and timeframes **within 5 business days** after approval of such updates by OHA.<br>*42 CFR §438.414*<br>*Contract: Exhibit I (1)(b)* | | |
| **HSAG Findings:** The *Medicaid Member Grievances and Appeal* policy stated that the CCO is to inform its subcontractors of the information outlined in this element. The CCO's Participating Provider Agreement informed providers and subcontractors of their contractual requirements to comply with stipulations outlined in the CCO contract. However, the agreement did not provide the information required regarding the grievance, appeal, and contested case hearing procedures and time frames. The provider manual communicated the requirements to providers, and during the site visit, CCO staff asserted that the provider manual was given to providers during the onboarding process upon contracting. However, the CCO did not offer evidence of providing the required information during the provider onboarding process. Additionally, CCO staff asserted during the site visit that its subcontractors are provided the appropriate time frames and procedures for grievances and appeals at the time of contracting, and within five business days after OHA approves revisions. The CCO was provided an opportunity post-site visit to submit evidence. In response, the CCO resubmitted the participating provider agreement, and an email demonstrating the Grievance and Appeal policy was provided to its subcontractors for feedback prior to receiving approval from OHA. This response does not align with the requirement to provide written notification of updates to these procedures and time frames within five business days after OHA update approval. This requirement was *Partially Met*. | | |
| **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, notice of adverse benefit determination, 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 also must provide written notification of updates to these procedures and time frames within five business days after OHA approval of such updates. Evidence of providing the appropriate information could include:<br>• Attachments, supplemental documentation, or emails provided to subcontractors and providers at the time of contracting; or,<br>• Evidence of providing the provider manual during the onboarding process; or<br>• Evidence of providing any updates to the procedures and time frames within five business days after OHA approval; and/or<br>• 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.<br><br>*Note: Readily accessible means electronic information which complies with 508 guidelines, Section 504 of the Rehabilitation Act, and W3C's Web Content Accessibility Guidelines.*<br><br>*42 CFR §438.10(c)(1)*<br>*Contract: Exhibit B Part 3 (4)(d)(4);(6)*<br>*OAR 410-141-3585 (2)* | **Suggested Documents:**<br>• Policies and procedures on member materials and dissemination of information to members<br>• (HSAG will evaluate the reading level of letters, handbooks, and other materials submitted for requirements throughout this standard.)<br>**Documents Submitted for Desk Review:**<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• EOCCO Revised Ride Guide 08.2022_Compiled.pdf<br>• EOCCO-Flyer-Material Development_122022_tagged.pdf<br>• Case Sample 1 NEMT Griev Resolution Letter.pdf<br>• EOCCO Language Access and Effective Communication Policy.pdf<br>• EOCCO Medicaid Member Non-Discrimination Policy.pdf<br>• EOCCO Member Handbook and Annual Notification Policy.pdf<br>• EOCCO Member Services and Outreach Communication Policy.pdf | ☐ Met<br>☒ Partially Met<br>☐ Not Met |

| Standard XIV—Member Information (42 CFR §438.10) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | • REV2-0788-EOCCO-Postcard Annual Notice_FINAL_Print.pdf<br>• REV2-0788-EOCCO-Postcard AnnualNotice_Spanish_FINAL_Print.pdf<br>• Member Engagement Committee Meeting Minutes 03232022.docx<br>• EOCCO ED Patient Resource_Hermiston_SP_Web.pdf<br>• EOCCO ED Patient Resource_Hermiston_Web.pdf | |
| **HSAG Findings:** The CCO's *Member Services and Outreach Communication* policy stated that all member materials and communications (including member newsletters, new member welcome letter, member handbook, etc.) are to be provided in an easily understood manner and format, at sixth-grade reading level or below. The CCO's material development checklist document provided a procedure for how the CCO ensures compliance with the requirement. The CCO's member handbook and welcome letter met the reading level requirement. However, no statement in the CCO's policy or desk procedure addressed how the CCO ensured that electronic documents met Rehabilitation Act §508(c) (hereinafter "§508") accessibility guidelines.<br>During the site visit, the CCO confirmed that all website and member-facing documents undergo review for compliance with §508 accessibility guidelines and referenced its *Materials Development Checklist* that included an item to check and confirm that materials were accessible via screen-readers or audio plug-in. Additionally, CCO staff confirmed the use of WebAim to test and ensure §508 compliance for its websites through a comprehensive set of quality checks. However, the CCO was unable to provide documentation outlining its processes used to ensure its electronic documents (e.g., reports, marketing materials, etc.) meet §508 regulatory requirements. Following the site visit, the CCO provided copies of its *Materials Development Checklist* and *Brand Guidelines*. However, neither of the documents nor staff responses confirmed processes in place to ensure the compliance of electronic documents with §508 accessibility requirements. This requirement was *Partially Met*. | | |
| **Required Actions:** The CCO must ensure that it has a process for assessing member materials for compliance with federal accessibility requirements. | | |

| Standard XIV—Member Information (42 CFR §438.10) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| 2. The CCO has in place a mechanism to help members understand the requirements and benefits of the plan.<br>*42 CFR §438.10(c)(7)*<br>*Contract: Exhibit B Part 3 (2)(f)*<br>*OAR 410-141-3585(3)* | **Suggested Documents:**<br>• Policies and procedures on member materials and dissemination of information to members<br>• Internal protocols/training materials for staff<br>• Member-facing communications<br>**Documents Submitted for Desk Review:**<br>• EOCCO Language Access and Effective Communication Policy.pdf<br>• EOCCO Member Handbook and Annual Notification Policy.pdf<br>• EOCCO Member Services and Outreach Communication Policy.pdf<br>• EOCCO-Flyer-Material Development_122022_tagged.pdf<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• Draft_2022_Welcome Packet_ENG.pdf<br>• 2022 Welcome Packet_Spanish.pdf<br>• EOCCO ED Patient Resource_Hermiston_SP_Web.pdf<br>• EOCCO ED Patient Resource_Hermiston_Web.pdf<br>• EOCCO Revised Ride Guide 08.2022_Compiled.pdf<br>• Member Engagement Committee Meeting Minutes 03232022.docx<br>• EOCCO Website: EOCCO Benefits for 19-63 year olds | ☒ Met<br>☐ Partially Met<br>☐ 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. | | |
| 3. For consistency in the information provided to members, the CCO uses the following as developed by the State:<br>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.<br>b. Model member handbooks and member notices.<br>*42 CFR §438.10(c)(4)*<br>*Contract: Exhibit A; Exhibit B Part 3 (5)(a)* | **Suggested Documents:**<br>• Policies and procedures on member materials and dissemination of information to members<br>• Member handbook<br>• Training or other materials that include definitions<br>• (HSAG will assess policies and procedures submitted throughout.)<br>**Documents Submitted for Desk Review:**<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• EOCCO Member Services and Outreach Communication Policy.pdf<br>• EOCCO Member Handbook and Annual Notification Policy.pdf<br>• REV2-0788-EOCCO-Postcard Annual Notice_FINAL_Print.pdf<br>• Spanish Sample PCP Term Letter Draft 12172021_APPROVED (002).docx<br>• Sample PCP Term Letter Draft 12172021_Updated 012402022.docx | ☒ Met<br>☐ Partially Met<br>☐ 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.<br>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.<br>b. All written materials for members must:<br>i. Use a font size no smaller than 12 point.<br>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.<br>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.<br>*42 CFR §438.10(d)(3);(6)*<br>*Contract: Exhibit B Part 3 (4)(d)*<br>*OAR 410-141-3585 (5)(a-b)* | **Suggested Documents:**<br>• Policies and procedures on member materials and dissemination of information to members<br>• Interpretation/translation/alternate format/communication policies and procedures<br>• Methodology for providing copies of translated member handbooks to members<br>• Member marketing materials<br>• Examples of materials available in the prevalent non-English language (Spanish).<br>• (HSAG will assess materials submitted throughout this standard.)<br>**Documents Submitted for Desk Review:**<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• EOCCO-Flyer-Material Development_122022.pdf<br>• Draft_2022_Welcome Packet_ENG.pdf<br>• 2022 Welcome Packet_Spanish.pdf<br>• EOCCO Member Services and Outreach Communication Policy.pdf<br>• EOCCO Medicaid Member Grievances and Appeals Policy.pdf | ☐ Met<br>☒ Partially Met<br>☐ Not Met |

| Standard XIV—Member Information (42 CFR §438.10) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | • EOCCO OHA Contested Case Hearings Policy.pdf<br>• EOCCO Ride Guide Spanish 01.2022.pdf<br>• EOCCO ED Patient Resource_Hermiston_SP_Web.pdf<br>• EOCCO ED Patient Resource_Hermiston_Web.pdf<br>• General resources (eocco.com)- ZIP file for member handbook audio files in English and Spanish<br>• REV2-0788-EOCCO-Postcard Annual Notice_FINAL_Print.pdf<br>• REV2-0788-EOCCO-Postcard Annual Notice_Spanish_FINAL_Print.pdf<br>• ProviderDirectory-EOCCO-English 202203.pdf<br>• ProviderDirectory-EOCCO-Spanish 202203.pdf<br>• English Single Preventive Services Letter #12922.docx<br>• Sample EOCCO-Letter Medicare existing duals_SPA_11182022updated.docx<br>• Sample EOCCO-Letter Medicare existing duals_ENG_11182022updated.docx<br>• Spanish Sample PCP Term Letter Draft 12172021_APPROVED (002).docx<br>• Sample PCP Term Letter Draft 12172021_Updated 012402022.docx | |

