Oregon Health Authority

2019 CCO Readiness Review

for

Trillium Community Health Plan

September 2019

Interim Report

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1. Overview

Background

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

Methodology

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

Table 1-1—Readiness Review Activities and Timing

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

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

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

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

Phase 1—Critical Areas Readiness Review

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

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

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

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

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

Phase 2—Operations Policy Readiness Review

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

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

Results

This report documents results of the Phase 1—Critical Areas Readiness Review and (pending completion of Phase 2 of the RR) Phase 2—Operations Policy Readiness Review for Trillium Community Health Plan (TCHP), beginning on page 2-1 and 3-1, respectively. Each Results section also contains summaries of the findings relative to the CCO's general readiness to comply with federal and State regulations and CCO contractual requirements.

Detailed findings can be found in appendices A through C. Appendix A includes the completed Phase 1 RR Tool containing reviewer findings as well as recommended and required actions for improvement. Appendix B addresses the CCO's capacity to deliver required services. Appendix C (pending completion of Phase 2 of the RR) includes the completed Phase 2 RR Tool containing reviewer findings as well as recommended and required actions for improvement.

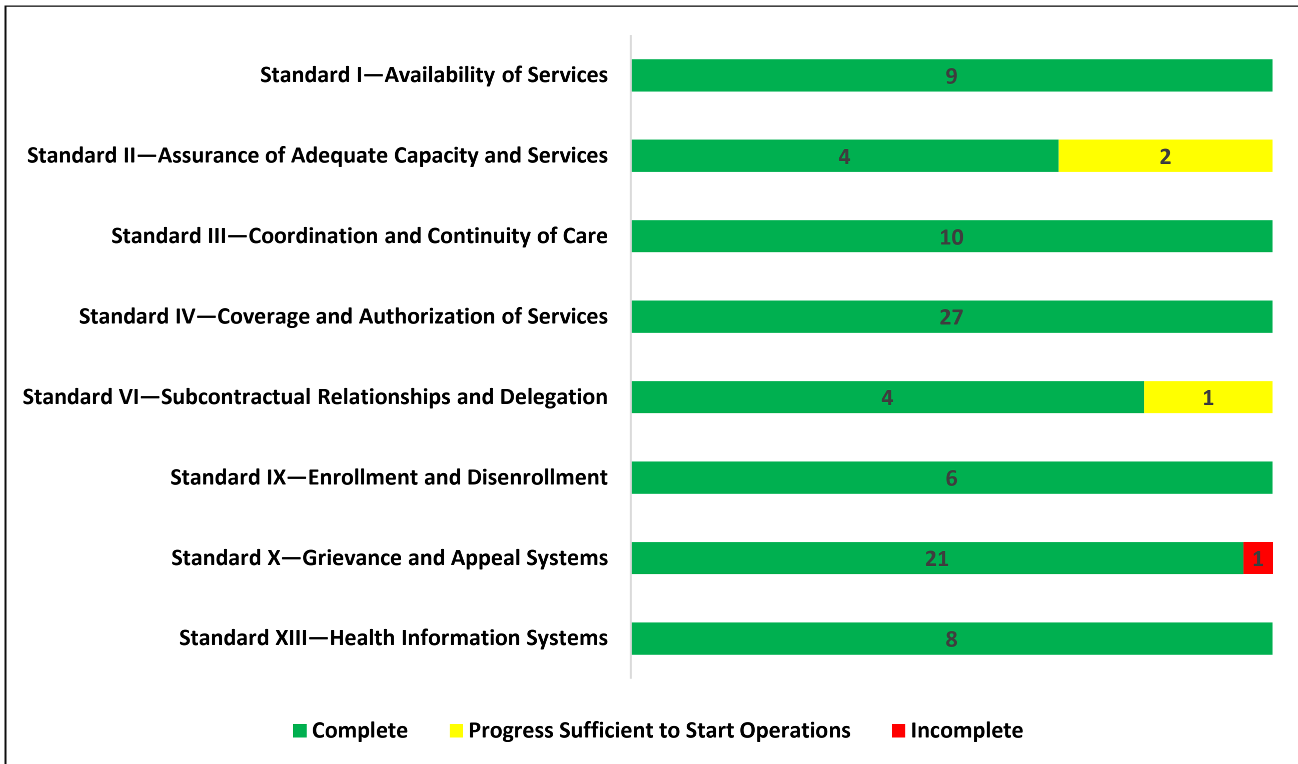
2. Phase 1 Results

Across all eight standards, TCHP's overall percentage of complete elements is 95.7 percent. The CCO demonstrated:

- *Complete* ratings for 89 of the 93 total elements.
- *Progress Sufficient to Start Operations* ratings for three elements across two standards.
- *Incomplete* ratings for one element across one standard, indicating areas of greater deficiency. These areas *require action* to ensure readiness prior to providing services.

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

Figure 2-1—TCHP Phase 1—Critical Areas Readiness Review Results



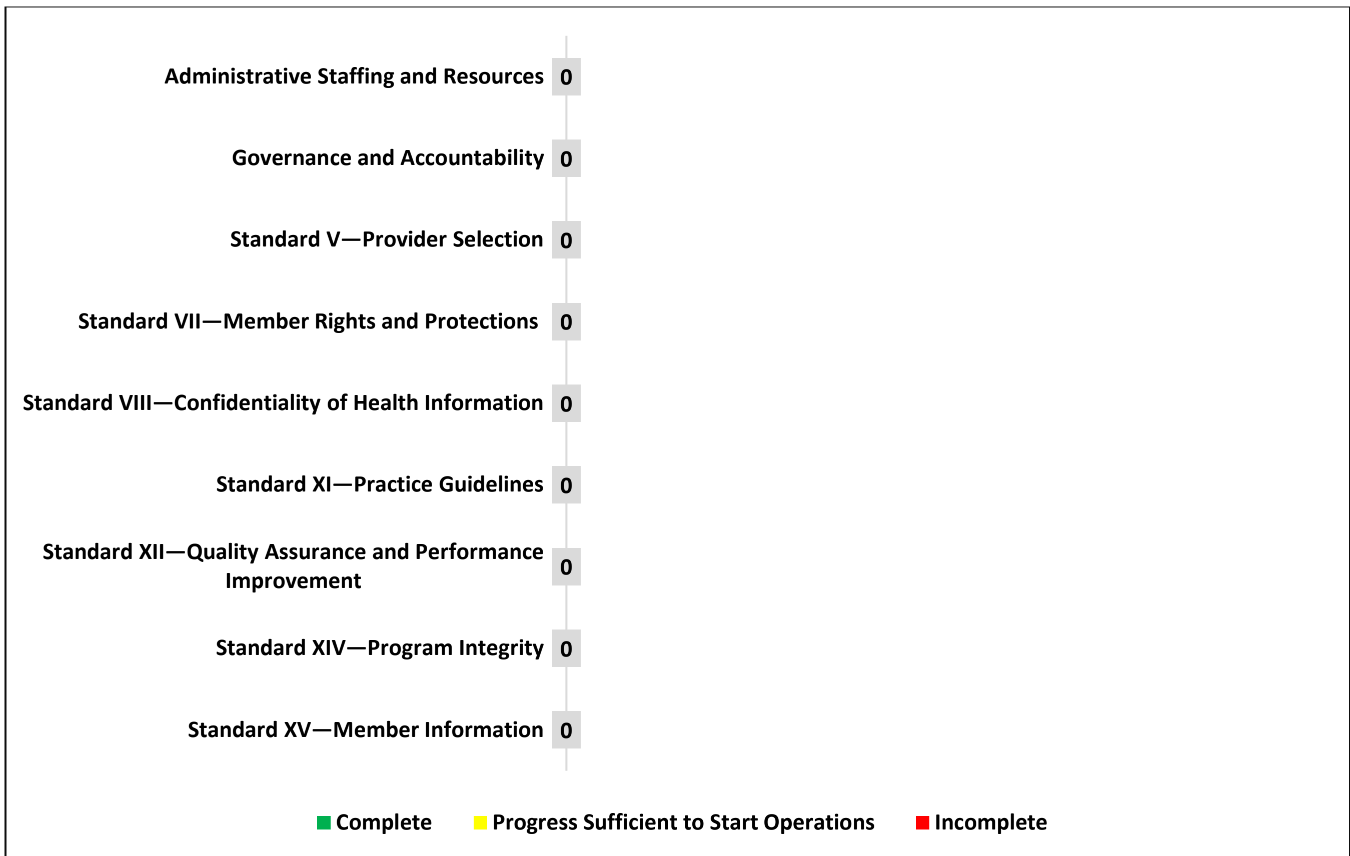
3. Phase 2 Results

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

Across all eight standards, TCHP's overall percentage of complete elements is XX.X percent. The CCO demonstrated:

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

Figure 3-1—TCHP Phase 2—Operations Policy Readiness Review Results



Appendix A. Phase 1 Evaluation Tool

Following this page is the completed readiness review Phase 1 tool HSAG used to evaluate TCHP's performance for each requirement