| Standard XIV—Member Information (42 CFR §438.10) | | |
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| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| **HSAG Findings:** The CCO's *Member Services and Outreach Communication* policy stated that all written informational materials are be made available in prevalent non-English languages within its service area, in alternative formats and languages, and at no cost to members. The policy's definition of prevalent non-English languages aligned with the State's definition as the lesser of 5 percent of total member enrollment or 1,000 members within its service area. The member handbook, welcome letter, and printed provider directory used a 12-point font size and was available in alternative formats. However, the 2022 printed provider directories did not include 18-point font taglines in English and Spanish regarding the availability of interpretive or auxiliary aids and services; although the taglines are currently available in the 2023 English and Spanish provider directories. Additionally, the printable formulary used font sizes smaller than the required 12-point-size font. This requirement was *Partially Met*. | | |
| **Required Actions:** The CCO must ensure that written materials that are critical to obtaining services, including but not limited to the provider directory, feature 18-point font taglines 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. Additionally, the CCO must ensure these materials use a font no smaller than a 12-point-size. | | |
| 5. If the CCO makes information available electronically—Information provided electronically must meet the following requirements:<br>a. The format is readily accessible (see definition of readily accessible above).<br>b. The information is placed in a website location that is prominent and readily accessible.<br>c. The information can be electronically retained and printed.<br>d. The information complies with content and language requirements.<br>e. The member is informed that the information is available in paper form without charge upon request and is provided within five business days.<br>*42 CFR §438.10(c)(6)*<br>*Contract: Exhibit B Part 3 (4)(d)(6)*<br>*OAR 410-141-3585 (5)(c)* | **Suggested Documents:**<br>• Policies and procedures on member materials and dissemination of information to members<br>• 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.)<br>• Example of how members are informed that materials accessed electronically are available in paper form within five business days.<br>• Policies and procedures on dissemination of information to members | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard XIV—Member Information (42 CFR §438.10) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | • Sample member communications<br>**Documents Submitted for Desk Review:**<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• EOCCO-Flyer-Material Development_122022.pdf<br>• Case Sample 1 NEMT NOABD.pdf<br>• EOCCO Member Request for Material Translation and Alternative Formats Policy.pdf<br>• EOCCO Member Services and Outreach Communication Policy.pdf<br>• EOCCO Revised Ride Guide 08.2022_Compiled.pdf<br>• EOCCO member home<br>• Member Engagement Committee Meeting Minutes 03232022.docx<br>• REV2-0788-EOCCO-Postcard Annual Notice_FINAL_Print.pdf | |
| **HSAG Findings:** This requirement was *Met*. | | |
| **Required Actions:** None. | | |
| 6. The MCE makes the following pharmacy information available to its members in electronic or paper form:<br>a. Which medications are covered (both generic and name brand).<br>b. What tier each medication is on. | **Suggested Documents:**<br>• Policies and procedures on member materials and dissemination of information to members<br>• Link to Formulary List, including machine-readable | ☐ Met<br>☒ Partially Met<br>☐ Not Met |

| Standard XIV—Member Information (42 CFR §438.10) | | |
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| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| 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.<br>*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.*<br>*42 CFR §438.10 (h)(4)(i)*<br>*Exhibit B, Part 2 (7)(e)(7)*<br>*OAR 410-141-3585(7)* | • CCO website address<br>**Documents Submitted for Desk Review:**<br>• EOCCO Coverage Criteria Policies by Medication: Coverage criteria policies by medication (eocco.com)<br>• EOCCO member pharmacy<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• EOCCO Member Services and Outreach Communication Policy.pdf | |
| **HSAG Findings:** EOCCO's member handbook offered summary information about prescription medication coverage under OHP, phone contact information for the CCO's pharmacy customer service, and a URL for the formulary section of the CCO's website. The website included both a searchable formulary tool and a complete formulary list in PDF format. The formulary indicated which generic and name-brand medications were covered as well as their medication tiers. However, the formulary was not available on the CCO's website in a machine-readable format, as specified by the Secretary of Health Human Services via 45 CFR §180.20 (e.g., JavaScript Object Notation [JSON], Comma-Separated Values [CSV] formats). This requirement was *Partially Met*. | | |
| **Required Actions:** The CCO must ensure that its formulary is available on its website in both human-readable (e.g., PDF) and machine-readable (e.g., JSON) formats. | | |
| 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.<br>a. This includes oral interpretation and use of auxiliary aids such as TTY/TDD and American Sign Language.<br>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. | **Suggested Documents:**<br>• Policies and procedures on member materials and dissemination of information to members<br>• Member handbook<br>• Interpretation/translation/alternate format/communication policies and procedures | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard XIV—Member Information (42 CFR §438.10) | | |
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| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| *42 CFR §438.10(d)(4-5)*<br>*Contract: Exhibit B Part 3 (4)(d)(3)*<br>*OAR 410-141-3585 (10)* | **Documents Submitted for Desk Review:**<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• EOCCO Language Access and Effective Communication Policy.pdf<br>• EOCCO Member Services and Outreach Communication Policy.pdf<br>• EOCCO Revised Ride Guide<br>• 08.2022_Compiled.pdf<br>• Draft_2022_Welcome Packet_ENG.pdf<br>• 2022 Welcome Packet_Spanish.pdf<br>• REV2-0788-EOCCO-Postcard Annual Notice_FINAL_Print.pdf<br>• REV2-0788-EOCCO-Postcard Annual Notice_Spanish_FINAL_Print.pdf<br>• 2648-EOCCO-Flyer - Interpreter resource - Linguava_final.pdf<br>• EOCCO Phone Interpreter Instructions 2021.pdf | |
| **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 | **Suggested Documents:**<br>• Policies and procedures on member materials and dissemination of information to members<br>• Redacted example letter | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard XIV—Member Information (42 CFR §438.10) | | |
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| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| received his or her primary care from, or was seen on a regular basis by, the terminated provider.<br>*42 CFR §438.10(f)(1)*<br>*OAR 410-141-3585(13)(f)* | • Template letter<br>**Documents Submitted for Desk Review:**<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>– Pg.35<br>• EOCCO Member Services and Outreach Communication Policy.pdf | |
| **HSAG Findings:** The CCO's *Member Services and Outreach Communication* policy stated that once EOCCO receives notification of a provider's contract termination, it "provide[s] written notice of the termination to members who received primary care" from the terminated provider. Further, the policy states that such notification is given within 15 days of receipt or issuance of the notice. However, the policy did not align with the element that requires written notice within 15 calendar days after receipt or issuance of the termination notice or 30 calendar days prior to the effective termination date, whichever is later. Additionally, the policy only stated that such member notifications are given to members who received primary care from the terminated provider. Yet, the requirement also specifies written notification to members who were regularly seen by the terminated provider (e.g., a specialist providing regular care to members). However, during the site visit, the CCO reviewed its technical specifications for managing the selection and notification of terminated providers, which demonstrated the CCO was correctly identifying providers terminations for member notifications. The CCO also reviewed its automated processes for identifying terminated providers and subsequent member mailings. The process occurs on the 1st and 15th of each month, addresses all providers, except for select facility-based providers, to ensure timely notification. The CCO then reviewed its process for handling larger transition of care situations when large provider groups, clinics, and facilities are removed from its network. The CCO provided a sample termination notice letter, which met language and formatting requirements but did not contain sufficient information to determine whether the letter was sent on time. This requirement was *Met*. | | |
| **Required Actions:** None. | | |
| **Recommendation:** HSAG recommends the CCO update the *Member Services and Outreach Communication* policy to state that written notification to members includes terminated providers who saw members regularly (e.g., a specialist providing regular care to members). In addition, the policy should state that the CCO will provide written notice to members within 15 days of receipt or termination notice issuance, or 30 calendar days prior to the effective termination date, whichever is later. This update will ensure its policy reflects the CCO's processes. | | |
| 9. The CCO must make available, upon request, within five business days, additional information that the CCO has | **Suggested Documents:** | ☐ Met<br>☒ Partially Met |

| Standard XIV—Member Information (42 CFR §438.10) | | |
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| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| 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.<br>*42 CFR §438.10(f)(3)*<br>*Contract: Exhibit B Part 3(4)(g)* | • Policies and procedures on member materials and dissemination of information to members<br>• Member communication templates on incentive plans and structure/operations<br>**Documents Submitted for Desk Review:**<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• EOCCO Language Access and Effective Communication Policy.pdf<br>• EOCCO Member Services and Outreach Communication Policy.pdf<br>• EOCCO Members- Rights and Responsibilities Policy.pdf<br>• Std XV - Member Information\9.5.23\Draft Physican Incentive Letter V1.docx | ☐ Not Met |
| **HSAG Findings:** While the *EOCCO Member Services and Outreach Communication* policy stated that "all materials available to members [are available] at no cost and within 5 business days," the policy did not specifically address the dissemination of information regarding the CCO's structure and operations or any physician incentive plans to members. The member handbook stated that members have the right to ask for information about provider payment arrangements by calling the CCO's Customer Service department. However, the member handbook does not provide evidence of the information availability on physician incentive plans for members. Prior to and following the site visit, the CCO provided a draft and final OHA-approved template letter that lists general information on the use of provider incentive programs and states that these programs do not impact member care. The CCO further discussed its process for submitting this letter to members upon request within five business days of the request. However, the template letter still did not include specific information regarding the CCOs' incentive plans and was not in place during the review period. This requirement was *Partially Met*. | | |
| **Required Actions:** The CCO has since implemented a process for disseminating information upon request within five business days, on its structure, operations, and any physician incentive plans in place. However, this process was not in place during 2022. The CCO must ensure that it provides information to members regarding provider incentive payments on request within five business days. | | |

| Standard XIV—Member Information (42 CFR §438.10) | | |
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| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| 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 and oral health providers, NEMT providers, and LTSS providers (as appropriate):<br>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.<br>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.<br>c. Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment.<br>d. Whether the provider offers both telehealth and in-person appointments;<br>e. Availability of auxiliary aids and services for all members with disabilities upon request and at no cost;<br>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 | **Suggested Documents:**<br>• Policies and procedures on member materials and dissemination of information to members<br>• Provider directory<br>**Documents Submitted for Desk Review:**<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• EOCCO Member Handbook and Annual Notification Policy.pdf<br>• EOCCO Member Services and Outreach Communication Policy.pdf<br>• EOCCO Provider Directory & DSN Report Policy.pdf<br>• EOCCO \| Provider Search<br>• ProviderDirectory-EOCCO-English 202203.pdf<br>• ProviderDirectory-EOCCO-Spanish 202203.pdf | ☐ Met<br>☒ Partially Met<br>☐ Not Met |

| Standard XIV—Member Information (42 CFR §438.10) | | |
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| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| accessibility of providers' offices, exam rooms, restrooms, and equipment.<br>*42 CFR §438.10(h)(1)*<br>*Contract: Exhibit B Part 3 (6)(e);(f)*<br>*OAR 410-141-3585(6)* | | |

**HSAG Findings:** The CCO's *Provider Directory & DSN Report* policy included a process for developing and maintaining its provider directory, including information sources, responsible parties, and update frequencies. The member handbook directed members to the CCO's searchable online directory and stated that a printed copy of the provider directory is made available upon request. However, while the online and printable provider directories included data fields to support the reporting of required information, many of the fields continue to indicate that the "information was not yet available." During the site visit, the CCO noted that it began collecting required provider and practice data elements, including accessibility accommodations and provider websites, through ongoing outreach by its Provider Network department. Following the site visit, the CCO confirmed that it has only captured websites for approximately 12 percent of its providers.