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. The CCO provides all covered services specified in the contract and as required by 42 CFR §438.206: a. The CCO has written policies and procedures to ensure that all services covered under the State plan are available and accessible to members in a timely manner. *42 CFR §438.206(a)* *Contract: Exhibit B Part 4 (2)*	Demonstrating our network adequacy and policies, procedures and processes to ensure timely access to covered services specified in the contract and as required by 42 CFR §438.206 are a collection of plan documents and reports cited and referenced in the attached crosswalk document: • 1.1 Compliance Crosswalk 073119.xls	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
2. The CCO maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract (inclusive of non-emergent medical transportation, alternative therapies [e.g., acupuncture, chiropractic medicine, massage, yoga], and access to traditional health care workers) for all members, including those with limited English proficiency, physical or mental disabilities, or special health care needs. *42 CFR §438.206(b)(1)* *Contract: Exhibit B Part 4 (3)(a)(1)*	2019 Trillium DSN Provider Capacity and Narrative Report for Trillium's current service area. • See 2019 Trillium DSN Provider Capacity and Narrative Report Contract Templates (Ancillary, ASC, BHSUD, Clinic, DCO, DME, Hospital, Lab, Pharmacy, Physician, Transportation) • See documents CC. MBRS.16 Hearing Impaired and Interpreter Service Policy • Policy (pg. 1-5) 2018 Trillium Network Availability Analysis • Introduction (pg. 1-5) OR.MM.CC.100_Health_Related_Services • Policy (pg. 1-3) CC.CRED.05 Practitioner Office Site Review • Policy (pg.1-4)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	RFA4690-Trillium-Att 7 DSN Provider Capacity Report includes tri-county expansion • See attached excel spreadsheet. "Member Handbook (REV & Tri-County), • pg #24, 2nd Paragraph. Crosswalk **(2) Access and cultural considerations.** "Member Handbook (REV & Tri-County), • pg #25, 4th Paragraph Crosswalk **(2) Access and cultural considerations** Network Development Plan and Strategy CCO 2.0 • Tab 1: Pre-Go Live Network Development Strategy • Tab 2: Network Development Plan • Tab 3: Description of network development and contracting cycles for those pending signature and those in contract negotiations	
3. The CCO provides female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the female member's designated source of primary care if that source is not a woman's health specialist. *42 CFR §438.206(b)(2)* *Contract: Exhibit B Part 4 (2)(m)*	CCO-A MbrHandbook REV- FINAL and CCO-A MbrHandbook TRICOUNTY REV • pg #36, bullets 3,4 & 5, • pgs #39,40, bullets 2,3,4,5,6,7,8 &10 • pg 41 "Summary of Benefits Checklist" OR.MM.159 Covered Benefits and Services • Procedure, section 1.11 (pg. 5)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
4. The CCO has a mechanism to allow members to obtain a second opinion from a network provider or arrange for the member to obtain one outside the network, at no cost to the member. *42 CFR §438.206(b)(3)* *Contract: Exhibit B Part 4 (2)(n)*	Member Handbook (REV & Tri-County), • page 35, first paragraph OR.MM.153 Second Opinions, Non-Participating Providers, Referrals and AuthorizationsMU Second Opinions Section • Policy, Section 2.1.2 &2.1.3 (pg. 2) UM.153 Work Process Second Opinion Monitoring, Entire Document, to meet mechanism for tracking second opinions • Policy (pg. 1)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
5. If the CCO is unable to provide medically necessary covered services to a particular member using contract providers, the CCO shall adequately and timely cover these services for that member using non-contract providers for as long as the CCO's provider network is unable to provide them. a. The CCO shall coordinate payment with out-of-network providers and ensure that the cost to the member is no greater than it would be if services were provided within the network. *42 CFR §438.206(b)(4-5)* *Contract: Exhibit B Part 4 (4)(g)*	Trillium Single Case Agreement Template (SCA) • Section1 (pg. 1-3) OR.MM.153 Second Opinions, Non-Participating Providers, Referrals and AuthorizationsMU - Page 2, 3. and 4, Paragraph 3 - 5.1 • Section 3, 4, and 5.1 (pg. 2-3)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
6. The CCO demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services: a. In accordance with 42 CFR §431.51(b)(2), members shall not be restricted in freedom of choice of providers of family planning services.	Family Planning Network Adequacy: See Family Planning Adequacy Analysis (Tri-County and Linn); • Access overview (pg. 2-4) Trillium Provider Network Adequacy for Lane and Douglas;	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
b. Therefore, members are permitted to self-refer to any provider for the provision of family planning services, including those not in the CCO's network. *42 CFR §431.51(b)(2)* *42 CFR §438.206(b)(7)* *Contract: Exhibit B Part 2 (6)(b)*	• Access by detail (Pg. 9-10) and FE CAID Planned Parenthood Agreement • Plan Covered (pg.1-5) Freedom of Choice and Self-Referral: OR.MM.159 Covered Benefits and Services Pages • Section 1.12 (pg. 5-6) PDF Lane and Tri-county Member Handbook (REV & Tri-County), • pg #46, 1st paragraph, pg# 36, 5th Bullet	
7. The CCO ensures its provider network observe the timely access to services provisions and complies with the following requirements: a. Meet and require its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. b. Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid Fee for Service (FFS), if the provider serves only Medicaid enrollees. c. Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary. d. Establish mechanisms to ensure compliance by network providers.	OR.PNM.100 Monitoring and Evaluation of Access to Services • Policy (pg. 1-5) Contract.Trillium.Template.Base.Physician • Section 2.4 to 2.8 (pg. 5) • Exhibit 12.16 pg. (12-13) 2018 Trillium Community Health Plan Practitioner Access Report • Full Document Trillium AA PPG Report Card • Full Document Trillium OHP Provider Manual • Accessibility of Practitioners Pg. 17-19 Trillium Provider Network Adequacy Lane and Douglas • Full Document	☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
e. Monitor network providers regularly to determine compliance. f. Take corrective action if there is a failure to comply by a network provider. *42 CFR §438.206(c)(1)* *Contract: Exhibit B Part 4 (2)(a)* *Contract: Exhibit B Part 4 (13)(b)(3), (4)*	Corrective Action Plan Template	
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		
8. The CCO demonstrates that its network includes sufficient specialty behavioral health providers to ensure timely access to covered specialty behavioral health services for the following priority populations in accordance with the timeframes below, with access prioritized in accordance with OAR 309-019-0135 and 410-141-3220. a. If a timeframe cannot be met due to lack of capacity, the member must be placed on a waitlist and provided interim services within 72 hours of being put on a waitlist. Interim services should be as close as possible to the appropriate level of care and may include referrals, methadone maintenance, compliance reviews, HIV/AIDS testing, outpatient services for substance use disorder, risk reduction, residential services for substance use disorder, withdrawal management, and assessments or other services described in OAR 309-019-0135. b. Pregnant women, veterans and their families, women with children, unpaid caregivers, families, and children ages birth through five years, individuals with HIV/AIDS or tuberculosis, individuals at the risk of first episode psychosis	Trillium Provider Network Adequacy Lane and Douglas • Access Overview- BH Practitioner type 1 – 2018 (pg13-18) Waitlist and Timelines for Specialty Populations Policy, • Full Document Behavioral Health Provider Site Visit Tracker- Tri Counties, Green cells indicate provider agreed to join network. • Full Document OR.PNM.100 Monitoring and Evaluation of Access to Services (Routine BH Appointments), Section 2, Pg#2 • Policy, section 2 (pg. 2)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
and the I/DD population: Immediate assessment and intake. If interim services are necessary due to capacity restrictions, treatment at appropriate level of care must commence within 120 days from placement on a waitlist. c. IV drug users: Immediate assessment and intake. Admission required within 14 days of request, or, if interim series are necessary due to capacity restrictions, admission must commence within 120 days from placement on a waitlist. d. Opioid use disorder: Assessment and intake within 72 hours. e. Medication assisted treatment: No more than 72 hours for assessment and induction, with efforts to do such as soon as possible. f. Children with serious emotional disturbance: Any limits that the Authority may specify in the contract or in guidance. g. Routine behavioral health care for other populations: Seen for an intake assessment within seven days from date of request, with second appointment within 14 days and 4 appointments (including the second appointment) within 48 days. Appointments must be therapeutic in nature and expand beyond administrative activities. *Contract: Exhibit B Part 4 (2)* *Contract: Exhibit M*		
9. The CCO has written policies and procedures that ensure scheduling and rescheduling of member appointments are appropriate to the reasons for and urgency of the visit. The member shall be seen, treated, or referred within the following timeframes:	OR.PNM.100 Monitoring and Evaluation of Access to Services standards • Full Document 2018 Trillium Community Health Plan Practitioner Access Report Final	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
a. *Well care:* Within four (4) weeks from the date of a patient's request. b. *Urgent care:* Within seventy-two (72) hours or as indicated in the initial screening for urgent care. c. *Emergency care:* Immediately or referred to an emergency department depending on the member's condition. d. *Emergency oral care:* Seen or treated within twenty-four (24) hours. e. *Urgent oral care:* Within one (1) to two (2) weeks or as indicated in the initial screening. f. *Routine oral care:* Within eight (8) to twelve (12) weeks, or the community standard, whichever is less. g. *Non-urgent behavioral health treatment:* Seen for an intake assessment within two (2) weeks of the request. *42 CFR §438.206(c)(1)(i)* *Contract Exhibit B Part 4 (2)(a)*	• Full Report Contract.Trillium.Template.Base.Physician • Section 2.4 – 2.8 (Page 5) • Exhibit 12.16 pg. (12-13) PDF Lane and Tri-County Member Handbook (REV & Tri-County), • pg #29 Bullet 7 Trillium AA PPG Report Card • Full Document	
10. The CCO participates in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. These efforts must ensure that members have access to covered services that are delivered in a manner that meet their unique needs. *42 CFR §438.206(c)(2)* *Contract: Exhibit B Part 4 (4)(e)*	Site Review Tool (7/26 added) • Full Document 2018 Trillium Network Availability Analysis • Intro (pg.1-5) OR.PNM.104 Provider Network Selection, Monitoring and Retention • Policy (pg. 1-4) CC.MBRS.16_Hearing_Impaired_Language_Specific_Interpreter_Services • Full Document TrilliumOregon_ProviderDIRECTORY	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• page 2 of manual (page 13 of pdf) "PDF Member Handbook (REV & Tri-County), • pg #20, 2-4th paragraph. pg.#26, 6th & 7th bullet, **Crosswalk (2) Access and cultural considerations, (3) Accessibility consideration**Contract. Trillium.Template.Base.Physician • Policy, Section 3.13.1/.2 (pg. 10) OR.MRKT.102_Member_Communication_Translation_Alternate_Format • Full Document CLAS Training Presentation • Full Document Equity and Quality Improvement Plan 2019, Section 2 Pg#2, Section 3 Pg#2,3 • Section 2 (pg. 2) • Section 3 (pg. 3) Continuity and Coordination of Medical Care • Policy, section 7 (pg. 4) Oregon Provider Directory, PDF • Pgs. 9, 12, 14, 15, 16, 18, 19, 20,21, 22, 23, 24, 25, 26, 27, 34, 43, 92, 130, 131, 140, 144, and 180 Annual Report 2019 - Trillium Diversity and Health Equity Committee	

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• Full Document 2019 Equity Quality Improvement Plan Status Updates • Entire Document OHA Response to Deficiencies • Entire Document	
11. The CCO ensures that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities. *42 CFR §438.206(c)(3)* *Contract: Exhibit B Part 4 (3)(a)(2)(e)*	Trillium OHP Provider Manual • Site Evaluation (pg. 14) CC.CRED.05 Practitioner Office Site Review • Policy, section IV (pg. 3-4) Contract.Trillium.Template.Base.Physician • Physician pages 7 • Exhibit 12.16 page 13" PDF Tri-County and Lane County Member Handbook (REV & Tri-County), • pg #20, 2-4th paragraph. Crosswalk **(3) Accessibility Considerations** TrilliumOregon_ProviderDIRECTORY • Legend (pg. 10) Pract Office Site evaluation tool • Page 1	☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		

Standard I- Availability of Services	
	Total #
Complete	9
Progress Sufficient	0
Incomplete	0
Not Applicable (NA)	2

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. The CCO submits documentation to the State, in a format specified by the State, to demonstrate that it complies with the following requirements: a. Offers an appropriate range of preventive, primary care, specialty services, that is adequate for the anticipated number of enrollees for the service area. b. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. *42 CFR §438.207(b)(1-2)* *Contract: Exhibit G*	OR.CONT.113 Delivery Systems Network • Entire Document Trillium Provider Network Adequacy Lane and Douglas • Entire Document OR.PNM.104 Provider Network Selection, Monitoring, and Retention • Procedure Section 1.d (Pg. 4) Attachment A: Network Adequacy Standards by LOB • Trillium OHP and Oregon Small Group Commercial (Pg. 1-2)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
2. The CCO submits the documentation described above as specified by the State, but no less frequently than the following: a. At the time it enters into a contract with the State. b. On an annual basis. c. At any time there has been a significant change (as defined by the State) in the CCO's operations that would affect the adequacy of capacity and services, including: i. Changes in the CCO's services, benefits, geographic service area, composition of or payments to its provider network; or ii. Enrollment of a new population. *42 CFR §438.207(c)(1-3)* *Contract: Exhibit G*	OR.CONT.113 Delivery Systems Network • Entire Document OR.CONT.108 Monitoring to Ensure Provider Netw ork Adequacy • Entire Document OR.CONT.114 Material Change in Provider Network • Procedure Section 1 (Pg. 1)	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

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Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: The CCO's Material Change in Provider Network policy describes how it will "notify OHA in advance if it experiences a Material change or is engaged in the termination or loss of a Provider or group or affected by other factors which have significant impact on access in its service Area." Documentation provided does not address significant changes related to the CCO's services, benefits, geographic service area, composition of or payments to its provider network; or the enrollment of a new population.		
Required Actions: HSAG recommends that the CCO update its policies and procedures to include language about how it addresses and reports significant changes related to the CCO's services, benefits, geographic service area, composition of or payments to its provider network; or the enrollment of a new population that would affect the adequacy and capacity of services.		
3. Adult & Pediatric Primary Care, PCPCH, OB/GYN, Behavioral Health, Oral Health Access Standards—Time and Distance: a. In urban areas - Thirty (30) minutes or thirty (30) miles from the personal residences of members. b. In rural areas – Sixty (60 minutes) or sixty (60) miles from the personal residence of members. *42 CFR §438.68* *42 CFR §438.206(c)(1)(i)* *Contract: Exhibit B (2)(a)*	Trillium Provider Network Adequacy Lane and Douglas • Entire Document OR.PNM.104 Provider Network Selection, Monitoring, and Retention page 4 • Procedure Section 1.d (Pg. 4) Attachment A Network Adequacy Standards by LOB • Trillium OHP and Oregon Small Group Commercial (Pg. 1-2) 2019 Trillium DSN Provider Capacity and Narrative Report • Entire Document	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: The CCO's Network Selection Monitoring and Retention policy does not include time and distance standards for the patient-centered primary care home (PCPCH) provider type.		
Required Actions: HSAG recommends that the CCO add PCPCH time and distance standards into its Network Selection Monitoring and Retention policy, Attachment A.		

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
4. Adult & Pediatric Specialty Care Access Standards— Time and Distance: a. In urban areas - Thirty (30) minutes or thirty (30) miles from the personal residences of members. b. In rural areas – Sixty (60 minutes) or sixty (60) miles from the personal residence of members. *42 CFR §438.68* *42 CFR §438.206(c)(1)(i)* *Contract: Exhibit B (2)(a)*	2019 Trillium DSN Provider Capacity and Narrative Report • Entire Document OR.PNM.104 Provider Network Selection, Monitoring, and Retention • Procedure Section 1.d (Pg. 4) Attachment A Network Adequacy Standards by LOB • Trillium OHP and Oregon Small Group Commercial (Pg. 1-2) Trillium Provider Network Adequacy Lane and Douglas • Entire Document	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
5. Hospital and Emergency Services Access Standards—Hospitals—Time and Distance: a. In urban areas - Thirty (30) minutes or thirty (30) miles from the personal residences of members. b. In rural areas – Sixty (60 minutes) or sixty (60) miles from the personal residence of members. *42 CFR §438.68* *42 CFR §438.206(c)(1)(i)* *Contract: Exhibit B (2)(a)*	Trillium Provider Network Adequacy Lane and Douglas • Entire Document OR.PNM.104 Provider Network Selection, Monitoring and Retention • Procedure Section 1.d (Pg. 4) Attach A Network Adequacy Standards by LOB • Trillium OHP and Oregon Small Group Commercial (Pg. 1-2) 2019 Trillium DSN Provider Capacity and Narrative Report • Entire Document	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
6. Pharmacy—Time and Distance: a. In urban areas - Thirty (30) minutes or thirty (30) miles from the personal residences of members. b. In rural areas – Sixty (60 minutes) or sixty (60) miles from the personal residence of members. *42 CFR §438.68* *42 CFR §438.206(c)(1)(i)* *Contract: Exhibit B (2)(a)*	Oregon Trillium Q42018 GeoAccess • Entire Document OR Expansion Geo for Tri Counties 06.19.2019 • Entire Document 2019 Trillium DSN Provider Capacity and Narrative Report includes Pharmacy Time & Distance Standards • Entire Document	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard II—Assurance of Adequate Capacity and Services	
	Total #
Complete	**4**
Progress Sufficient	**2**
Incomplete	**0**
Not Applicable (NA)	**0**

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Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. The CCO ensures that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member. a. The member must be provided information on how to contact their designated person or entity. b. The CCO implements a standardized approach to effective transition planning and follow-up. *42 CFR §438.208(b)(1)* *Contract: Exhibit B Part 4 (2)(k)*	OR.CM.01 Case Management Program Description • Transition of Care (Pg. 26) Member Handbook (Rev/TRICOUNTY) • Pg. 7,18, 22, 31-36, 39-40 Medicaid TOC Workflow • Full Document CC.UM.20 Continuity and Coordination of Services • Full Document	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
2. The CCO coordinates the services it furnishes to the member: a. Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays; b. With the services the member receives from any other MCO, PIHP, or PAHP; c. With the services the member receives in FFS Medicaid; and d. With the services the member receives from community and social support providers. *42 CFR §438.208(b)(2)* *Contract: Exhibit B Part 4 (1)(c)*	Trillium works closely with our members, providers and other community partners to help provide our members with services and resources that may need to live the healthiest life possible. For members that may be transitioning either to home or other levels of care from a recent hospital or inpatient stay, our Transition of Care Medicaid Case Management Team works closely with our members, their families, providers and other community partners to evaluate and assist members in meeting their overall needs as they are transitioning from care. This process is outlined in our attached **Transitions of Care Workflow**, and contains information on our engagement process including discharge planning. For dual eligible members enrolled in our CCO and our companion D-SNP, our **Model of Care** also addresses how we address our members' needs during transitions of care. Whether a member is in our affiliated D-SNP,	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Medicare Advantage (MA) plan, unaffiliated plan, or fee-for-service Medicare, we work with the member and other stakeholders to help identify and address barriers to care, and ensure members appropriately access care primary care under their Medicare benefit. This could include, Interdisciplinary Care Teams, coordinating with other providers, case managers or other affiliated plans through use of shared data, telephonic or in-person meetings. Our Care Management team also works closely with our members, their families, as well as any others involved in the members care to build a complete picture of their abilities and needs. This includes evaluating their available benefits, need for community resources and if they are eligible for services such as Long-Term Services and Supports (LTSS) that are provided as a Medicaid fee-for-service benefit, as outlined in **OR.CM.01 Case Management Program Description**. This document also describes Trillium's approach to assessing members' Social Determinants of Health and connecting them with appropriate community resources and services. In addition to our Care Management team's efforts to address our members' needs, we have launched additional initiatives to help connect members with important social services provided in the community. Two examples of these initiatives are our **Trillium Resource Exchange Database (T-REX)** and our **Veggie RX Program.** Our T-REX database is available on our website and allows	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	members and their caregivers to search for local programs that can help address their social needs, such as food, housing and transportation support. Our Veggie RX program is a pilot partnership with Food for Lane County that aims to provide access to fresh produce along with diabetes prevention education. Finally, our Long-Term Services and Supports policy and executed MOUs speaks to our efforts to work collaboratively with our local Area Agency on Aging (AAA) and Aging and People with Disabilities (APD) Districts community partners to supports members that are eligible for and receiving Medicaid funded LTSS under an FFS arrangement. Trillium maintains a MOU with the Lane Council of Governments (LCOG) Senior and Disability Services (SDS) and APD Districts 6 and 7 to ensure coordination of services for individuals in our current Service Area served by Trillium and the Type B AAA and APD local offices. Based on our engagement activities to date in the Tri-County Region, Trillium has a signed Letter of Agreement (LOA) with Multnomah County Aging, Disability & Veterans Services Division, Washington County Developmental Disability Program and Clackamas County Mental Health/Developmental Disabilities with respect to the negotiation and development of a mutually agreeable MOU. Our intent is to have an executed MOU in place for the Tri-County region by 10/30/2019. Corresponding Documentation • Medicaid TOC Workflow –	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	– Section Background page 1 – Discharge Planning Section 12 page 3 • Model of Care 2018 – For TOC: o Description of Program Activities page 9. o ICT Program pages 49-50. o Transition Protocols page 73. – For Connecting Members with Community Support: o Section 4 Establishing Relationships with Community Partners pages 13 • OR.CM.01 Case Management Program Description – – Care Manager Evaluation pages 21-22, – Description of Care and Levels of Care pages 9-10, – Plan of Care Development pages 23-24 • T-REX Website Snap Shot – Full Document • Veggie RX Program Announcement, – Full Document • Long Term Support Services, pages 1-2 – Policy Section pg. 1 – Procedure Section: pg. 2 • TCHP LCOG MOU LTSS CCO 2.0 – Full Document	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
3. The CCO conducts an initial screening of each member's needs, within 30 days of the effective date of enrollment for all new members, including documentation of subsequent attempts if the initial attempt to contact the member is unsuccessful. *42 CFR §438.208(b)(3)* *Contract: Exhibit B Part 4 (1)*	Trillium will conduct an initial risk screening on every new enrollee within 30 days of enrollment, followed by a more detailed Health Risk Screening as identified. Processes attached: • Medicaid Initial Risk Screening and Health Risk Screening Policy – Entire Document • Trillium New Member Welcome Calls – Entire Document Risk Screeners attached. (Each entire document is applicable): • Initial Risk Screener • HRS.Adult.Age18.64 • HRS.Less than 6 months • HRS.Child 6 mo to 17 years	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
4. The CCO's service agreements with specialty and hospital providers must: i. Address the coordinating role of patient-centered primary care; ii. Specify processes for requesting hospital admission or specialty services; and iii. Establish performance expectations for communication and medical records sharing for specialty treatments: – At the time of hospital admission; or	The CCO's service agreements with specialty and hospital providers must: i. Address the coordinating role of patient-centered primary care. • See page 5, Section 2.6 of Contract. Base. Physician document • See page 5, Section 2.4 of Contract Base Hospital document • See page 22, No. 44 of 7-31-19 #2337920-v2-Centene_Oregon_2019_Medicaid_Attachment_to_Trillium_Provider_Agreements.docx	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
– At the time of Hospital discharge for the purpose of facilitating after-Hospital follow up appointments and care. *Contract: Exhibit B Part 4 (9)*	• See pages 15 and 16 Section 4.6 of Provider Manual. Our Provider Manual provides detailed operational and policy information that in conjunction with our provider and hospital agreements. ii. Specify processes for requesting hospital admission or specialty services. • See page 5, Section 2.8 of Contract Base Physician document • See pages 5 and 6, Section 2.6, 2.7 and 2.8 of Contract Base Hospital document • See page 22, No. 44 of 7-31-19 #2337920-v2-Centene_Oregon_2019_Medicaid_Attachment_to_Trillium_Provider_Agreements.docx • See page 16, Section 4.6; page 28 Section 6.2; page 29 Section 6.3, pages 29 and 30 Section 6.5 of Provider Manual. Our Provider Manual provides detailed operational and policy information that in conjunction with our provider and hospital agreements. iii) Establish performance expectations for communication and medical records sharing for specialty treatments, at the time of Hospital admission, or at the time of Hospital discharge for the purpose of facilitating after-Hospital follow up appointments and care. • See page 8, Section 3.5 of Contract Base Hospital document	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• See page 9, Section 3.9 of Contract Base Physician document • See page 22, No. 44 of 7-31-19 #2337920-v2-Centene_Oregon_2019_Medicaid_Attachment_to_Trillium_Provider_Agreements.docx • See pages 25 and 26, Section 5.8 of Provider Manual. Our Provider Manual provides detailed operational and policy information that in conjunction with our provider and hospital agreements.	
5. The CCO has processes in place to ensure that: a. Hospitals and specialty service providers are accountable for achieving successful transitions of care. b. Primary care teams are responsible for transitioning members out of hospital settings into the most appropriate, independent, and integrated care settings, including home and community-based as well as hospice and other palliative care settings. *Contract: Exhibit B Part 4 (9)*	Trillium OHP Provider Manual • Care Transitions section. (Pg. 33) Medicaid TOC Workflow • Entire document Contract.Base.Hospital • Section 2.5 (Pg. 9) OR.CM.01_Case_Management_Program_Description • Referral Sources 4th bullet. (Pg. 19) • Interdisciplinary Care Team Meetings 2nd bullet (pg. 26) • Transition of Care (pg. 26)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
6. The CCO shares with the PCP, State or other MCOs, PIHPs, and PAHPs serving the member the results of any identification and assessment of that member's needs to prevent duplication of those activities. *42 CFR §438.208(b)(4)*	Trillium has established systems, processes and policies in place to share the results of assessment and care plan information with Primary Care Providers (PCPs) and other Managed Care Entities that are	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Contract: Exhibit B Part 4 (2)(f)(3)	serving the member in accordance with Applicable Laws governing confidentiality. There are a variety of ways in which we share assessment and information on a member's needs with the member's assigned PCP to facilitate optimal care and prevent duplication of work and services. One of the ways that we accomplish this is through our Hot-spotter report, which we share with PCPs and Dental Care Organizations (DCOs). Each month we share key indicators from this data in our **Hot-Spotter Report**, which we securely transmit to our providers. The Hot-Spotter Report includes over 40 data elements that support care management and population health management including but not limited to: future risk (prospective relative risk scores), ED and inpatient visits, BH risk, last PCP visit, demographic information, indicators for conditions such as SPMI, ED visit probability, inpatient stay probability, and SDOH-HE ICD-10 codes such as Z55-Z65. Providers can use data elements such as "ER Visit Probability," "Inpatient Stay Probability," and "Maximum Impact Score" as opportunities to provide support, education, and build engagement with members. An overview of this report, including information on how our PCP and DCO partners utilize this actionable data and member information can be found on the attached Hot Spotter Report (Redacted) excel document. We also facilitate the sharing of assessment and care plan information with the member's assigned PCP and	☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Interdisciplinary Care Team through our ***Provider Portal.*** This portal allows providers to access information on their members, such as any associated Care Plans, Care Gaps and Assessments. In the attached Provider Website Manual, you will find step by step instructions and screen shots of the portal on how providers can review this information. We will also offer our ***Community Partner Portal*** allowing authorized users, such as Medicare Advantage Plans, Oregon Department of Human Services (DHS), Type B AAAs and APD Districts offices, and other agencies to check member eligibility; submit documents; view risk and care alerts, and ICPs; and submit and view associated notes We also utilize **Collective Medical's EDIE and PreManage**tools to facilitate the sharing of assessment and care plan information for transitions of care. Trillium is working closely with community partners to establish best practices on how to efficiently utilize this tool across through an ED Utilization Collaborative facilitated by our Quality Department. This tool provides real time information on assigned membership and allows for collaborative information sharing on items such as the members Care Team and Care Guidelines. The attached EDIE PreManage Information Share Guide outlines the features of this tool, and best practices for collaboratively using this tool.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Additionally, our Policy and Procedure **CC.UM.19 Continuity and Coordination of Services**, provides an outline on how we share member information to promote continuity and coordination of care. This includes procedure on how pertinent information is shared with other MCEspayers when members are new to, or are transitioning from our health plan. Corresponding Documentation • Hot Spotter Report (Redacted) 7.19.19 (v2) – FAQ Tab 1 – Tab 4 ,Redacted Example Report • Secure Website Provider Portal Manual – Overview of Member Record Component page 20 – How to Access Care Plans pages 26 -27 – Viewing Submitted Assessment Responses page 23 – Health Record page 24-26 • CC.UM.19 Continuity and Coordination of Care – New Member Enrollment to Health Plan Procedure Section 2 page 2 – Care Transition Termination from Health Plan Procedure Section 3, page 2 • EDIE PreManage Information Sharing Resource Guide - Overview and Definitions of Features pages 3-4.	