The online provider directory search tool allowed members to search providers by entering a member ID number or by searching as a guest. During the site visit, the CCO confirmed that the online directory is limited to participating EOCCO providers and the use of Member ID restricted search results based on the members' benefit package. Searching as a guest yielded all active, participating providers within the CCO's network regarding a location within the CCO's service area. The online directory allowed members to search by name, telehealth options, specialty, languages spoken, gender, location, distance, and accepting new patients. An "additional options" function allowed searching for available translation services and ages served. Searching for pharmacy services redirected users to an external site, which was functional and offered options for searching by location, distance, and mail order options. The online provider directory tool included a phone number for obtaining non-emergent medical transportation (NEMT) but did not provide the name of the NEMT brokerage(s).

The printable provider directory submitted for review (i.e., calendar year [CY] 2022) and the version downloaded from the CCO's website were more than 15,000 pages long, and organized by primary care provider (PCP)/county and specialty. However, unlike the online directory, the print directory included providers and locations in counties that were non-adjacent or very distant, providers located in non-adjacent counties or distant communities in Washington, California, and Idaho, and some providers located as far away as Montana, Alaska, and Hawaii. As such, many entries in the print directory were unlikely to be relevant or accessible to OHP members. During the site visit, EOCCO staff noted that if members called customer service and requested a printed directory, their requests were generally tailored to the specialty requested and geographic requirements of the members.

Further, while the CCO's provider directory (printed and online) consistently listed provider names, titles, specialty, gender, clinic name, telephone number, address, accepting new patient status, telehealth options, and website URLs if any existed, it did not provide all required information consistently, with many informational fields for accessibility options, languages spoken, and certified interpreters available listed as "information

| Standard XIV—Member Information (42 CFR §438.10) | | |
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| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| not yet available." Additionally, when a provider's website information was listed as "Provider has no website," this information was sometimes found to be incorrect by random spot-checking providers through an Internet search. During the site visit, the CCO confirmed that it has undertaken efforts to collect this information since Q4 2022. In follow-up, the CCO confirmed that this information concerned approximately 12 percent of its provider population. The CCO also noted that it will be working with a third-party vendor in the future to collect required data elements at the enterprise level. The printable provider directory also did not list contact information for NEMT services.<br>Element 10 is an outstanding finding from the CY 2020 CMR. The requirement continues to be unresolved. This requirement was *Partially Met*. | | |
| **Required Actions:** The CCO must continue to take steps and ensure the completeness and accuracy of provider website and accessibility information available to members within its online and printed provider directories. Additionally, both the searchable and print versions of the provider directory must list both the NEMT vendor's contact information and brokerage name**.** The CCO also must ensure that the printable provider directory is both relevant and functionally useful to OHP members by including only those providers who are actually available and meaningfully accessible to OHP members. | | |
| 11. The provider directory in:<br>a. A paper format must be updated at least:<br>i. Monthly, if the CCO does not have a mobile-enabled, electronic directory; or<br>ii. Quarterly, if the CCO has a mobile-enabled, electronic provider directory.<br>b. An electronic format must be updated no later than 30 calendar days after the CCO receives updated provider information.<br>*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.*<br>*42 CFR §438.10(h)(3)*<br>*Contract: Exhibit B Part 3(6)(g)*<br>*OAR 410-141-3585(6)(m)* | **Suggested Documents:**<br>• Policies and procedures for managing and updating provider directory information<br>• PDF of hard copy provider directory<br>• Link to online provider directory<br>• Link to machine-readable format<br>**Documents Submitted for Desk Review:**<br>• ProviderDirectory-EOCCO-English 202203.pdf<br>• ProviderDirectory-EOCCO-Spanish 202203.pdf<br>• EOCCO \| Provider Search<br>• EOCCO Provider Directory & DSN Report Policy.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met |
| **HSAG Findings:** This requirement was *Met*. | | |
| **Required Actions:** None. | | |

| Standard XIV—Member Information (42 CFR §438.10) | | |
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| **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.<br>*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.*<br>*42 CFR §438.10(h)(4)*<br>*Contract: Exhibit B Part 3(6)(j)*<br>*OAR 410-141-3585 (6)(m)* | **Suggested Documents:**<br>• Policies and procedures on member materials and dissemination of information to members<br>• Link to the CCO's provider directory on the website<br>**Documents Submitted for Desk Review:**<br>• EOCCO Member Handbook and Annual Notification Policy.pdf<br>• EOCCO Provider Directory & DSN Report Policy.pdf<br>• EOCCO \| Provider Search<br>• ProviderDirectory-EOCCO-English 202203.pdf<br>• ProviderDirectory-EOCCO-Spanish 202203.pdf | ☐ Met<br>☐ Partially Met<br>☒ Not Met |
| **HSAG Findings:** The CCO's provider directory was available on the EOCCO website in PDF format. However, it was not available on its website in a machine-readable format, as specified in 45 CFR §180.20 (e.g., Extensible Markup Language [XML], JSON, CSV). This requirement was *Not Met*. | | |
| **Required Actions:** The CCO must ensure that 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 and defined 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:<br>a. A welcome letter,<br>b. A member handbook, and | **Suggested Documents:**<br>• Policies and procedures on member materials and dissemination of information to members<br>• Evidence of providing member materials<br>• Vendor tracking of timeliness | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard XIV—Member Information (42 CFR §438.10) | | |
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| **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.<br>*42 CFR §438.10(g)(1)*<br>*OAR 410-141-3585 (8)* | **Documents Submitted for Desk Review:**<br>• Draft_2022_Welcome Packet_ENG.pdf<br>• 2022 Welcome Packet_Spanish.pdf<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• EOCCO Member Handbook and Annual Notification Policy.pdf<br>• EOCCO Member Services and Outreach Communication Policy.pdf<br>• EOCCO Fulfillment Order 2022.xlsx | |
| **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.<br>a. The CCO shall send hard copies upon request within five days.<br>*Contract: Exhibit B Part 3 (5)(c)*<br>*OAR 410-141-3585 (9)* | **Suggested Documents:**<br>• Policies and procedures on member materials and dissemination of information to members<br>• Evidence of providing annual notices<br>• Evidence of tracking timeliness<br>**Documents Submitted for Desk Review:**<br>• REV2-0788-EOCCO-Postcard Annual Notice_FINAL_Print.pdf<br>• REV2-0788-EOCCO-Postcard Annual Notice_Spanish_FINAL_Print.pdf<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• EOCCO Member Handbook and Annual Notification Policy.pdf | ☐ Met<br>☒ Partially Met<br>☐ Not Met |

| Standard XIV—Member Information (42 CFR §438.10) | | |
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| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| **HSAG Findings:** The CCO's Member Handbook and *Annual Notification* policy stated that members are to be notified annually via a mailed postcard with information of where members could access or request a copy of the current member handbook and provider directory. However, the policy states that hard copies of the handbook and provider directory are to be provided within five business days and not five days as required by OAR and the CCO contract. The CCO also provided its submitted sample postcard stating that documents are available in print upon request. During the site visit, CCO staff indicated that requests are tracked and monitored by Member Services to ensure timely processing of requests for printed copies. However, tracking documentation submitted after the site visit did not demonstrate monitoring of the timeliness of processing ad hoc requests for hard copies. This requirement was *Partially Met*. | | |
| **Required Actions:** The CCO must update its Member Handbook and *Annual Notification* policy to state that printed materials will be provided within five days upon request. The CCO also must demonstrate it is tracking requests for hard copies and monitoring the mailing of member materials to ensure compliance with timeliness requirements. | | |
| 15. The member handbook provided to members following enrollment includes:<br>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.<br>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.<br>c. The extent to which and how members may obtain benefits, including family planning services and supplies from out-of-network providers.<br>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.<br>e. The process of selecting and changing the member's primary care provider. | **Suggested Documents:**<br>• Policies and procedures on member materials and dissemination of information to members<br>• Member handbook<br>**Documents Submitted for Desk Review:**<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• EOCCO Member Handbook and Annual Notification Policy.pdf<br>• EOCCO Member Services and Outreach Communication Policy.pdf | ☐ Met<br>☒ Partially Met<br>☐ Not Met |

| Standard XIV—Member Information (42 CFR §438.10) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| f. Any restrictions on the member's freedom of choice among network providers.<br>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.<br>*42 CFR §438.10(g)(2)*<br>*Contract: Exhibit B Part 3 (5)(a)(1)*<br>*OAR 410-141-3585 (12)* | | |
| **HSAG Findings:** The CCO's Member Handbook and *Annual Notification* policy provided a process for ensuring that the CCO's member handbook was compliant on at least an annual basis. EOCCO's member handbook provided information to members on the amount, duration, and scope of benefits available to them in sufficient detail to understand their benefits. It also showed members how to use them via a table which stated categories of benefits or services, examples of the benefit or service, and prior authorization requirements if any were applicable. The handbook explained how to: obtain referrals from PCPs, obtain prior authorization when necessary, and seek specialty care. The handbook stated that members may obtain family planning services from any provider contracted with OHA that is licensed to perform such services, whether in or out of the CCO's network, and that prior authorization was not required for family planning services. The handbook directed members to use the provider search tool or to call Customer Service to select a PCP within the EOCCO's network. No further restrictions were placed on selecting providers within the network, except for providers requiring a referral from a PCP or other prior authorization. The member handbook clearly stated that the CCO did not deny access to services based on moral or religious beliefs. However, while the member handbook provided sufficient information for how to select a PCP, it also stated that members were restricted to changing their PCP up to twice per year, which was counter to 42 CFR 438.52 and CCO contract language. This limitation also was not consistent with OHA's model member handbook, which removed all language related to limiting members' ability to change PCPs. During the site visit, the CCO explained that it does not currently, nor has it in the past, restricted members from changing PCPs. Rather, it monitors members' requests to manage the quality of members' care. The CCO noted that it has adopted the model member handbook to address this concern moving forward. This requirement was *Partially Met*. | | |
| **Required Actions:** The CCO must ensure that its policies, procedures, and member materials, including the member handbook, are compliant with 42 CFR §438.52 regarding limitations on a member's ability to change primary care providers. Specifically, remove the limitation that members are restricted to changing PCPs up to twice per year. | | |