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
7. The CCO ensures that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards. *42 CFR §438.208(b)(5)* *Contract: Exhibit B Part 8 (1)(d-f)*	N/A	☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		
8. The CCO ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable. *42 CFR §438.208(b)(6)* *Contract: Exhibit B Part 4 (1)(a)*	Confidentiality of PHI policy- speaks to compliance with federal laws. • Policy, Section 1 (pg. 1) Disclosing Minimum Necessary PHI Policy • Policy, Section 2 (pg. 1) Requesting Restrictions on PHI Use and Disclosure Policy • Policy, Section 1 (pg. 1) Right to Inspect and Obtain PHI Policy • Policy, Section 1 and 2 (pg. 1) Substance Abuse Records Release Policy • Purpose first para (pg. 1) Use and Disclosure of PHI Policy • Policy, first para (pg. 1) Authorization to Disclose PHI Form; member permission to disclose PHI to a third party • Entire Document	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• Member Handbook (REV and Tri-County), • pages 75-81	
9. The CCO implements mechanisms to comprehensively assess each member identified as needing LTSS or having special health care needs to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. *42 CFR §438.208(c)(2)* *Contract: Exhibit B Part 4 (10)(a)(4)*	**Trillium has several mechanisms to identify, serve and monitor members needing LTSS or special health care needs.** **New members**- Initial Risk Screeners are offered to all new members within 30 days of enrollment to capture risks and assist the member to an appropriate case management path. 1. Initial Risk Screening and Health Risk Screening Policy, Entire Document 2. Initial Risk Screener-Draft **Members Identified with Needs-**Members identified with a need for LTSS or special health care needs receive a comprehensive assessment (Health Risk Screening) to further understand their needs, develop a care plan, and monitor progress, with re-assessment at least annually or upon any change in condition or setting. Case Management-Members receive appropriate CM services identified from the IRS and HRS. 1. HRS.Adult.Age18.64 final.docx, Entire Document 2. HRS.Child 6 mo to 17 years final, Entire Document 3. OR.CM.01 Case_Management_Program_Description page 21-25 Care Plan	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Ongoing members –Health Risk Screeners and multiple data sources, such as predictive modeling, are used to monitor the status of members and assist in identification of newly experienced special health care needs or the need for a LTSS referral. See: 1. OR.CM.01 Case Management Program Description page 18-20 highlighted for data and referral sources 2. OR.CM.01 Case Management Program Description page 18 Predictive Modeling 3. LTSS Policy page 1 4. Initial Risk Screening and Health Risk Screening Policy, Entire Document For members that are receiving or using LTSS we work closely with the member's LTSS AAA or APD case manager to coordinate services and develop a whole person care plan. See: 1. LTSS Policy entire document	
10. The CCO has written policies and procedures for identifying, assessing and producing a treatment plan for each member identified as having a special healthcare need. *Contract: Exhibit B Part 4 (10)(a)(4)*	Care Management Monitoring Report • Full Document CCM.ICM Program Description • Case Management section (pg. 8-10) Care Manager User Guide. Care Plan Sample • Care Plan Summary Section pg. (151-179)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

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

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		
13. For members with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, the CCO must have policies or procedures in place to allow members to directly access a specialist (for example, through a standing referral or an approved number of visits) as appropriate for the member's condition and identified needs. *42 CFR §438.208(c)(4)* *Contract: Exhibit B Part 4 (2)(f)(2)*	OR.UM.01 UM Program Description • Referral section (pg. 21) OR.CM.01 Case Management Program Description • Care Management Functions section (pg. 10-12) Faces of CM. training Material • Entire Document Member Engagement Retention. training material • Entire Document	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care	
	Total #
Complete	**10**
Progress Sufficient	**0**
Incomplete	**0**
Not Applicable (NA)	**3**

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. In accordance with 42 C.F.R. §438.210, the CCO has processes in place to provide covered services outlined in the Contract that is no less than the amount, duration, and scope of the same services to beneficiaries under FFS Medicaid, as set for in 42 C.F.R. §440.230, and for members under the age of 21, as set forth in 42 C.F.R. subpart B of part 441. The CCO: a. Must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. b. May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary. *42 CFR §438.210(a)(3)(i-ii)* *Contract: Exhibit B Part 2 (2)(a-b)*	OR.CONT.100 Access to Services Policy and Procedure • Policy Sections 1-5 (Pg. 1) • Policy, Access Timeliness Standards Section 1-10, (Pg. 3) Physician Provider Agreement • Agreement, Sections 2.1, 2.11 (Pg. 7, 9) • Agreement, Sections 3.12, 3.13, 3.13.1, 3.13.2 (Pg.14) • Exhibit 12.6 Section 32 (Pg. 41) • Exhibit 12.6, Section 34 (Pg. 41) • Exhibit 12.17, Sections 13, 13.2 (Pg. 46_ OR.MM.159 Covered Benefits and Services Policy and Procedure • Policy, Sections 1-11 (Pg.1-2) • Procedure, Section 1.2 (Pg. 3)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
2. The CCO is permitted to place appropriate limits on a service: a. On the basis of criteria applied under the State plan, such as medical necessity; or b. For the purpose of utilization control, provided that: i. The services furnished can reasonably achieve their purpose, as required in paragraph (a)(3)(i) of this section; ii. The services supporting individuals with ongoing or chronic conditions or who require long-term services	OR.PHAR.17 Pharmaceutical Management Policy and Procedure • Procedure, Section I.B.1 (Pg. 2) Example Pharmacy Criteria for Chronic Condition and Associated Length of Approval • Policy/Criteria, Section I. A.6 (Pg. 2) • Policy/Criteria, Section II.A.1 OR.MM.159 Covered Benefits and Services Policy and Procedure	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
and supports are authorized in a manner that reflects the member's ongoing need for such services and supports; and iii. Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with §441.20 of this chapter. *42 CFR §438.210(a)(4)(i-ii)* *Contract: Exhibit B Part 2*	• Procedure, Section 1.11.1 (Pg. 5) • Policy, Section 5 (Pg. 1) • Procedure, Section 1.7 CC.UM.02 Clinical Decision Criteria and Application Policy and Procedure • Policy (Pg. 1) • Procedure I.A (Pg. 1)	
3. The CCO has processes to ensure that utilization or prior authorization standards for mental health or substance used disorder benefits and access to both in-network and out-of-network providers providing these benefits are no more stringent then the standards that are applied to medical/surgical benefits. *Contract: Exhibit E (22)*	CC.COMP.46 Mental Health Parity and Addiction Equity Policy and Procedure • Policy (Pg. 1) • Procedure, Sections 1.1, 1.3, 1.5.2 (Pg. 1-2) • Procedure, Section 5 (Pg. 4) Trillium Substance Use Algorithm • Entire Document OR.CONT.100 Access to Services Policy and Procedure • Policy, Sections 6, 7, 8 (Pg. 2) Single Case Agreement Workflow • Entire Document Outpatient Substance Use Disorders Treatment Services Policy and Procedure • Procedure, Sections 1, 4 (Pg. 2)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	CC.UM.02 Clinical Decision Criteria and Application Policy and Procedure • Entire Document CC.UM.02.05 Interrater Reliability Work Process • Work Process (Pg. 1-3) OR.MM.159 Covered Benefits and Services Policy and Procedure • Scope (Pg. 1)	
4. The CCO has processes to ensure that any financial requirements or treatment limits to mental health or substance use disorder benefits in any classification are no more restrictive then the financial requirements or treatment limits to medical/surgical benefits in the same classification (whether or not the benefits are furnished by the CCO). *Contract: Exhibit E (22)*	CC.COMP.46 Mental Health Parity and Addiction Equity Policy and Procedure • Procedure, Section 1.5.2 (Pg. 2) • Procedure, Sections 3-4 (Pg. 3-4) • Procedure, Section 5.2	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
5. The CCO must furnish medically necessary services as defined in the Contract and in a manner that: a. Is no more restrictive than that used in the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and b. Addresses:	OR.MM.159 Covered Benefits and Services Policy and Procedure • Policy Section 5 (Pg. 1) • Procedure, Section 1(Pg. 3) • Procedure, Section 1.7 (Pg. 4) • Definitions Section (Pg. 9)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
i. The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability. ii. The ability for a member to achieve age-appropriate growth and development iii. The ability for a member to attain, maintain, or regain functional capacity. *42 CFR §438.210(a)(5)(i-ii)* *Contract: Exhibit B Part 2 (2)(b)*		
6. The CCO establishes and adheres to written policies and procedures for both the initial and continuing service authorization requests consistent with utilization control requirements of 42 CFR Part 456. Policies and procedures must include: a. Mechanisms to ensure consistent application of review criteria for authorization decisions; b. Consultation with the requesting provider for medical services when appropriate. c. A process to ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs. *42 CFR §438.210(b)(1-3)* *Contract: Exhibit B Part 2 (3)(a & f)* *Contract: Exhibit B Part 2 (2)(c)*	Use of Professionals for Behavioral Health Utilization Management Decisions Policy and Procedure • Purpose (Pg. 1) • Policy, Sections 2.1.1-2.1.2 (Pg. 1) • Policy, Section 3.2 (Pg. 1) • Procedure, Sections C.2.2-2.6 (Pg. 2-4) • Procedure, Section 4.2 (Pg. 5) Clinical Criteria for Utilization Management Decision Making • Procedure, Section C 8-9 (Pg. 3) CC.UM.02 Clinical Decision Criteria and Application • Procedure, Section II.B (Pg. 4) • Procedure, Section I.C • Procedure, Section II.A	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
7. The CCO's utilization management policies are not structured in a way to provide incentives for its provider network, employees or other utilization reviewers to inappropriately deny, limit or discontinue medically appropriate services to any member. *42 CFR §438.210(e)* *Contract: Exhibit B Part 2 (2)(d)*	OR.MM.105 Affirmative Statement About Financial Incentives Policy and Procedure • Policy, Section 1 (Pg. 1), 4018 Affirmative Statements About Incentives • Incentive Attestation (Pg. 2) Provider Summer Newsletter 2019 • Reviewing the appropriate use of resources (Pg. 1)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
8. The CCO operates a drug utilization review program that complies with the requirements described in section 1927(g) of the Act and 42 CFR part 456, subpart K. *42 CFR §438.3(s)(4)* *Contract: Exhibit B Part 2 (4)(g)(2)*	OR.PHAR.19 Drug Utilization Review Policy and Procedure • Entire Document Example of DUR Monthly Report • Entire Document Trillium Pharmacy Work Process-DUR (DRAFT) • Entire Document	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
9. The CCO notifies the requesting provider, and gives the member written notice of any decision by the CCO to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. *42 CFR §438.210(c)* *Contract: Exhibit B Part 2 (3)(h)*	OR.MM.121 Denial Notices Policy and Procedure • Policy Section (Pg. 1)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
10. The written notice of adverse benefit determination must be consistent with the provisions under 42 CFR 438.10(c) and must include: a. The date of the notice;	MCA_RX26V3 Pharmacy Notice of Action Letter • Notice of Action (Pg. 1-3) MCA_DE33V7 OP Denial Letter	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
b. CCO name, address, phone number; c. Name of the member's Primary Care Practitioner, Primary Care Dentist, or behavioral health practitioner, as applicable; d. Member's name, address, and ID number e. Service requested or previously provided and adverse benefit determination the CCO made or intends to make; f. Date of the service or date service was requested by the provider or member; g. Name of the provider who performed or requested the service; h. Effective date of the adverse benefit determination if different from the date of the notice; i. Whether the CCO considered other conditions if the service was below the funding line of the OHP Prioritized List of Health Services; j. The reasons for the adverse benefit determination, including reference to the specific statutes and administrative rules to the highest level of specificity for each reason and specific circumstances identified in the notice that include, but is not limited to: k. The right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.	• Important Information Denial of Service or Treatment (Pg. 6) • Appeal and Hearing Information, Deadline Sections (Pg. 9) OR.MM.121 Denial Notices Policy and Procedure • Procedure, Sections 1.2-1.2.9, 1.2.11-1.2.15, 3 (Pg. 1-3)	☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
l. The member's right to request an appeal with the CCO within 60 days of the CCO's adverse benefit determination, including information on exhausting the CCO's one level of appeal described at §438.402(b) and the right to request a State fair hearing (contested case hearing) within 120 days after issuance of the CCO's Notice of Appeal Resolution or where the CCO failed to meet appeal timelines as outlin4ed in 410-141-3230; and the procedures for exercising these rights described in 410-141-3245. m. The circumstances under which an appeal process can be expedited and how to request it. n. The procedures for exercising the rights specified in this standard. o. The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the member may be required to pay the costs of these services. *42 CFR §438.404(b)* *Contract: Exhibit I (3)(b)*		
11. For standard authorization decisions, the CCO shall provide notice as expeditiously as the member's condition requires and within 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days: a. The member, or the provider, requests extension; or	EPS.PHARM.03A State Specific SOPs • Procedure, Section IV.b.a (Pg. 41-42) OR.MM.301 Timeliness of UM Decisions and Notifications Policy and Procedure • Procedure, Section C.1.a-C.d.1 (Pg. 3)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
b. The CCO justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest. *42 CFR §438.210(d)(1)(i-ii)* *Contract: Exhibit B Part 2 (3)(h)*	Undetermined Auths Dossier 07182019 (Turnaround Times) • Entire Document	
12. For cases in which a provider indicates, or the CCO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the CCO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service. a. The CCO may extend the 72-hour time period by up to 14 calendar days if the member requests an extension, or if the CCO justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest. *42 CFR §438.210(d)(2)(i-ii)* *Contract: Exhibit B Part 2 (3)(i)*	OR.MM.301 Timeliness of UM Decisions and Notifications Policy and Procedure • Procedure, Section C2 (Pg 4) Undetermined Auths Dossier 07182019 (Turnaround Times) • Entire Document EPS.PHARM.03A State Specific SOPs • Procedure, Section IV.b.a (Pg. 41-42)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
13. For all covered outpatient drug authorization decisions, provide notice as described in section 1927(d)(5)(A) of the Act. a. Provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization. *42 CFR §438.210(d)(3)* *Sec. 1927. [42 U.S.C. 1396r-8] (d)(5)(A)* *Contract: Exhibit B Part 2 (3)(j)*	EPS.PHARM.03A State Specific SOPs • Procedure, Section IV.b.a (Pg. 41) • Procedure, Section IV.b.b.i (Pg. 42) OR_US_MD_Dashboard_Trillium_06_June_201907 11 • OR Tab, Lines 18 and 20	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
14. For reduction, suspension, or termination of a previously authorized Medicaid-covered service, the CCO gives notice at least ten (10) days before the date of action except: • The CCO gives notice on or before the date of action if: – The agency has factual information confirming the death of a member. – The agency receives a clear written statement signed by the member that he/she no longer wishes services or gives information that requires termination or reduction of services and indicates that he/she understands that this must be the result of supplying that information. – The member has been admitted to an institution where he/she is ineligible under the plan for further services. – The member's whereabouts are unknown, and the post office returns agency mail directed to him/her indicating no forwarding address. – The agency establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth. – A change in the level of medical care is prescribed by the member's physician. – The notice involves an adverse determination made with regard to the preadmission screening requirements. • If probable member fraud has been verified, the CCO gives notice five (5) calendar days before the date of action.	OR.MM.301 Timeliness of UM Decisions and Notifications Policy and Procedure • Procedure, Section 3 (Pg. 6-7)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
42CFR438.404(c), 42CFR431.211, 42CFR431.213(a)-(g), 42CFR431.214(a) *Contract: Exhibit I (3)(c)*		
15. The CCO defines Emergency Services as covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish the services and needed to evaluate or stabilize an emergency medical condition. *42 CFR §438.114(a)* *Contract: Exhibit A (C)*	OR.MM.301 Timeliness of UM Decisions and Notifications Policy and Procedure • Definition Section Page 9	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
16. The CCO defines Poststabilization Care Services as covered services, related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition, or to improve or resolve the member's condition. *42 CFR §438.114(a)* *Contract: Exhibit A (H)(109)*	OR.MM.301 Timeliness of UM Decisions and Notifications Policy and Procedure • Definition Section Page 9	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
17. The CCO: a. Covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the CCO; and b. Does not deny payment for treatment obtained under either of the following circumstances: i. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in paragraphs (a), (b), and (c) of the definition of emergency medical condition in paragraph (a) of this section.	OR.MM.159 Covered Benefits and Services Policy and Procedure • Policy, Section 2 (Pg. 1) • Procedure, Section 1.9 (Pg. 4-5) • Definitions (Pg. 9) OP.OPS.177 Emergency Medical Care Policy and Procedure • Procedure, Sections 1.1, 1.4-1.6 (Pg. 1) OR.CLMS.OR-PPS Check Run Review Work Process	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
ii. A representative of the CCO instructs the member to seek emergency services. *42 CFR §438.114(c)(1)* *Contract: Exhibit B Part 2 (4)(a)(3,5&11)*	• PPS Work Process, Section 2 Emergency Room Claims (Pg. 4)	
18. The CCO does not: a. Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms; and b. Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, MCO, PIHP, PAHP or applicable State entity of the Member's screening and treatment within 10 calendar days of presentation for emergency services. *42 CFR §438.114(d)(1)* *Contract: Exhibit B Part 2 (4)(a)(1&10)*	OP.OPS.177 Emergency Medical Care Policy and Procedure • Entire Document • OR.MM.159 Covered Benefits and Services Policy and Procedure • Policy, Section 2 (Pg. 1) • Procedure, Section 1.9.2 (Pg. 4)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
19. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42 CFR §422.114(d)(2)* *Contract: Exhibit B Part 2 (4)(a)(9)*	OR.OPS.177 Emergency Medical Care Policy and Procedure • Procedure, Section 1.6 (Pg. 1)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
20. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in	OR.OPS.177 Emergency Medical Care Policy and Procedure • Procedure, Section 1.3 (Pg. 1)	☒ Complete ☐ Progress Sufficient to Start Operations