| Standard XIV—Member Information (42 CFR §438.10) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| 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:<br>• Receive information in accordance with information requirements (42 CFR §438.10).<br>• Be treated with respect and with due consideration for his or her dignity and privacy.<br>• Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.<br>• Participate in decisions regarding his or her health care, including the right to refuse treatment.<br>• Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.<br>• Request and receive a copy of his or her medical records, and request that they be amended or corrected.<br>• 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).<br>• 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.<br>*42 CFR §438.10(g)(2)(ix)*<br>*Contract: Exhibit B Part 3 (5)(a)(1)*<br>*OAR 410-141-3585 (12)* | **Suggested Documents:**<br>• Policies and procedures on member materials and dissemination of information to members<br>• Member Handbook<br>**Documents Submitted for Desk Review:**<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• EOCCO Member Handbook and Annual Notification Policy.pdf<br>• EOCCO Member Services and Outreach Communication Policy.pdf | ☒ Met<br>☐ Partially Met<br>☐ 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** |
| 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:<br>a. The right to file grievances and appeals.<br>b. The requirements and time frames for filing a grievance or appeal.<br>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.<br>d. The availability of assistance in the filing process for grievances and appeals.<br>e. The fact that, when requested by the member:<br>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.<br>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.<br>*42 CFR §438.10(g)(2)(xi)*<br>*Contract: Exhibit B Part 3 (5)(a)(1)*<br>*OAR 410-141-3585 (12)* | **Suggested Documents:**<br>• Policies and procedures on member materials and dissemination of information to members<br>• Member handbook<br>**Documents Submitted for Desk Review:**<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• EOCCO Medicaid Member Grievances and Appeals Policy.pdf<br>• EOCCO Member Handbook and Annual Notification Policy.pdf<br>• EOCCO Member Services and Outreach Communication Policy.pdf | ☒ Met<br>☐ Partially Met<br>☐ 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:<br>a. What constitutes an emergency medical condition and emergency services.<br>b. The fact that prior-authorization is not required for emergency services.<br>c. The fact that the member has the right to use any hospital or other setting for emergency care.<br>*42 CFR §438.10(g)(2)(v)*<br>*Contract: Exhibit B Part 3 (5)(a)(1)*<br>*OAR 410-141-3585 (12)* | **Suggested Documents:**<br>• Policies and procedures on member materials and dissemination of information to members<br>• Member handbook<br>**Documents Submitted for Desk Review:**<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• EOCCO Member Handbook and Annual Notification Policy.pdf<br>• EOCCO Member Services and Outreach Communication Policy.pdf<br>• CMR EOCCO ED paid claims.docx | ☒ Met<br>☐ Partially Met<br>☐ Not Met |
| **HSAG Findings:** This requirement was *Met*. | | |
| **Required Actions:** None. | | |
| 19. The member handbook provided to members following enrollment includes:<br>a. Cost-sharing, if any is imposed under the State plan.<br>b. How and where to access any benefits that are available under the State plan but not covered under the Medicaid managed care contract.<br>c. How transportation is provided.<br>d. The toll-free telephone number for member services, medical management, and any other unit providing services directly to members.<br>e. Information on how to report suspected fraud or abuse. | **Suggested Documents:**<br>• Policies and procedures on member materials and dissemination of information to members<br>• Member handbook<br>**Documents Submitted for Desk Review:**<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• EOCCO Member Handbook and Annual Notification Policy.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard XIV—Member Information (42 CFR §438.10) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| f. How to access auxiliary aids and services, including information in alternative formats or languages.<br>*42 CFR §438.10(g)(2)(ii, viii, xiii, xiv, xv)*<br>*Contract: Exhibit B Part 3 (5)(a)(1)*<br>*OAR 410-141-3585 (12)* | • EOCCO Member Services and Outreach Communication Policy.pdf | |
| **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).<br>*42 CFR §438.10(g)(2)(xii)*<br>*Contract: Exhibit B Part 3 (5)(a)(1)*<br>*OAR 410-141-3585 (12)* | **Suggested Documents:**<br>• Policies and procedures on member materials and dissemination of information to members<br>• Member handbook<br>**Documents Submitted for Desk Review:**<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• EOCCO Advance Directive Policy.pdf | ☒ Met<br>☐ Partially Met<br>☐ 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.<br>*42 CFR §438.10(g)(4)*<br>*Contract: Exhibit B Part 3 (4)(i)*<br>*AR 410-141-3585 (3)(f)* | **Suggested Documents:**<br>• Example notification (if applicable within the last year)<br>• Template letter (if available)<br>**Documents Submitted for Desk Review:**<br>• EOCCO Member Handbook and Annual Notification Policy.pdf | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard XIV—Member Information (42 CFR §438.10) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | • 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• EOCCO Provider Term Letter-E.pdf<br>• EOCCO Provider Term Letter-S.pdf | |
| **HSAG Findings:** This requirement was *Met*. | | |
| **Required Actions:** None. | | |
| 22. The CCO provides member information by either:<br>a. Mailing a printed copy of the information to the member's mailing address.<br>b. Provides the information by email after obtaining the member's agreement to receive the information by email.<br>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.<br>d. Provides the information by any other method that can reasonably be expected to result in the member receiving that information.<br>*42 CFR §438.10(g)(3)*<br>*Contract: Exhibit B Part 3 (4)(d)* | **Suggested Documents:**<br>• Policies and procedures on member materials and dissemination of information to members<br>• Member welcome or introductory materials<br>• Website links/screenshots<br>• Evidence of mailings<br>• Evidence of emails<br>**Documents Submitted for Desk Review:**<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>• EOCCO Member Services and Outreach Communication Policy.pdf<br>• REV2-0788-EOCCO-Postcard Annual Notice_FINAL_Print.pdf<br>• REV2-0788-EOCCO-Postcard Annual Notice_Spanish_FINAL_Print.pdf<br>• Draft_2022_Welcome Packet_ENG.pdf<br>• EOCCO Website: EOCCO member home | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard XIV—Member Information (42 CFR §438.10) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | • EOCCO Website: General resources (eocco.com)<br>• EOCCO Fulfillment Order 2022.xlsx<br>• EOCCO Member Request for Material Translation and Alternative Formats Policy.pdf | |
| **HSAG Findings:** This requirement was *Met*. | | |
| **Required Actions:** None. | | |

| Results for Standard XIV—Member Information | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Total** | Met | = | 14 | X | 1.0 | = | 14.0 |
| | Partially Met | = | 7 | X | 0.5 | = | 3.5 |
| | Not Met | = | 1 | X | 0.0 | = | 0.0 |
| **Total Applicable** | | = | 22 | **Total Score** | | = | 17.5 |

| | | |
|---|---|---|
| **Total Score ÷ Total Applicable** | = | **79.5%** |

# 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:<br>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;<br>b. Serious impairment to bodily functions; or<br>c. Serious dysfunction of any bodily organ or part.<br>*42 CFR §438.114(a)*<br>*Contract: Exhibit A*<br>*OAR 410-120-0000* | **Suggested Documents:**<br>• Emergency and poststabilization services coverage policies and procedures<br>• Member handbook<br>• Provider handbook or other provider messaging<br>**Documents Submitted for Desk Review:**<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>– Pg. 8-9, 35<br>• EOCCO Emergency Condition Care Policy.pdf<br>– II. B. | ☐ Met<br>☒ Partially Met<br>☐ Not Met |
| **HSAG Findings:** The *Emergency Condition Care* policy included the definition of an "emergency medical condition" as specified in this element. The member handbook included a member-appropriate definition of an "emergency medical condition." However, neither the provider manual nor the provider agreement included the definition.<br>During the site visit, the CCO reported that it recognized the provider manual was missing this information and was being updated. The CCO also reported that staff are informed of the definition and its impact on organizational processes during onboarding. This requirement was *Partially Met*. | | |
| **Required Actions:** The CCO must ensure provider materials (e.g., provider manual, provider agreement) include the definition of "emergency medical condition." | | |
| 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.<br>*42 CFR §438.114(a)*<br>*Contract: Exhibit A*<br>*OAR 410-120-0000* | **Suggested Documents:**<br>• Emergency and poststabilization services coverage policies and procedures<br>• Member handbook<br>• Provider handbook or other provider messaging | ☐ Met<br>☒ Partially Met<br>☐ Not Met |

| Standard XVI—Emergency and Poststabilization Services (42 CFR §438.114) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | **Documents Submitted for Desk Review:**<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>– Pg. 9<br>• EOCCO Emergency Condition Care Policy.pdf<br>– II. C. | |
| **HSAG Findings:** The *Emergency Condition Care* policy included the definition of "emergency services" as specified in this element. The member handbook included a member-appropriate definition of "emergency services." However, neither the provider manual nor the provider agreement included the definition.<br>During the site visit, the CCO reported that it recognized the provider manual was missing this information and was being updated. The CCO also reported that staff are informed of the definition and its impact on organizational processes during onboarding. This requirement was *Partially Met*. | | |
| **Required Actions:** The CCO must ensure provider materials (e.g., provider manual, provider agreement) include the definition of "emergency services." | | |
| 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.<br>*42 CFR §438.114(a)*<br>*Contract: Exhibit A* | **Suggested Documents:**<br>• Emergency and poststabilization services coverage policies and procedures<br>• Member handbook or other member messaging<br>• Provider handbook or other provider messaging<br>**Documents Submitted for Desk Review:**<br>• EOCCO Emergency Condition Care Policy.pdf<br>– II. E.<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>– Pg. 35<br>• Parents-Emergency-Room-Guidebook.pdf | ☐ Met<br>☒ Partially Met<br>☐ Not Met |