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
paragraph (b) of this section as responsible for coverage and payment. *42 CFR §422.114(d)(3)* *Contract: Exhibit B Part 2 (4)(a)(9)*		☐ Incomplete ☐ NA
21. Poststabilization care services are covered and paid for in accordance with provisions set forth at 42 C.F.R. §422.113(c). a. The CCO is financially responsible (consistent with §422.214) for post-stabilization care services obtained within or outside the CCO's network that are pre-approved by a plan provider or other organization representative; b. The CCO is financially responsible for post-stabilization care services obtained within or outside the CCO's network that are not pre-approved by a plan provider or other organization representative, but administered to maintain the member's stabilized condition within 1 hour of a request to the CCO for pre-approval of further post-stabilization care services; c. The CCO is financially responsible for post-stabilization care services obtained within or outside the CCO's network that are not pre-approved by a plan provider or other organization representative, but administered to maintain, improve, or resolve the member's stabilized condition if: i. The CCO does not respond to a request for pre-approval within 1 hour; ii. The CCO cannot be contacted; or iii. The CCO's representative and the treating physician cannot reach an agreement concerning the member's	OR.OPS.177 Emergency Medical Care Policy and Procedure • Entire Document OR.MM.159 Covered Benefits and Services Policy and Procedure • Procedure, Section 1.9.3-1.9.5 (Pg. 4-5)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
care and a plan physician is not available for consultation. In this situation, the CCO must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in §422.113(c)(3) is met. d. Must limit charges to members for post-stabilization care services to an amount no greater than what the organization would charge the member if he or she had obtained the services through the CCO's network. For purposes of cost sharing, post-stabilization care services begin upon inpatient admission. *42 CFR §438.114(e)* *42 CFR §422.113(c)(2)(i-iv)* *Contract: Exhibit B Part 2 (4)(a)(6&8)*		
22. The CCO's financial responsibility for post-stabilization care services it has not pre-approved ends when: a. A plan physician with privileges at the treating hospital assumes responsibility for the member's care; b. A plan physician assumes responsibility for the member's care through transfer; c. A CCO representative and the treating physician reach an agreement concerning the member's care; or d. The member is discharged. *42 CFR §438.114(e)* *42 CFR §422.113(c)(3)(i-iv)* *Contract: Exhibit B Part 2 (4)(a)(7)*	OR.OPS.177 Emergency Medical Care Policy and Procedure • Entire Document OR.MM.159 Covered Benefits and Services Policy and Procedure • Procedure, Section 1.9-1.9.7 (Pg. 4-5)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
23. The CCO has written policies and procedures that describe the process for receiving member requests, approving non-emergent medical transportation (NEMT) services, and scheduling, assigning, and dispatching providers. *Contract: Exhibit B Part 2 (4)(b)*	OR.OPS.196 Trillium Non-Emergency Transportation Calls Policy and Procedure • Purpose Section (Pg. 1) • Policy Section (Pg. 1) • Procedure, Transportation Section (Pg. 1-2) OR.OPS.174 Trillium Non Emergent Medical Transportation (NEMT) Policy and Procedure • Entire Document TCHP LTD ASA Transportation Services 01.01.16 • Agreement, Sections 2-6 (Pg. 3-5) • Agreement, Sections 14-14.11, 14.14-14.15,14.21-14.22.2 (Pg. 6-9) • Section 15 (Pg. 9-10) Desktop Workflow - Transportation Procedure 20190213 • Entire document MCA_AD10-Transportation-Tri-foldV11-web • Entire Document LTD NEMT Call Flow Handling • Entire Document MTM Short Notice Trip Request • Entire Document NEMT MTM Call Flow Training • Section 5.1- 5.7 (Pg. 51-63) • Section 6.1- (Pg. 64-67)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• Section 7.1 (Pg. 70-71) • Section 9 (Pg. 81-83) Lane NEMT Program Guide • Scheduling a Ride (Pg. 2-4) • When to Be Ready (Pg. 4) • Cancellation and No-Show Policy (Pg. 4-5) • Service Hours (Pg. 5)	
24. The CCO maintains a NEMT Call Center with minimum operating hours Monday through Friday from 9:00am to 5:00pm. For after hours arrangements, the CCO provides an afterhours message in English and Spanish instructing the caller how to access the alternative arrangement. *Contract: Exhibit B Part 2 (4)(b)(13)*	Trillium contracts with Lane Transit district for NEMT services, including an NEMT call center, including after-hours coverage. See attached documents listed below: TCHP LTD ASA Transportation Services 01.01.16 • Agreement, Section 2.1 (Pg. 3) LTD NEMT After Hours Phone Script • Entire Document Lane NEMT Program Guide • Scheduling a Ride (Pg. 2-4) • When to Be Ready (Pg. 4) • Cancellation and No-Show Policy (Pg. 4-5) • Service Hours (Pg. 5)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
25. The CCO has written policies and procedures for Emergency Dental Services and Urgent Care Services for Emergency Dental Conditions that describe when treatment of an emergency or urgent dental condition should be provided in an	OR.DCO.100 Dental Care Organizations Policy and Procedure • Procedure, Section 1.1 (Pg. 1) 1.1 shows that the Member's Primary Care Dental provider	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
ambulatory dental office setting and when emergency dental services should be provided in a hospital setting. *Contract: Exhibit B Part 2 (4)(k)(2)*	determines if a Member should go to a hospital emergency department for care. CCO Member Handbook (Tri County) • (Pg. 59) CCO Member Handbook (Lane County) • (Pg. 59)	☐ NA
26. The CCO has written policies and procedures and monitoring systems for an emergency response system that provides immediate, initial or limited duration response for emergency behavioral health situations. *Contract: Exhibit M (2)(g)*	**Policies and Procedures** • *OR.MM.108 Crisis, Urgent, and Emergency Services Policy and Procedure* – Purpose Section (Pg. 1) – Policy Sections (Pg. 1) • *OR.MM.116 Community Based Crisis, Urgent, and Emergency Services* – Purpose Section (Pg. 1) – Procedure Sections 3-4.3.2.1 (Pg. 3) **Illustration and Demonstration of Emergency System (Lane Region)** • *FastPass Workplan* – Paragraph 1 (Pg. 1) • *Trillium Adult Mental Health Referral System* – Entire Document • *Trillium Youth Mental Health Referral System* – Entire Document **Illustration and Demonstration of Emergency System (Tri-County Region)**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