| Standard XVI—Emergency and Poststabilization Services (42 CFR §438.114) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | – Pg.3<br>• ED Parent Guide- Advocating for your loved ones- Tracking sheet | |
| **HSAG Findings:** The *Emergency Condition Care* policy 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 CCO also submitted its ED [emergency department] Parent Guide, which included information for parents on advocating for their loved ones during a crisis. However, neither the provider manual nor the provider agreement included the definition.<br>During the site visit, the CCO reported that it recognized the provider manual was missing this information and was being updated. The CCO also reported that staff are informed of the definition and its impact on organizational processes during onboarding. This requirement was *Partially Met.* | | |
| **Required Actions:** The CCO must ensure provider materials (e.g., provider manual, provider agreement) include the definition of "poststabilization care services." | | |
| 4. The CCO may not require prior authorization for emergency services.<br>*42 CFR §438.10(g)(2)(v)(B)*<br>*Contract: Exhibit B Part 2(4)(a)(1)*<br>*OAR 410-141-3835(2)*<br>*OAR 410-141-3840(4)* | **Suggested Documents:**<br>• Emergency and poststabilization services coverage policies and procedures<br>**Documents Submitted for Desk Review:**<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>– Pg. 32, 35, 37<br>• Current EOCCO Provider Manual 10.5.22.pdf<br>– Pg. 12<br>• EOCCO Emergency Condition Care Policy.pdf<br>– I. III. D<br>• ED No Auth Sample 1.docx<br>• Referral and Auth Guideline.pdf<br>– Pg. 3 | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard XVI—Emergency and Poststabilization Services (42 CFR §438.114) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | • EOCCO Website: EOCCO referrals & authorizations<br>• EOCCO Participating Provider Agreement.docx<br>– Pg. 10<br>• EOCCO Non-Participating Referral and Service Authorization Policy.pdf<br>– Pg.1 | |
| **HSAG Findings:** This requirement was *Met.* | | |
| **Required Actions:** None. | | |
| 5. The CCO covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the CCO.<br>*42 CFR §438.114(c)(1)(i)*<br>*Contract: Exhibit B Part 2(4)(a)(3)* | **Suggested Documents:**<br>• Emergency and poststabilization services coverage policies and procedures<br>• Claims payment workflows and/or protocols – specific to payment of emergency services<br>**Documents Submitted for Desk Review:**<br>• EOCCO Emergency Condition Care Policy.pdf<br>– I.<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>– Pg. 60<br>• EOCCO 3108 Provider Enrollment Policy.pdf<br>– Pg.2<br>• 84M DMAP Registration Required.docx<br>• CMR EOCCO ED paid claims.docx | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard XVI—Emergency and Poststabilization Services (42 CFR §438.114) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| **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:<br>a. A representative of the CCO's organization (including the member's primary care provider) instructed the member to seek emergency services.<br>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.<br>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;<br>ii. Serious impairment to bodily functions; or<br>iii. Serious dysfunction of any bodily organ or part.<br>*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*<br>*42 CFR §438.114(c)(1)(ii)*<br>*Contract: Exhibit B Part 2(4)(a)(5) and (11)*<br>*OAR 410-141-3840(4) and (5)* | **Suggested Documents:**<br>• Emergency and poststabilization services coverage policies and procedures<br>• Claims payment workflows and/or protocols – specific to payment and denials of emergency services<br>**Documents Submitted for Desk Review:**<br>• EOCCO Emergency Condition Care Policy.pdf<br>– I. III. D. 1, 3. a.<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>– Pg. 35<br>• ED No Auth Sample 2.docx<br>• Current EOCCO Provider Manual 10.5.22.pdf<br>– Pg.17 | ☒ Met<br>☐ Partially Met<br>☐ 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** |
| 7. The CCO does not:<br>a. Limit what constitutes an emergency medical condition based on a list of diagnoses or symptoms.<br>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.<br>*42 CFR §438.114(d)(1)*<br>*Contract: Exhibit B Part 2(4)(a)(1) and (10)*<br>*OAR 410-141-3840(4)(b) and (c)* | **Suggested Documents:**<br>• Emergency and poststabilization services coverage policies and procedures<br>• Claims payment workflows and/or protocols – specific to payment and denials of emergency services<br>**Documents Submitted for Desk Review:**<br>• EOCCO Emergency Condition Care Policy.pdf<br>– III. D. 2-3.<br>• BH ED Census Report 3.31.22<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>– Pg. 35<br>• Current EOCCO Provider Manual 10.5.22.pdf<br>• EOCCO_ER Review Process.docx | ☒ Met<br>☐ Partially Met<br>☐ Not Met |
| **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.<br>*42 CFR §438.114(d)(2)*<br>*Contract: Exhibit B Part 2(4)(a)(9)*<br>*OAR 410-141-3840(4)* | **Suggested Documents:**<br>• Emergency and poststabilization services coverage policies and procedures<br>• Claims payment workflows and/or protocols – specific to coverage of poststabilization services<br>• Provider messaging | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard XVI—Emergency and Poststabilization Services (42 CFR §438.114) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | **Documents Submitted for Desk Review:**<br>• EOCCO Emergency Condition Care Policy.pdf<br>– III. D.<br>• Current EOCCO Provider Manual 10.5.22.pdf<br>– Pg.17<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>– Pg. 35 | |
| **HSAG Findings:** This requirement was *Met.* | | |
| **Required Actions:** None. | | |
| 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.<br>*42 CFR §438.114(d)(3)*<br>*Contract: Exhibit B Part 2(4)(a)(9)* | **Suggested Documents:**<br>• Emergency and poststabilization services coverage policies and procedures<br>• Claims payment workflows and/or protocols – specific to poststabilization services<br>• Provider messaging<br>**Documents Submitted for Desk Review:**<br>• EOCCO Emergency Condition Care Policy.pdf<br>– III. F.<br>• Transfer Case Sample 1.pdf<br>• Transfer Case Sample 2.pdf<br>• BH Physician Hold Case Sample 6-24-22<br>• BH Physician Hold Case Sample 8.9.22<br>• EOCCO Participating Provider Agreement.docx | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard XVI—Emergency and Poststabilization Services (42 CFR §438.114) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| | – Pg.10<br>• BH Auth Case Sample Hold_Acute_DC plan with County.pdf | |
| **HSAG Findings:** This requirement was *Met*. | | |
| **Required Actions:** None. | | |
| 10. The CCO is financially responsible for poststabilization services that are:<br>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.<br>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.<br>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:<br>i. The organization does not respond to a request for pre-approval within one hour;<br>ii. The organization cannot be contacted; or<br>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 | **Suggested Documents:**<br>• Emergency and poststabilization services coverage policies and procedures<br>• Claims payment workflows and/or protocols – specific to poststabilization services<br>• Provider messaging<br>**Documents Submitted for Desk Review:**<br>• EOCCO Emergency Condition Care Policy.pdf<br>– III. D.<br>• BH Auth Case Sample Hold_Acute_DC plan with County.pdf<br>• Current EOCCO Provider Manual 10.5.22.pdf<br>– Pg.17<br>• Referral and Auth Guideline.pdf<br>– Pg.3 | ☐ Met<br>☒ Partially Met<br>☐ Not Met |

| Standard XVI—Emergency and Poststabilization Services (42 CFR §438.114) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| 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.<br>*42 CFR §438.114(e); 422.113(c)(2)(i-iii)*<br>*Contract: Exhibit A and Exhibit B Part 2(4)(a)(6) and (8)*<br>*OAR 410-141-3840(5)* | | |
| **HSAG Findings:** The *Emergency Condition Care* policy did not address the CCO requirement to pay for poststabilization services that are *not pre-approved* by a plan provider or other organizational representative. Specifically, regarding services administered to maintain the member's stabilized condition within one hour of a pre-approval request to the organization for further poststabilization care services. In addition, the policy stated that the CCO will pay for non-pre-authorized poststabilization services if:<br>• The CCO or the on-call provider failed to respond within one hour to a pre-authorization request; or<br>• The member could not contact EOCCO or the provider on call.<br>However, the regulatory language is specific to the organization not responding to the facility or the facility being unable to reach the health plan. It does not include requirements for the member to contact the health plan or the facility to contact an on-call provider.<br>The Referral and Auth Guideline process document stated that the CCO processes received notifications of emergent/urgent admissions within 24 hours and that continued review of the admission depends on the actual length of stay. When a member stays beyond two nights, a care coordinator will follow up with the facility and conduct a clinical review. The care coordinator will request clinical documentation and review all available information to determine the medical necessity of an ongoing stay. This requirement was *Partially Met*. | | |
| **Required Actions:** The CCO must ensure its *Emergency Condition Care* policy aligns with the stated requirements related to the CCO's financial responsibility for poststabilization care services. | | |
| 11. The CCO's financial responsibility for poststabilization care services it has not pre-approved ends when:<br>a. A plan physician with privileges at the treating hospital assumes responsibility for the member's care;<br>b. A plan physician assumes responsibility for the member's care through transfer; | **Suggested Documents:**<br>• Emergency and poststabilization services coverage policies and procedures<br>• Claims payment workflows and/or protocols - specific to poststabilization services | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard XVI—Emergency and Poststabilization Services (42 CFR §438.114) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| c. A plan representative and the treating physician reach an agreement concerning the member's care; or<br>d. The member is discharged.<br>*42 CFR §438.114(e); 422.113(c)(3)(i-iv)*<br>*Contract: Exhibit B Part 2(4)(a)(7)*<br>*OAR 410-141-3840(6)* | **Documents Submitted for Desk Review:**<br>• EOCCO Emergency Condition Care Policy.pdf<br>– III. D. 3. c.<br>• BH Auth Case Sample Hold_Acute_DC plan with County.pdf<br>• Emergency discharge out of state.docx<br>• Emergency and discharge case.pdf | |
| **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 she had obtained the services through an in-network provider.<br>*42 CFR §438.114(e); 422.113(c)(2)(iv)*<br>*Contract: Exhibit B Part 2(4)(a)(6)*<br>*OAR 410-141-3840(8)* | **Suggested Documents:**<br>• Emergency and poststabilization services coverage policies and procedures<br>• Example of communication to out-of-network emergency provider<br>• Member messaging related to financial liability<br>**Documents Submitted for Desk Review:**<br>• 2022 EOCCO Member Handbook_Compiled_04132023.pdf<br>– Pg. 15-16, 36<br>• EOCCO Emergency Condition Care Policy.pdf<br>– III. D. 3. b.<br>• EOCCO_ER Review Process.docx\<br>– Pg. 1 | ☒ Met<br>☐ Partially Met<br>☐ Not Met |

| Standard XVI—Emergency and Poststabilization Services (42 CFR §438.114) | | |
|---|---|---|
| **Requirement** | **Evidence as Submitted by the CCO** | **Score** |
| **HSAG Findings:** The *Emergency Condition Care* policy stated, "EOCCO limits the member's cost-sharing for poststabilization services, which begins upon admission for cost-sharing purposes, to an amount no greater than what the charges would have been for the member if the member had obtained the services within the EOCCO network."<br>During the site visit, the CCO reported that its policy included language related to cost-sharing to comply with the stated requirements. However, members do not have any cost-sharing responsibilities. In addition, the CCO described its process for informing providers that they may not balance bill members. The member handbook informed members that they should call the CCO for assistance if they get a bill from a provider. This requirement was *Met.* | | |
| **Required Actions:** None. | | |
| **Recommendations:** HSAG recommends that the CCO update its *Emergency Condition Care* policy to clarify that members do not have any cost-sharing responsibilities. | | |

| Standard XVI—Emergency and Poststabilization Services | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Total** | Met | = | 8 | X | 1.0 | = | 8.0 |
| | Partially Met | = | 4 | X | 0.5 | = | 2.0 |
| | Not Met | = | 0 | X | 0.0 | = | 0.0 |
| **Total Applicable** | | = | 12 | **Total Score** | | = | 10.0 |

| | | |
|---|---|---|
| **Total Score ÷ Total Applicable** | = | **83.3%** |

# Appendix B. CY 2022 Improvement Plan Findings

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

## 2020 Findings

| Standard XV—Member Information | |
|---|---|
| **Element #10** | For each of the providers listed in the provider directory, MCE must also include the following information:<br>a. The provider's or subcontractor's name and group affiliation.<br>b. Specialty (as appropriate).<br>c. Street address.<br>d. Telephone number.<br>e. Web site URL, as appropriate.<br>f. Whether the provider is accepting new MCE members.<br>g. Whether the provider's office has accommodations for people with physical disabilities, including offices, exam rooms, and equipment.<br>h. Non-English language spoken and information on cultural and the linguistic capabilities (including American Sign Language) offered by the provider or an OHA-approved qualified or certified interpreter at the providers office and whether the provider has completed cultural competency training.<br>*(Note: Information included in a paper provider directory must be updated at least monthly and electronic provider directories must be updated no later than 30 calendar days after the MCE receives updated provider information.)*<br>*42 CFR §438.10(h)(1,3)*<br>*Contract: Exhibit B Part 3 (6)(f)*<br>*OAR 410-141-3585 (6)* |
| **Finding:** Although EOCCO's provider directory included most of the required components, it did not consistently list provider websites, accessibility for disabled persons, or whether or not providers had completed cultural competency training. This requirement was *Partially Met*. | |
| **Required Action:** EOCCO must ensure that its provider directory includes provider websites, information on accessibility for disabled persons, and whether or not providers have completed cultural competency training. | |

**CCO Improvement Plan**

| CCO Action Plan/Interventions | Individual(s) Responsible | Completion Date |
|---|---|---|
| EOCCO is in the process of adding the following text for the website field "Provider has no website" to differentiate between the providers for which a website has not populated into the directory and those who truly do not have a website. | • Mina Zarnegin<br>• Kayla Jones | 6/30/2021 and ongoing |

| Standard XV—Member Information | | |
|---|---|---|
| EOCCO is actively working on a solution to ensure that accessibility information is accurately reflected on provider rosters and generated in the provider directory. Language will be developed for providers from whom we have not yet received confirmation of accessibility resources.<br>Regarding the cultural competency element, EOCCO is actively working with providers to collect and populate this information into the provider directory/search tool. This will be updated on a rolling basis as providers update the monthly roster submissions. | | |
| **HSAG Assessment of Plan** | 03/22/2022. A review of EOCCO's online provider directory revealed placeholder statements for websites, accessibility services available, bilingual services/languages offered, and cultural competency training completion. EOCCO's improvement plan described a process of entering "Provider has no website" to differentiate between providers with no website from provider websites not populated in the directory. HSAG conducted a random review of primary and preventive care providers in the online provider directory and noted multiple providers designated as having no website; however, an internet search of the providers revealed websites existed. In addition, all providers randomly selected for review indicated "Information not yet available" for accessibility and bilingual services/languages offered. CCOs are required to make the provider information outlined in 42 CFR 438.10(h)(1)(i-viii), and any additional State required information, available to members in electronic and paper form. EOCCO's improvement plan did not include its plan of action or implementation schedule for obtaining and updating the provider directory with the elements required by the CFR. At a minimum, required information should be routinely collected during credentialing and recredentialing activities. EOCCO should work with its credentialing department to identify providers due for recredentialing in CY 2022, then focus outreach activities on those who fall outside the CY 2022 timeframe and prioritize the provider specialty types with the highest utilization. While updating the provider directory as provider information changes is an ongoing requirement, EOCCO must identify milestones and target completion dates for ensuring required information is available for the providers currently listed in the provider directory. This finding remains **unresolved**. |
| **CCO Status Update** | Beginning in 2022, EOCCO will expand the scope of validation of its online provider directory in response to The Consolidated Appropriations Act (CAA). This requires that health plans establish a process to verify and update provider directory information at least every 90 days. Providers are required to have in place processes to ensure the timely provision of provider directory information to support the health plan's compliance with CAA requirements. The new requirements now require that we outreach to all our providers in all of our geographies. Specific elements include name, address, specialty, accepting new patients, telephone number, and digital contact. Implementation of updates will take place by Q4-2022.<br>EOCCO is also participating in OHA's Provider Directory workgroup to discuss any rule change concerns and best practices for how CCOs are providing particular fields within their Provider Directories. |

| Standard XV—Member Information | | |
|---|---|---|
| **Documentation Submitted as Evidence** | • OHA Provide Directory Workgroup Email.pdf<br>• Practitioner Survey.pdf<br>• Clinic Survey.pdf<br>• Good Shepherd Screenshot.PNG<br>• Lifeways Provider Search Tool.PNG<br>• Lifeways Facets.png | |
| **HSAG Assessment of Resolution** | Prior to the virtual onsite, review of the provider directory revealed the information on accessibility for disabled persons, and whether providers have completed cultural competency training continued to read, "Information not yet available." The CCO must include the necessary information, provider websites, information on accessibility for disabled persons, and whether providers have completed cultural competency training, in its Provider Directory. ECCO reported the implementation of updates to the Provider Directory will take place by Q4 2022.<br>During the virtual "onsite" review, EOCCO described a process where practitioner and clinic surveys as well as information obtained during the credentialing process was used to collect the required components in the provider directory and this information was being added to the directory on a rolling basis. EOCCO provided screenshots as evidence that the information on accessibility for disabled persons and whether providers have completed cultural competency training was being added to the directory. As of 1/1/2023, the cultural competency training component of the provider directory will no longer be required by the state. EOCCO noted provider's websites were not currently being displayed on the online directory and the IT team was working to resolve the issue. EOCCO must make the provider website information available to members in electronic and paper form and provide evidence to HSAG once this issue has been resolved. This finding remains **unresolved**. | ☐ Resolved<br>☐ Resolved, with recommendations<br>☒ Not Resolved |
| **CCO Status Update** | EOCCO is continuing to update provider information on the directory as its received. There is also a directory accuracy project that will start in 2023 to help address this gap.<br><br>EOCCO's paper directory is up and running. | |

| Standard XV—Member Information | | |
|---|---|---|
| **Documentation Submitted as Evidence** | 1. EOCCO_Provider_Directory_English_Print Version.Final<br>2. Strawberry Wilderness Clinic Directory Clip | |
| **HSAG Assessment of Resolution** | This finding was assessed in the 2023 compliance review in the 2023 Standard XIV—Member Information tool. Please see the tool for detailed findings on this element.<br><br>This finding remains **unresolved**. | ☐ Resolved<br>☐ Resolved, with recommendations<br>☒ Not Resolved |

## 2021 Findings

| Standard I—Availability of Services | |
|---|---|
| **Element #3** | The CCO provides female members with direct access to a women's health specialist within the network for covered services necessary to provide women's routine and preventive health care services. This is in addition to the female member's designated source of primary care if that source is not a woman's health specialist.<br>*Note: Direct access means no prior authorization or referral is required.*<br>*42 CFR §438.206(b)(2)*<br>*Contract: Exhibit B Part 4 (2)(n)* |
| **Finding:** The *Member Access to Care* and *Members' Rights and Responsibilities* policies aligned with the requirement to provide female members with direct access to women's health specialists. This information was communicated correctly in the member handbook; however, the provider manual limited direct access to family planning services. This was out of compliance with the requirement to provide female members with direct access to a women's health specialist for routine and preventive health care services when the female member's source of primary care was not a women's health specialist. This requirement was *Partially Met*. | |
| **Required Action:** EOCCO must revise the provider manual to align with the requirement to provide female members with direct access to a women's health specialist for routine and preventive health care services. | |

**CCO Improvement Plan**

| CCO Action Plan/Interventions | Individual(s) Responsible | Completion Date |
|---|---|---|
| EOCCO added the following section to the Provider Manual on page 12:<br>***Services that do not require a referral***<br>*Members can see any network provider for*<br>*• Urgent and emergency care*<br>*• Family planning services and supplies, such as birth control*<br>*• Routine Vision exam*<br>*• Prenatal care*<br>*• Immunizations*<br>*• Women's routine and preventive health care*<br>*• Routine laboratory and radiology services* | • Noah Pietz | 01/2022 |

| Standard I—Availability of Services | | | |
|---|---|---|---|
| • *Orthopedic providers*<br>• *Behavioral health services, including mental health and substance use disorder (SUD)*<br>• *Intensive care coordination* | | | |
| **Documentation Submitted as Evidence** | April 2022 EOCCO Provider Manual.pdf | | |
| **HSAG Assessment of Resolution** | EOCCO revised its provider manual to include women's routine and preventive health care and family planning services as services that do not require a referral. However, EOCCO did not revise the provider manual to align with the requirement to provide female members with direct access to women's health specialist for routine and preventative health care services. This finding remains **unresolved**. | ☐ Resolved<br>☐ Resolved, with recommendations<br>☒ Not Resolved | |
| **CCO Status Update** | EOCCO removed the word "women's" and replaced with "females". Here is the new language:<br><br>"All routine and preventive health care for females" | | |
| **Documentation Submitted as Evidence** | 2023 EOCCO Provider Manual_FINAL.pdf | | |
| **HSAG Assessment of Resolution** | The provider manual was updated, changing terminology from "women's" to "females" regarding female enrollees having the ability to see any network provider without a PCP referral. The provider manual also referenced a prior authorization document for use by providers. The document further demonstrated that the CCO does not require prior authorization for female members to access women's routine and preventive health care services. During the site visit, the CCO confirmed direct access to women's routine and preventive health care services without prior authorization or referral from the PCP.<br><br>This finding was **resolved**. | ☒ Resolved<br>☐ Resolved, with recommendations<br>☐ Not Resolved | |

| Standard XI—Practice Guidelines | |
|---|---|
| **Element #3** | Decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.<br>*42 CFR §438.236(d)*<br>*Contract: Exhibit B Part 4(10)* |
| **Finding:** While EOCCO demonstrated how practice guidelines are aligned with utilization and coverage decisions, the CCO was unable to demonstrate that its member education decisions were consistent with practice guidelines, nor was this addressed in policy. This requirement was *Partially Met*. | |
| **Required Action:** EOCCO must ensure there is a documented process for vetting member education decisions with its practice guidelines and demonstrate evidence of this. | |