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

	• *Trillium Portland Metro Crisis Services Timeline and Plan*
	  − Entire Document
	• *Tri Counties Crisis System*
	  − Entire Document
	Demonstrate procedures and monitoring systems for emergency response system that provides immediate, initial or limited duration response for emergency behavioral health situations.
	• *OR Market Business Continuity Plan* V2
	  − Leadership Response Team (LRT) Roles and Responsibilities (Pg. 6)
	  − OR.OPS.201, Policy Sections 5 (Pg. 49-50)
	• *Non-Claims Contract Review Process*
	  − Scope and Purpose Sections (Pg. 1)
	  − Process Sections 1-1.3.3.1) (Pg. 1-2)	

27. The CCO ensures that all members have access to Mobile Crisis Services to promote stabilization in a community setting rather than arrest, presentation to an emergency department, or admission to an acute psychiatric care facility. *Contract: Exhibit M (2)(g)(2)*	OR.MM.BH.108 Crisis, Urgent, and Emergency Services Policy and Procedure • Policy, Section 2 (Pg. 1) Policy Section Line 2, Pg#1 Crisis Services For Lane County: Trillium coordinates with Lane County and has agreements with Child and Adult Crisis services organizations that currently serve 100% of the Lane County service area OHP membership (with The Child Center, White	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Bird, and Columbia Care HourGlass). See attached documents listed below: • Trillium Child Crisis Services Agreement (The Child Center) – Agreement, Section 1(Pg. 1) – Exhibit 1 (Pg. 4-5) – Exhibit 2 (Pg. 6 • Trillium Adult Crisis Services Agreement (White Bird) – Agreement, Section 1 (Pg. 1) – Exhibit 1, Section 1 (Pg. 4) – Exhibit 2 (Pg. 6) • Trillium Child Crisis Services Agreement (HourGlass), Pages 1, 5 – Recitals, Section B (Pg. 1) – Exhibit 1, Section I (Pg. 5) In addition, Trillium and Trillium Behavioral Health actively monitor these organizations through quarterly reviews. These quarterly reviews will include monitoring Crisis Services staffing adequacy and accessibility. See attached: • Non-Claims Contract Review Process – Process, Section 1.3.2.2.1.5-1.3.2.2.1.6 (Pg. 2) – Section F (Pg. 3) • Non-Claims Contract Summary 2019	

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	– Crisis Services Section (Pg. 2) • Child Center Report 2019 – Entire Document • Columbia Care HourGlass Client Report 2019 – Entire Document • WBC Crisis Detail Report 2019 – Entire Document Crisis Services For Portland Metro service area: Trillium is in discussions to enter appropriate MOUs and Agreements with the 3 Counties that will include how we will coordinate and adequately fund and support the Crisis Services system for each County (including resources for Mobile Crisis Services). See attached: • Trillium Washington Co LMHA MOU (DRAFT) – Exhibit 1, Section 1, 2 (in chart) (Pg. 5) • Trillium Portland Metro Crisis Services Timeline and Plan – Entire Document Parallel to these discussions and engagement with the Counties, we are gathering all necessary information that identifies the network of providers and organizations involved in managing the Crisis services in Portland Metro. Depending on each County's Crisis Support set-up, Trillium will either (1) coordinate with County or (2) enter direct	

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Agreements with Crisis Services organizations. See attached: • Trillium Crisis Services Agreement (TEMPLATE) – Recitals, Section B (Pg. 1) – Agreement, Section 1 (Pg. 1) – Exhibit 1, Sections 1-2 (Pg. 6-7) – TriCounties Crisis System 7.29.19	

Standard IV—Coverage and Authorization of Services	
	Total #
Complete	**27**
Progress Sufficient	**0**
Incomplete	**0**
Not Applicable (NA)	**0**

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. Notwithstanding any relationship(s) that the CCO may have with any subcontractor, the CCO maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. *42 CFR §438.230(b)(1)* *Contract: Exhibit B Part 4(13)*	Trillium Vendor Agreement Template • Attachment 7, Delegated Services Agreement (Pg. 52) Trillium Subcontractor Management Policy and Procedure (DRAFT) • Procedure Section A (Pg. 1)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
2. All contracts or written arrangements between the CCO and any subcontractor must be submitted to OHA annually and within 30 days of addition of a subcontractor and must include: • The delegated activities or obligations, and related reporting responsibilities. Contractor shall not fully subcontract the provision of Behavioral Health services and Care Coordination to another entity. • The subcontractor agreement to perform the delegated activities and reporting responsibilities specified in compliance with the CCO's obligations. • The contract or written arrangement must either provide for revocation of the delegation of activities or obligations or specify other remedies in instances where the State or CCO determine that the subcontractor has not performed satisfactorily. • The requirements for written agreements as outlined in the CCO's contract with OHA, including fully integrated service delivery and funding (as defined in ORS 414.025).	TCHP Lane County ASA 04.01.19 • Section 6.5 (Pg. 8) • Section 9 (Pg. 9) • Exhibit A, Scope of Services (Pg. 13-16) • Exhibit B, Delegated Services Agreement − Section 2 (Pg. 19) − Section 3-3.2 (Pg. 20-21) − Section 7 (Pg. 22) − Section 8 (Pg. 23) − Section 9 (Pg. 23) − Exhibit B-2 (Pg. 27-34) • Article 3, OHP Program Compliance, Section 3.10 (Pg. 77) Trillium Vendor Agreement Template • Article II, Section 2.4 (Pg. 3) • Article III, Section 3.1 (Pg. 7) • Article V, (Pg. 8-9)	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

HSAG HEALTH SERVICES ADVISORY GROUP

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**

42 CFR §438.230(c)(1-3)
Contract: Exhibit B Part 4 (12), (13)(a)(1) and (13)(b)(1)(a-j), Exhibit M(1)
	• Article VIII, Section 8.2.2 (Pg. 11)
	• Attachment 1 to Vendor Agreement (Pg. 17)
	• Attachment IV to Vendor Agreement (Pg. 23, 28)
	• Attachment VI-A, Article 1, Section 1.4 (Pg. 32)
	• Attachment VI0A, Article III, Sections 3.1, 8.3, 8.5, 8.6, 8.8.1, 8.8.2, 8.9, 8.14, 8.15, 8.16, 8.18, 8.19, 8.23, 8.26, 8.26.10. j, 8.26.13 (Pg. 35-41, 46,)
	• Attachment VII, Delegated Services Agreement (Pg. 50)
	  – Sections 3-3.1, 3.4 (Pg. 52-53)
	  – Section 10 (Pg. 55)
	  – Section 12(d) (Pg. 55)
	  – Exhibits B-1—B-18 (Pg. 61-93)
	TCHP LTD ASA Transportation Services 01.01.16
	• Agreement, Sections 7, 8, 12, 14.5-14.7, 14.15, 14.24, 16.2.2, 17.4-17.5 (Pg. 5-7, 9-10, 12)
	• Exhibit 3, Section 2 (Pg. 37)
	TCHP LTD ASA Transportation Services Amendment 01.03.18 with OHP Product Attachment
	• Article I, Section 1.4 (Pg. 3)
	• Article III, Sections 3.1, 3.12-3.13, 3.15-3.16, 3.21-3.22, 3.25-3.26, 3.30, 3.33, 3.33.8, 3.33.10.j, 3.33.13 (Pg. 6, 8-13, 16, 18)
	TCHP LTD BAA Transportation Services 08.01.13	

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• Entire Document TCHP Envolve Vision (OptiCare) VSA 01.01.16 • Article III, Sections 3.1-3.2, 3.6, (Pg. 5-6) • Article V, Section 5.5 (Pg. 7) • Article VI, Sections 6.1-6.3 (Pg. 8-9) • Article IX, Section 9.2 (Pg. 10) • Attachment A, Section 4 (Pg. 17-18) • Attachment B, Sections 2.1-2.2, 2.4 (Pg. 40-41) • Exhibit 1 (All, Pg. 45) • Exhibit 2, Section V (Pg. 47-49) Exhibits 7-8 (All, Pg. 59-61) TCHP Envolve Vision VSA Amendment 2 01.01.19 with OHP Prod Attachment • Article I, Section 1.4 (Pg 5) • Article III, Section 3.1, 3.12-3.13, 3.15-3.16, 3.21-3.22, 3.25-3.26, 3.30, 3.33, 3.33.8, 3.33.9.j, 3.33.13, (Pg. 8, 10-15, 18-20) TCHP Envolve Vision VSA Amendment 3.05.01.19 • Exhibits 4, 1, 3, 5, 5A, 6, 9, (All, Pg. 5-16) TCHP Advantage Dental Services DCO Agreement 01.01.14 • Agreement, Sections 3.1, 3.3, 3.6, 3.10, 3.15-3.16, 3.21, 3.23 (Pg. 10-14, 16-17,) • Agreement, Section 6.1-6.2 , (Pg. 21)	

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• Agreement, Section 7 (Pg. 23-24) • Agreement, Section 8 (Pg. 24-25) • Agreement, Section 10 (Pg. 25-27) • Agreement, Section 11.3 (Pg. 28) • Exhibit 3.30, Section 4-6 (Pg. 37-38) • Exhibit 4.1, Section 1c, 1e, (Pg. 39) • Exhibit 10.2, Section 5.4 (Pg. 46) TCHP Advantage Dental Services OHP Product Attachment. 01.03.19 • Article 1, Section 1.4 (Pg.2-3) Article 3, Section 3.1, 3.12, 3.13, 3.15-3.16, 3.31-3.22, 3.25-3.26, 3.30. 3.33, 3.33.8, 3.33.10.j, 3.33.13 (Pg. 6-13, 16, 18) 6-13, 16, 18 TCHP Advantage Dental Services BAA 07.01.16 • Entire Document TCHP EPS PBMSA Medicaid PBM 01.01.18 • Section 2, 2.1.2, 2.10 (Pg. 5, 14) • Section 4.2.iii (Pg. 17) • Section 11.8 (Pg. 25-26) • Exhibits 2-3 (Pg. 51-,63) • Exhibit 4, Section 5 (Pg. 65-66) TCHP EPS PBMSA Medicaid PBM OHP Product Attachment 01.01.18 • Article I, Section 1.4 (Pg. 3)	

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• Article III, Sections 3.1, 3.12-3.13, 3.15, 3.16, 3.21, 3.22, 3.25, 3.26, 3.30, 3.33, 3.33.8, 3.33.9.j, 3.33.13 (Pg. 6, 8-13, 16, 18) • , 8-13, 16, 18 TCHP EPC (NurseWise) MSA Telemedicine 12.28.15 • Section 4.2.1-4.2.2 (Pg. 4) • Section 6.1-6.2, 6.4 (Pg. 5-6) TCHP EPC (NurseWise) SOW Telemedicine 12.28.15 • Sections 1-2 (Pg. 1-3) • Section 6 (Pg. 5-6) • Exhibit 1 (Pg. 9-10) TCHP EPC MSA Amendment 1 07.01.16 • Section 1 (Pg. 1) TCHP EPC MSA Amendment 4 11.01.18 • Section 2, Table 1 (Pg. 3) • Section 3 (Pg. 3) • Exhibit 1 (Pg. 11) • Schedule 1-A – 1K (Pg. 12 -34) • Schedule 1-M (Pg. 37-39) • Exhibit 2, Section IV (Pg. 41) • Exhibit 2, Section V.D (Pg. 42) • Schedule 1-2 (Pg. 43-47)	

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**

	TCHP EPC MSA Amendment 6 OHP Prod Attachment 01.01.19
	• Section E (Pg. 2)
	• Section 3 (Pg. 3-4)
	• Attachment B, Article I, Section 1.4 (Pg. 38)
	• Attachment B, Article III, Section 3.1, 3.12, 3.13, 3.15.1-3.15.2, 3.16, 3.21-3.23, 3.25-3.26, 3.30, 3.33, 3.33.8, 3.33.10.j, 3.33.13 (Pg. 42-48, 51, 53)
	• Schedule 1-M (Pg. 56-57)
	• Schedule 2 (Pg. 57-60)
	OR Mkt NIA RSMA Radiology Services 01.01.18
	• Article IV, Section 4.1 (Pg. 9)
	• Article V, Sections 5.5-5.6 (Pg. 11)
	• Article VI, Section 6.2-6.3 (Pg. 11-12)
	• Article IX, Section 9.2 (c), 9.4 (Pg.14)
	• Article X, Section 10.3 (Pg. 15)
	• Exhibit 1 (Pg. 24-30)
	  – Section 5 f-h (Pg. 28-29)
	  – Section 8 (Pg. 30-31)
	• Exhibit 2, Section 7 (Pg. 44)
	• Exhibit 4, Section 2.9.4 (Pg. 61)
	• Exhibit 4, Section 8.2 (Pg. 65)
	• Exhibit 4, Section 11.3, 11.3 (j), 11.5, (Pg. 67)
	• Exhibit 5 (Pg. 84-85)	

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• Exhibit 5A (Pg. 86-89) • Exhibit 5B (Pg. 90-94) • Exhibit 6 (Pg. 95-97) • Exhibit 8 (Pg. 118-123) Trillium Subcontractor Management Policy and Procedure (DRAFT) • Procedure, Section B.2, B.7., (Pg. 1, 2-3) • Procedure, Section C.b. (Pg. 4)	
HSAG Findings: TCHP's Subcontractor Management policy states that the CCO will provide the Subcontractor Assignment Report to OHA within 30 days of a change in a subcontractor and annually. Upon review of TCHP's Vendor Agreement Template and several current subcontractor agreements, the agreements were missing the subcontractor's requirement to report any other primary, third-party insurance to the CCO and the time frame for reporting (as the CCO is required to report this information to OHA within 30 days of the subcontractor becoming aware) the subcontractor's requirement to document, maintain, and provide to the CCO all encounter data records that document the subcontractor's reimbursement to Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), and Indian Health Care Providers; and the fact that, if the CCO is not paid or not eligible for payment by OHA for services provided, the subcontractor will not be paid or eligible for payment either.		
Required Actions: HSAG recommends that TCHP update the template vendor agreement and all currently executed subcontractor agreements to ensure they include all requirements for written agreements as outlined in the CCO's contract with OHA.		
3. The CCO evaluates the prospective subcontractor's readiness and ability to perform the scope of work outlined in the written agreement prior to the effective date of the contract. • Copies of the evaluation must be provided to OHA any time the CCO enters into a new subcontractor agreement. *Contract: Exhibit B Part 4(13)(a)(1)*	CC.COMP.21 Third Party Oversight Program Description Policy and Procedure • Program Description (Pg. 4) • Entity-Compliance (Pg. 11) • Entity-Quality Improvement (Pg. 12) • Entity-Third Party Oversight Staff (Pg. 14) • Pre-Contracting, Validation and Annual Audits (Pg. 14-17	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	CC.COMP.21.04 Third Party Audit Program Policy and Procedure • Procedure, Pre-Service Audits Section (Pg. 5) Trillium Delegated Services Agreement Attachment (TEMPLATE) • Exhibit B-2, Section II (Pg. 9-10) • Exhibit B-2, Section V F 12 New Vendor Security Intake Assessment Process Description • Entire Document Inherent Risk Questionnaire (IRQ) Vendor Intake Form • Entire Document Trillium Business Associate Agreement (BAA) (TEMPLATE) • Security and Privacy Addendum (Pg. 11-22) • Annual Attestation (Pg. 23) Trillium Subcontractor Management Policy and Procedure (DRAFT) • Procedure, Section B.3 (Pg. 1-2) • Procedure, Section B.7.v (Pg. 3-4)	
4. The CCO has a process to monitor the subcontractor's performance on an ongoing basis. • Formal reviews shall be conducted by the CCO at least annually.	CC.COMP.21 Third Party Oversight Program Description Policy and Procedure • Entire document	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Contract: Exhibit B Part 4(13)(a)(12-14)	CC.COMP.21.04 Third Party Audit Program Policy and Procedure Entire document Trillium Vendor Agreement Template • Article II, Sections 2.5, 2.7, 2.10 (Pg. 4) • Article V, Section 5.4 (Pg. 9) • Attachment IV (Pg. 23-25) • Attachment V (Pg. 26-28) • Attachment VII, Section 3, 3.1 (Pg. 52) • Attachment VII, Section 7 (Pg. 55) • Attachment VII, Section 10 (Pg.55) • Exhibit B-2, Section III--IV (Pg. 59-60) 2019 Vendor Audit JOC Schedule • Entire document Sample Vendor JOC Agenda and Minutes (Advantage Dental) • Entire document Sample Vendor Monitoring Dashboard • Entire document Trillium CAP Request Template 2019 • Entire document Trillium Master Desk Tool 2019 • Entire document Vendor Audit Results Example (Advantage Dental) • Entire document	☐ NA

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
5. Whenever deficiencies or areas of improvement are identified, the CCO and subcontractor shall take corrective action. *Contract: Exhibit B Part 4(13)(a)(15-17)*		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		
6. The Contractor must provide to OHA, annually and within 30 days of any change in subcontractor, the Subcontractors and Delegated Entities Report. The report should identify any activities the Contractor has agreed to perform under the contract that have been subcontracted or delegated, and include information related to the subcontracted work including: • The legal name of the Subcontractor; • The scope of work being subcontracted; • Copies of ownership disclosure form, if applicable; • Copies of all written agreements with Subcontractors to ensure all contracts meet the requirements outlined in 42 CFR 438.230; • Any ownership stake between the Contractor and Subcontractor. *Contract: Exhibit B Part 4(13)(a)(5-6)*	Trillium Subcontractors and Delegated Entities Report • Entire Document Trillium Subcontractor Management Policy and Procedure (DRAFT) • Procedure, Section B.7 (Pg. 2-3) • Procedure, Section C.3 (Pg. 6)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

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

Standard VI—Subcontractual Relationships and Delegation	
	Total #
Complete	**4**
Progress Sufficient	**1**
Incomplete	**0**
Not Applicable (NA)	**2**

Standard IX—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. In compliance with 42 C.F.R. §438.3(d), the CCO: a. Shall accept individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), up to the limits set under the Contract. b. Shall not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll. c. Shall not discriminate against individuals eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability. *42 CFR §438.3(d)(1-4)* *Contract: Exhibit B Part 3 (6)(a)(2-3)*	OR.OPS.175 Oregon Health Plan Enrollment Practices 11.19.2018 • Policy Section 2, 2.1.1-2.1.13 (Pg. 1) • Policy Section 3 (Pg. 2)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
2. The CCO shall not request disenrollment because of an adverse change in the member's health status, or because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment in the CCO seriously impairs the entity's ability to furnish services to either this particular member or other members). *42 CFR §438.56(b)(2)* *Contract: Exhibit B Part 3 (6)(a)(4)*	OR.OPS.175 Oregon Health Plan Enrollment Practices 11.19.2018 • Policy Section 2, 2.1.1-2.1.3 (Pg. 1)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IX—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the CCO**	**Score**
3. The CCO shall assure the State that it does not request disenrollment for reasons other than those permitted under the Contract. The CCO may request disenrollment if a member: a. Is uncooperative or disruptive, except where this is a result of the member's special needs or disability; b. Commits fraudulent or illegal acts such as permitting the use of his or her OHP Client identification card by another person, altering a prescription, theft or other criminal acts committed in any provider's or CCO's premises; c. Makes a credible threat to cause grievous physical injury, including but not limited to, death to others in the near future, and that significant risk cannot be eliminated by a modification of policies, practices or procedures; or d. Commits an act of physical violence, to the point that the member's continued enrollment in the CCO seriously impairs the CCO's ability to furnish services to either the member or other members. *42 CFR §438.56(b)(3)* *Contract: Exhibit B Part 3 (6)(b)(4-5)*	OR.OPS.175 Oregon Health Plan Enrollment Practices 11.19.2018 • Policy Section 2.2, 2.2.1-2.2.4 (Pg. 2-3)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
4. The CCO allows a member to request disenrollment as follows: a. For cause, at any time. b. Without cause, at the following times: i. During the 90 days following the date of the member's initial enrollment into the CCO, or during the 90 days following the date the State sends the member notice of that enrollment, whichever is later.	OR.OPS.175 Oregon Health Plan Enrollment Practices 11.19.2018 • Policy Section 3, 3.1-3.2.5 (Pg. 2)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IX—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the CCO**	**Score**
ii. At least once every 12 months thereafter. iii. Upon automatic reenrollment under paragraph (g) of this section, if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity. iv. When the State imposes the intermediate sanction specified in 42 CFR §438.702(a)(4) and this Contract. *42 CFR §438.56(c)(1),(2)(i-iv)* *Contract: Exhibit B Part 3 (6)(b)(3)*		
5. The member (or his or her representative) must submit an oral or written disenrollment request, as required by the State— i. To the State (or its agent); or ii. If the request is received by the CCO, the CCO forwards that request to OHA or DHS Eligibility. *42 CFR §438.56(d)(1)* *Contract: Exhibit B Part 3 (6)(b)(3)(a)*	OR.OPS.175 Oregon Health Plan Enrollment Practices 11.19.2018 • Policy Section 3.3, 3.3.1, 3.3.2 (Pg. 2)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
6. The following are cause for disenrollment: a. The member moves out of the CCO's service area. b. The CCO does not, because of moral or religious objections, cover the service the member seeks. c. The member needs related services (for example, a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the provider network; and the member's primary care provider	OR.OPS.175 Oregon Health Plan Enrollment Practices 11.19.2018 • Policy Section 3-3.1.5 (Pg. 2)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IX—Enrollment and Disenrollment		
Requirement	**Evidence as Submitted by the CCO**	**Score**
or another provider dete1mines that receiving the services separately would subject the member to unnecessary risk. d. For Members that use MLTSS, the Member would have to change their residential, institutional, or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider with the CCO and, as a result, would experience a disruption in their residence or employment. e. Other reasons, including but not limited to poor quality of care, lack of access to services covered under the Contract, or lack of access to providers experienced in dealing with the member's care needs. *42 CFR §438.56(d)(2)* *Contract: Exhibit B Part 3 (6)(b)(3)(a)(ii)*		