**CCO Improvement Plan**

| CCO Action Plan/Interventions | Individual(s) Responsible | Completion Date |
|---|---|---|
| EOCCO put together a Practice Guidelines workgroup that included representatives from Medicaid Operations, Quality, Healthcare Services, and Behavioral Health. The purpose of the workgroup is to create a process for vetting member education decisions with its practice guidelines. The work group met on 03/09/2022 and 04/08/2022 to develop goals and action items to ensure member education is aligned with best practices and clinical practice guidelines. | • Kristi Swank | Q2-2022 |

| | |
|---|---|
| **Documentation Submitted as Evidence** | EOCCO Clinical practice guidelines workgroup.docx<br>EOCCO Member Education Materials.xlsx |
| **HSAG Assessment of Resolution** | EOCCO provided a meeting summary for EOCCO's Clinical Practice Guidelines Workgroup, which described the goals of the workgroup that included ensuring member education was aligned with best practices/clinical practice guidelines. EOCCO also provided a list of member education materials with documentation of sources used to create the member materials. During the virtual review, EOCCO indicated the Clinical Practice Guidelines Workgroup meeting schedule has been delayed and the next meeting is set to occur in August, therefore, the *Clinical Practice Guidelines* policy was not updated to include a documented review process. EOCCO must provide an updated *Clinical Practice Guidelines* policy and August |
| | ☐ Resolved<br>☐ Resolved, with recommendations<br>☒ Not Resolved |

| Standard XI—Practice Guidelines | | |
|---|---|---|
| | meeting minutes to demonstrate that its member education decisions are consistent with practice guidelines. This finding remains **unresolved**. | |
| **CCO Status Update** | EOCCO updated its policy to include a review and revision section and included August 2022 meeting notes where the change was discussed. | |
| **Documentation Submitted as Evidence** | 1. EOCCO Clinical Practice and Coverage Guidelines Policy<br>2. EOCCO Clinical practice guidelines workgroup | |
| **HSAG Assessment of Resolution** | The *Clinical Practice and Coverage Guidelines* policy was revised to include a process to review and update member education materials anytime clinical practice guidelines are revised during the biennial review. The CCO also submitted a summary from the August 2022 Clinical Practice Guidelines Workgroup to show a review and approval of the policy.<br>HSAG recommends that the CCO include the names of participants in the Clinical Practice Guidelines Workgroup meeting minutes to demonstrate attendance by appropriate individuals and support compliance in the calendar year (CY) 2024 CMR audit of the Practice Guidelines standard.<br>This finding was **resolved with a recommendation**. | ☐ Resolved<br>☒ Resolved, with recommendations<br>☐ 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.<br>*42 CFR §438.3(d)(3-4)*<br>*CCO Contract Exhibit B Part 3(8)(c)* |
| **Finding:** EOCCO's *Enrollment Data and Requests for Disenrollment from CCO* policy stated the CCO does not discriminate against individuals eligible to enroll or 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, national origin, sex, sexual orientation, gender identity, or disability; however, the policy did not address religion, marital status, or age. EOCCO's nondiscrimination notice and 2021 member handbook asserted the CCO follows State and federal civil rights laws and does not treat people unfairly in their services or programs because of a person's age, color, disability, gender identity, marital status, national origin, race, religion, sex, or sexual orientation; however, the nondiscrimination notice did not address discrimination on the basis of health status or need for health care services. During the virtual audit review, EOCCO staff members noted that the member handbook is not used to support communication with individuals eligible to enroll. Also, EOCCO did not demonstrate the appropriate State and federal requirements regarding non-discrimination against individuals eligible to enroll are addressed within its materials utilized to train its enrollment staff members on its policies. This requirement was *Partially Met*. | |
| **Required Action:** EOCCO must update its *Enrollment Data and Requests for Disenrollment from CCO* policy to include the requirement of the CCO to not discriminate on the basis of religion, marital status, and age. Additionally, EOCCO must update its nondiscrimination notice and other materials utilized to inform potential members of its nondiscrimination policies to align with State and federal requirements to include the required language asserting the CCO does not discriminate against individuals on the basis of health status or need for health care services. Also, EOCCO must demonstrate the appropriate State and federal requirements regarding non-discrimination against individuals eligible to enroll are addressed within its employee handbook or other materials utilized to train enrollment staff members on its policies. | |

| CCO Improvement Plan | | |
|---|---|---|
| **CCO Action Plan/Interventions** | **Individual(s) Responsible** | **Completion Date** |
| EOCCO made the following updates:<br>1. Updated the *Enrollment Data and Requests for Disenrollment from CCO* policy to include the requirement of the CCO to not discriminate on the basis of religion, marital status, and age. | • Kayla Jones | April 2023 |

| Standard IX—Enrollment and Disenrollment | | | |
|---|---|---|---|
| 2. Used OHA's Non-Discrimination Notice (NDN) template to update EOCCO's NDN notice.<br>3. Updated the *EOCCO Medicaid Member Non-Discrimination Policy* to state that EOCCO does not discrimination again individuals on the basis of health status or need for Health Care Services | | | |
| **Documentation Submitted as Evidence** | 1. EOCCO Medicaid Member Non-Discrimination Policy<br>2. EOCCO Enrollment Data and Requests for Disenrollment from CCO Policy<br>3. EOCCONondiscriminationStatement_Black_Print | | |
| **HSAG Assessment of Resolution** | EOCCO revised the appropriate policies and the Nondiscrimination Notice to include the appropriate nondiscrimination characteristics aligning with State and federal requirements. During the site visit, CCO staff stated that the training for nondiscrimination of members eligible for enrollment would occur during the CCO staff's annual/new hire training and provider training. Evidence of training was reviewed from the documentation provided for another standard. This finding is **resolved**. | ☒ Resolved<br>☐ Resolved, with recommendations<br>☐ 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:<br>a. Utilization of health services.<br>b. Physical, intellectual, developmental, or mental disability.<br>c. Uncooperative or disruptive behavior resulting from the member's special needs, disability or any condition that is a result of their disability.<br>d. Being in the custody of DHS/Child Welfare.<br>e. Prior to receiving any services, including, without limitation, anticipated placement in or referral to a psychiatric residential treatment facility.<br>f. A member's decision regarding their own medical care with which the contractor disagrees.<br>g. Filing a grievance or exercising any appeal or contested case hearing rights.<br>*42 CFR §438.56(b)(2)*<br>*OAR 410-141-3810(4)(c)*<br>*CCO Contract Exhibit B Part 3(9)(d)* |
| **Finding:** The *Enrollment Data and Requests for Disenrollment from CCO* policy asserted EOCCO does not disenroll members from the CCO in accordance with the appropriate state-required reasons. EOCCO provided an ad hoc disenrollment report, which was produced by the CCO's Medicaid Operations team. During the virtual "onsite" review, the CCO clarified that it only reviews disenrollment reports as needed and reports any issues identified to the QIC. A review of 2021 QIC meeting minutes demonstrated disenrollment was not a routine discussion topic and EOCCO lacked evidence of ongoing monitoring of disenrollment requests to ensure compliance with the regulatory requirements. This requirement was *Partially Met.* | |
| **Required Action:** EOCCO must demonstrate it is regularly monitoring reasons for disenrollment, other than for the 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 were received or initiated. | |

**CCO Improvement Plan**

| CCO Action Plan/Interventions | Individual(s) Responsible | Completion Date |
|---|---|---|
| EOCCO presented disenrollment numbers at the December 2022 QIC meeting. | • Kayla Jones | December 2022 |

| Standard IX—Enrollment and Disenrollment | | |
|---|---|---|
| **Documentation Submitted as Evidence** | 1. 12.19.2022 QIC Committee Meeting Minutes.doc.docx | |
| **HSAG Assessment of Resolution** | The CCO demonstrated reviewing its disenrollment report during its December Quality Improvement Committee (QIC) meeting. CCO staff asserted that disenrollment reports will be monitored either quarterly or annually. HSAG recommends that the CCO identify the frequency of report monitoring, either quarterly or annually, because this will be assessed in the subsequent compliance review for this standard. This finding is **resolved with a recommendation**. | ☐ Resolved<br>☒ Resolved, with recommendations<br>☐ 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:<br>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.<br>b. Newly eligible members may change plans, if another plan is available within ninety (90) days of their initial plan enrollment.<br>c. A member may request to change plans, after six (6) months of their initial plan enrollment.<br>d. A member may request disenrollment during "OHP eligibility renewal," which is typically twelve (12) months.<br>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.<br>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.<br>g. Whenever the member's eligibility is re-determined by OHA.<br>h. When OHA has imposed sanctions on the CCO, including the suspension of all new enrollment (consistent with 42 CFR 438.702(a)(4).<br>i. Members have one additional opportunity to request a plan change during the eligibility period if none of the above options can be applied<br>*42 CFR §438.56(c)(2) and (g)*<br>*OAR 410-141-3810(1)(b)(A)*<br>*CCO Contract Exhibit B Part 3(9)(c)(1)(a)* |
| **Finding:** The *Enrollment Data and Requests for Disenrollment from CCO* policy asserted members may request disenrollment without cause, at the following times:<br>• *During the 90 days following the date of the member's initial enrollment into EOCCO, or during the 90 days following the date the State sends the member notice of that enrollment, whichever is later.*<br>• *At least once every 12 months thereafter.*<br>• *Upon automatic reenrollment, if the temporary loss of Medicaid eligibility (two months or less) has caused the member to miss the annual disenrollment opportunity.*<br>• *When the State imposes the intermediate sanction specified in 42 CFR 438.702(a)(4)—"notification from OHA that EOCCO can no longer have any new members assigned to them."*<br>However, the policy did not address the following without cause reasons: | |

| Standard IX—Enrollment and Disenrollment |
| --- |
| • OHP clients auto-enrolled or manually enrolled in error may change plans, if another plan is available, within 30 days of the member's enrollment.<br>• A member may request to change plans after six months of their initial plan enrollment.<br>EOCCO's 2021 member handbook informed members there were several chances for them to change their CCO and asserted American Indians and Alaska Natives can change plans at any time. The member handbook also stated another CCO must be available in the member's area or have an OHP-approved medical reason for Open Card enrollment. The following reasons members may request disenrollment without cause were communicated in the member handbook:<br>• *If you are new to the Oregon Health Plan, during the first 90 days after you enroll.*<br>• *If you have been on OHP before, during the first 30 days after you enroll in a CCO.*<br>• *When you renew your OHP coverage (usually once each year).*<br>• *If you have been enrolled for 6 months in your CCO, you can request a change in CCO.*<br>• *For any other reason, one time each year.*<br>• *If you move to a place that your CCO doesn't serve, as soon as you can, tell OHP Customer Service about the move; at 1-800-699-9075.*<br>The member handbook did not address the following reasons a member may request disenrollment without cause:<br>• Upon automatic reenrollment (e.g., a recipient who is automatically reenrolled after being disenrolled, solely because such recipient loses Medicaid eligibility for a period of two months or less), if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity.<br>• When OHA has imposed sanctions on the CCO, including the suspension of all new enrollment (consistent with 42 CFR 438.702[a][4]).<br>The handbook also incorrectly communicated that members may request disenrollment "If you have been on OHP before, during the first 30 days after you enroll in a CCO" rather than "If you have been on OHP before and you are auto-enrolled or manually enrolled in error may you change plans, within 30 days of the member's enrollment." This requirement was *Partially Met*. |
| **Required Action:** EOCCO must update the *Enrollment Data and Requests for Disenrollment from CCO* policy and member handbook to align with state-established reasons members may request disenrollment without cause. |

| Standard IX—Enrollment and Disenrollment | | | |
|---|---|---|---|
| **CCO Improvement Plan** | | | |
| **CCO Action Plan/Interventions** | | **Individual(s) Responsible** | **Completion Date** |
| • EOCCO's policy already references OAR 410-141-3810 and the OAR includes language similar to "OHP clients auto-enrolled or manually enrolled in error may change plans, if another plan is available, within 30 days of the member's enrollment and A member may request to change plans after six months of their initial plan enrollment." | | • Kayla Jones | April 2023 |
| **Documentation Submitted as Evidence** | 1. Enrollment-Disenrollment OAR Reference<br>2. EOCCO 2023 member_handbook<br>3. EOCCO Enrollment Data and Requests for Disenrollment from CCO Policy | | |
| **HSAG Assessment of Resolution** | The CCO did not revise the *Enrollment Data and Requests for Disenrollment from CCO* policy to include all without cause reasons. The member handbook was revised to align with state-established reasons members may request disenrollment without cause. The CCO must revise its policy to include all reasons for which members can request disenrollment without cause.<br>This finding remains **unresolved**. | ☐ Resolved<br>☐ Resolved, with recommendations<br>☒ 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:<br>c. The member moves out of the CCO's service area;<br>d. The CCO does not, because of moral or religious objections, cover the service the member seeks;<br>e. 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;<br>f. 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:<br>• Services not provided in the member's preferred language;<br>• Services not provided in a culturally appropriate manner;<br>• It would be detrimental to the member's health to continue enrollment;<br>• For continuity of care.<br>*42 CFR §438.56(c)*<br>*OAR 410-141-3810(1)(b)(B)*<br>*CCO Contract Exhibit B Part 3(9)(c)(1)(b)* |
| **Finding:** The *Enrollment Data and Requests for Disenrollment from CCO* policy defined reasons that members may request disenrollment from EOCCO with cause by referencing the OHA CCO Contract citation, Exhibit B Part 3(9)(c)(b); however, the correct citation is Exhibit B Part 3(9)(c)(1)(b). Additionally, EOCCO's 2021 member handbook did not inform members of the appropriate "with cause" reasons for which members could disenroll. This requirement was *Partially Met*. | |
| **Required Action:** EOCCO must update its *Enrollment Data and Requests for Disenrollment from CCO* policy and member handbook to align with state-established reasons members may request disenrollment with cause. | |

**CCO Improvement Plan**

| CCO Action Plan/Interventions | Individual(s) Responsible | Completion Date |
|---|---|---|
| EOCCO updated its policy to reference "Exhibit B Part 3 (9) (c) (1)" of the OHA CCO Contract. There is no little b for this section and EOCCO used the 2023 contract.<br><br>EOCCO used OHA's approved member handbook to revise the "with cause" disenrollment. | • Kayla Jones | April 2023 |

| Standard IX—Enrollment and Disenrollment | | |
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| **Documentation Submitted as Evidence** | 1. EOCCO Enrollment Data and Requests for Disenrollment from CCO Policy<br>2. EOCCO 2023 member_handbook | |
| **HSAG Assessment of Resolution** | The CCO revised the *Enrollment Data and Requests for Disenrollment from CCO* policy to identify the correct citation and its member handbook to align with state-established reasons members may request disenrollment with cause. HSAG recommends the CCO list the appropriate with cause reasons in the policy.<br>This finding is **resolved with a recommendation**. | ☐ Resolved<br>☒ Resolved, with recommendations<br>☐ Not Resolved |

| Standard XII—Quality Assessment and Performance Improvement | | | |
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| **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:<br>• Assessment of care between settings<br>• A comparison of services and supports received with those set forth in the member's treatment/service plan, if applicable<br>*42 CFR §438.330(b)(5)(i)*<br>*OAR 410-141-3860(8)(d)* | | |
| **Finding:** EOCCO 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. EOCCO demonstrated its actions for overseeing transition of care and referrals for LTSS members in 2021. Although EOCCO's *Transformation and Quality Strategy* policy described the CCO's collaboration with the APD in order to coordinate the care of members with SHCN, the policy did not address members receiving LTSS specifically or the mechanisms utilized to assess the quality and appropriateness of the care received. This requirement was *Partially Met*. | | | |
| **Required Action:** EOCCO must update its *Transformation and Quality Strategy* policy to include its mechanisms to assess the quality and appropriateness of care furnished to members using LTSS. | | | |
| **CCO Improvement Plan** | | | |
| **CCO Action Plan/Interventions** | | **Individual(s) Responsible** | **Completion Date** |
| EOCCO updated its *Transformation and Quality Strategy* policy to include its mechanisms to assess the quality and appropriateness of care furnished to members using LTSS. | | • Kristi Swank | April 2023 |
| **Documentation Submitted as Evidence** | 1. EOCCO Transformation and Quality Strategy Policy | | |
| **HSAG Assessment of Resolution** | The CCO revised the *Transformation and Quality Strategy* policy to:<br>• Describe its process for care coordination. | ☐ Resolved<br>☐ Resolved, with recommendations<br>☒ Not Resolved | |

| Standard XII—Quality Assessment and Performance Improvement | | |
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| | • Include that the CCO assesses the quality and appropriateness of care for members. Specifically, it does so for members receiving LTSS in biweekly MDT meetings via referrals to community providers, behavioral health/physical health case management, a care coordinator, and the APD partner as well as through emergency department and inpatient information from the Collective Platform.<br><br>However, the CCO does describe how this information is used to assess the quality and appropriateness of care between settings. The CCO must identify a defined process or mechanism to evaluate the population and/or relevant subpopulations for the appropriate care, including, at a minimum, care between settings and comparing the services and supports received with those outlined in the member's treatment/service plan, if applicable. The CCO should describe the data used and how these data will be used to assess the population.<br><br>This finding remains **unresolved**. | |

| Standard XII—Quality Assessment and Performance Improvement | |
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| **Element #8** | The CCO has a Quality Improvement (QI) committee that meets the following requirements:<br>• 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<br>• Maintains oversight and accountability of any delegated functions<br>• Approves the annual quality strategy and retains oversight and accountability of quality efforts and activities performed by other CCO committees<br>• 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<br>*OAR 410-141-3525(11)*<br>*CCO Contract Exhibit B Part 10(2)(c)(2* |
| **Finding:** EOCCO submitted its QIC meeting minutes, which demonstrated the committee met every two months and included committee deliberations; recommendations regarding corrective actions to address issues identified; and review of results, progress, and effectiveness of corrective actions recommended at previous meetings. The QIC meeting minutes also demonstrated accountability of delegation and subcommittee oversight. EOCCO's QIC Charter demonstrated the committee was comprised of the appropriate leadership positions, including the QI coordinator, chief compliance officer, and the chief medical officers; however, review of the QIC meeting minutes demonstrated the chief medical officer only attended the April, October, and December meetings and was sometimes listed as an "additional attendee." Additionally, EOCCO did not demonstrate approval of its quality strategy/QAPI policy/program description within its QIC meeting minutes. This requirement was *Partially Met*. | |
| **Required Action:** EOCCO must demonstrate its QIC meetings include participation of its chief medical officer. EOCCO must also ensure the QIC approves the annual quality strategy. | |

**CCO Improvement Plan**

| CCO Action Plan/Interventions | Individual(s) Responsible | Completion Date |
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| EOCCO's Medical Director, Dr. Holly Jo Hodges attended the December QIC meeting. | • Sam Shea | December 2022 |

| Standard XII—Quality Assessment and Performance Improvement | | |
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| **Documentation Submitted as Evidence** | 1. 12.19.2022 QIC Committee Meeting Minutes.doc.docx | |
| **HSAG Assessment of Resolution** | The CCO demonstrated that the medical director is no longer listed on the meeting minutes as an additional attendee and the medical director attended the December meeting. HSAG recommends that the CCO ensure the consistent attendance of the medical director at committee meetings. EOCCO did not demonstrate approval by the QIC of its annual quality strategy. During the site visit, the CCO asserted that the quality strategy was approved between January and March 2023. The CCO was offered an opportunity to submit additional meeting minutes. However, the CCO submitted the same meeting minutes from December 2022 that were provided previously without annotation. The CCO must demonstrate approval of its annual quality strategy.<br><br>This finding remains **unresolved**. | ☐ Resolved<br>☐ Resolved, with recommendations<br>☒ Not Resolved |