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

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. The CCO develops and implements a grievance system for members that includes an appeals process, a grievance process, and a process to access the State's fair hearing system as specified in rule (subpart F). If the CCO is responsible for sending notice of action, they must notify members in a timely manner. *42 CFR §438.228(a)* *Contract: Exhibit I*	OR.QMI.111 Grievance System – Grievances, Appeals, Contested Case Hearings Policy and Procedure • Policy Section (Pg. 1) • Procedure, Section A.3 (Pg. 7) • Procedure, Appeals Section C.6 (Pg. 11) • Procedure, Contested Case Hearings Section Da-D.b.ii (Pg. 14) CCO Member Handbook (REV & Tri County) • (Pg. 66-69)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
2. The CCO has internal grievance procedures under which Medicaid members may challenge the denial of coverage of, or payment for medical assistance (adverse benefit determination). • The CCO may have only one level of appeal for members. • A member may request a State fair hearing (contested care hearing) after receiving an appeal resolution notice from the CCO that the adverse benefit determination has been upheld. • If the CCO fails to adhere to required timeframes for processing appeals, the member is deemed to have exhausted the CCO's appeal process and the member may initiate a State fair hearing (contested case hearing). *42 CFR §438.402(a-c)* *42 CFR §438.400(a)(3), (b)* *Contract: Exhibit I (1)(a-b)*	OR.QMI.111 Grievance System – Grievances, Appeals, Contested Case Hearings Policy and Procedure • Procedure, Appeals Section A.1-A.3 (Pg. 8) Notice of Appeal Resolution Letter (TEMPLATE) • (Pg. 4) Notice of Adverse Benefit Determination Letter • (Pg. 2)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
3. The CCO defines an Adverse Benefit Determination as: a. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. b. The reduction, suspension, or termination of a previously authorized service. c. The denial, in whole or in part, of payment for a service. d. The failure to provide services in a timely manner, as defined by the State. e. The failure of the CCO to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. f. For a resident of a rural area with only one CCO, the denial of a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network. g. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities. *42 CFR §438.400(b)* *42 CFR §438.52(b)(2)(ii)* *RFA: Appendix A (C)*	OR.QMI.111 Grievance System – Grievances, Appeals, Contested Case Hearings Policy and Procedure • Definitions Section (Pg. 16)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
4. The CCO defines Appeal as a review by the CCO of an Adverse Benefit Determination. *42 CFR §438.400(b)* *RFA: Appendix A (H)(11)*	OR.QMI.111 Grievance System – Grievances, Appeals, Contested Case Hearings Policy and Procedure • Definitions Section (Pg. 16)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
5. The CCO defines Grievance as an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. • Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. Grievances include the member's right to dispute an extension proposed by the CCO to make an authorization decision. *42 CFR §438.400(b)* *RFA: Appendix A (H)(57)*	OR.QMI.111 Grievance System – Grievances, Appeals, Contested Case Hearings Policy and Procedure • Definitions Section (Pg. 16)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
6. A member may file a grievance with the CCO at any time, either orally or in writing. Grievances can be submitted to the State or the CCO. *42 CFR §438.402(c)(2)(i), (c)(3)(i)* *Contract: Exhibit I (2)(a)*	OR.QMI.111 Grievance System – Grievances, Appeals, Contested Case Hearings Policy and Procedure • Procedure, Member Grievances Section A.1 (Pg. 6) CCO Member Handbook (REV & Tri County) • (Pg. 66-69)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
7. A member may file an appeal within 60 calendar days from date on the notice of adverse benefit determination. • The member may request an appeal either orally or in writing. Unless the member requests an expedited resolution, an oral appeal must be followed by a written, signed appeal. *42 CFR §438.402(c)(2)(ii), (c)(3)(ii)* *Contract: Exhibit I (1)(b)(2), (1)(c)(2-3)*	OR.QMI.111 Grievance System – Grievances, Appeals, Contested Case Hearings Policy and Procedure • Procedure, Appeals Section C.2-3 (Pg. 10) CCO Member Handbook (REV & Tri County) • (Pg. 66-69) Notice of Adverse Benefit Determination Letter • (Pg. 2)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
8. The CCO must acknowledge receipt of each grievance and appeal. *42 CFR §438.406(b)(1)* *Contract: Exhibit I (4)(a)(1)*	OR.QMI.111 Grievance System – Grievances, Appeals, Contested Case Hearings Policy and Procedure • Procedure, Member Grievances Section A.3 (Pg.7) • Procedure, Appeals Section C.4 (Pg. 10) Appeal Acknowledgement Letter Tracking – MicroStrategy Report • Entire Document	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
9. A member may file an appeal within 60 calendar days from date on the notice of adverse benefit determination. • The member may request an appeal either orally or in writing. Unless the member requests an expedited resolution, an oral appeal must be followed by a written, signed appeal. *42 CFR §438.402(c)(2)(ii), (c)(3)(ii)* *Contract: Exhibit I (1)(b)(2), (1)(c)(2-3)*	OR.QMI.111 Grievance System – Grievances, Appeals, Contested Case Hearings Policy and Procedure • Procedure, Appeals Section C.2-3 (Pg. 10) CCO Member Handbook (REV & Tri County) (Pg. 66-69) Notice of Adverse Benefit Determination Letter (Pg. 2)	☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: This element was a duplication of element #7.		
Required Actions: None.		
10. The CCO resolves each grievance in writing and provides notice as expeditiously as the member's health condition requires. Within five (5) business days from the date of the CCO's receipt of the grievance, the CCO: a. Notifies the member that a decision on the grievance has been made and what the decision is; or b. Acknowledges receipt of the grievance and notifies the member that there will be a delay in the CCO's decision of up to 30 days. c. Notice to the member must be in a format and language that may be easily understood by the member. *42 CFR §438.408(a)-(b)(1), (d)(1)* *Contract: Exhibit I (2)(h)*	OR.QMI.111 Grievance System – Grievances, Appeals, Contested Case Hearings Policy and Procedure • Procedure, Section 10.g (Pg. 4) • Procedure, Member Grievances Section A.3.a-A.3.b (Pg. 7) CCO Member Handbook (Tri County) • (Pg. 66-69) CCO Member Handbook (Lane County) • (Pg. 66-69) Notice of Grievance Resolution Letter (TEMPLATE) • Entire Document	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA
HSAG Findings: The CCO submitted its Grievance System policy, which included the requirement that the CCO either notify the member of its grievance decision or acknowledge receipt of the grievance within five days. However, the CCO did not acknowledge that it must resolve each grievance in writing, including those received orally. This requirement is reflected in the CCO's contract with the State, effective January 1, 2020.		
Required Actions: The CCO should revise its Grievance System policy, prior to January 1, 2020, to reflect the contract requirement that it respond in writing to all grievances (including those received orally).		
11. In handling grievances and appeals, the CCO must give members any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-	OR.QMI.111 Grievance System – Grievances, Appeals, Contested Case Hearings Policy and Procedure • Procedure, Section A.3-A.4 (Pg. 2) CCO Member Handbook (Tri County)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
free numbers that have adequate TTY/TTD and interpreter capability. *42 CFR §438.406(a)* *Contract: Exhibit I (1)(c)(4)*	• (Pg. 66-69) CCO Member Handbook (Lane County) • (Pg. 66-69)	☐ NA
12. The CCO ensures that the individuals who make decisions on grievances and appeals are individuals who: • Were not involved in any previous level of review or decision-making nor a subordinate of any such individual. • Have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding any of the following: • An appeal of a denial that is based on lack of medical necessity. • A grievance regarding the denial of expedited resolution of an appeal. • A grievance or appeal that involves clinical issues. • Take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. *42 CFR §438.406(b)(2)* *Contract: Exhibit I (1)(c)(6-7)*	OR.QMI.111 Grievance System – Grievances, Appeals, Contested Case Hearings Policy and Procedure • Procedure, Section A.10.f (Pg. 3)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
13. The CCO's appeal process must provide: a. That oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the member or the provider requests expedited resolution. b. The member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The CCO must inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in §438.408(b) and (c) in the case of expedited resolution. c. The member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the CCO (or at the direction of the CCO) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals. d. That included, as parties to the appeal, are: i. The member and his or her representative, or ii. The legal representative of a deceased member's estate. *42 CFR §438.406(b)(3-6)* *Contract: Exhibit I (4)(b)*	OR.QMI.111 Grievance System – Grievances, Appeals, Contested Case Hearings Policy and Procedure • Procedure, Appeals Section C.1.a-C.1.d (Pg. 9-10)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
14. The CCO must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, no later than 16 days from the day the CCO receives the appeal. • For expedited resolution of an appeal and notice to affected parties, within 72 hours after the CCO receives the appeal. • For notice of an expedited resolution, the CCO must also make reasonable efforts to provide oral notice of resolution. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR §438.408(b)(2)-(3)* *Contract: Exhibit I (4)(c)(2)*	OR.QMI.111 Grievance System – Grievances, Appeals, Contested Case Hearings Policy and Procedure • Procedure, Section A.10.g (pg 4) • Procedure, Appeals Section C.6 (Pg. 11) NOAR Letter Tracking - MicroStrategy Report • Pg 1	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
15. The CCO may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: • The member requests the extension; or • The CCO shows (to the satisfaction of the State, upon request) that there is need for additional information and how the delay is in the member's interest. • If the CCO extends the timeframes, it must—for any extension not requested by the member: – Make reasonable efforts to give the member prompt oral notice of the delay.	OR.QMI.111 Grievance System – Grievances, Appeals, Contested Case Hearings Policy and Procedure • Procedure, Appeals Section A.1-A.3 (Pg. 8) • Procedure, Appeals Section C.6.c (Pg. 11) • Procedure, Appeals Section C.7.c (Pg. 12) • Procedure, Contested Case Hearings Section A.3.a-A.3.b (Pg. 13)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
– Within 2 calendar days, give the enrollee written notice of the reason for the delay and inform the enrollee of the right to file a grievance with the CCO if he or she disagrees with that decision. – Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. • If the CCO fails to adhere to the notice and timing requirements for extension of the appeal resolution timeframe, the member may initiate a State fair hearing (contested case hearing). *42 CFR §438.408(c)* *Contract: Exhibit I (4)(c)(1)(c), (4)(c)(2)*		
16. The written notice of appeal resolution must include: The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing (contested case hearing), and how to do so. – The right to request that benefits/services continue while the hearing is pending, and how to make the request. – That the member may be held liable for the cost of these benefits if the hearing decision upholds the CCO's adverse benefit determination. *42 CFR §438.408(e)* *Contract: Exhibit I (4)(c)(4)*	OR.QMI.111 Grievance System – Grievances, Appeals, Contested Case Hearings Policy and Procedure • Procedure, Appeals Section B.3 (Pg. 9) Notice of Appeal Resolution Letter (TEMPLATE) • (Pg. 4)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
17. The member may request a State fair hearing (contested case hearing) after receiving notice that the CCO is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of resolution. • The parties to the State fair hearing (contested case hearing) include the CCO, as well as the member and his or her representative or the representative of a deceased member's estate. *42 CFR §438.408(f)* *Contract: Exhibit I (5)*	OR.QMI.111 Grievance System – Grievances, Appeals, Contested Case Hearings Policy and Procedure • Procedure, Contested Case Hearings Section A.3.a-A.3.b (Pg. 13) Notice of Appeal Resolution Letter (TEMPLATE) • (Pg. 4) CCO Member Handbook (Lane County) • (Pg. 66-69) CCO Member Handbook (Tri County) • (Pg. 66-69)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
18. The CCO maintains an expedited review process for appeals, when the CCO determines, or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. The CCO's expedited review process includes: • The CCO ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. • If the CCO denies a request for expedited resolution of an appeal, it must: – Transfer the appeal to the time frame for standard resolution. – Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and	OR.QMI.111 Grievance System – Grievances, Appeals, Contested Case Hearings Policy and Procedure • Procedure, Appeals Section C.7 (Pg. 12) Notice of Appeal Resolution Letter (TEMPLATE) • (Pg. 4) Notice of Adverse Benefit Determination Letter • (Pg. 2)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

HSAG HEALTH SERVICES ADVISORY GROUP

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
follow-up within two calendar days with a written notice. *42 CFR §438.410* *Contract: Exhibit I (4)(c)(3)(e)*		
19. The CCO provides for continuation of benefits/services while the CCO-level appeal and the State fair hearing (contested case hearing) are pending if: • The member files timely* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the CCO mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal in accordance with required timeframes. **Note: This definition of timely filing only applies when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced. The provider may not request continuation of benefits on behalf of the member.* *\42 CFR §438.420(a)-(b)* *Contract: Exhibit I (6)(a)-(b)*	OR.QMI.111 Grievance System – Grievances, Appeals, Contested Case Hearings Policy and Procedure • Procedure, Continuation of Benefits Section 1-4 (Pg. 14-15) Notice of Appeal Resolution Letter (TEMPLATE) • (Pg. 4) Notice of Adverse Benefit Determination Letter • (Pg. 2)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
20. If, at the member's request, the CCO continues or reinstates the member's benefits while the appeal or State fair hearing (contested case hearing) is pending, the benefits must be continued until one of following occurs: • The member withdraws the appeal or request for State fair hearing. • The member fails to request a State fair hearing and continuation of benefits within 10 calendar days after the CCO sends the notice of an adverse resolution to the member's appeal. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR §438.420(c)* *Contract: Exhibit I (6)(c)*	OR.QMI.111 Grievance System – Grievances, Appeals, Contested Case Hearings Policy and Procedure • Procedure, Continuation of Benefits Section 3-4 (Pg. 15)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
21. If the final resolution of the appeal is adverse to the member, that is, upholds the CCO's adverse benefit determination, the CCO may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. *42 CFR §438.420(d)* *Contract: Exhibit I (6)(d)*	OR.QMI.111 Grievance System – Grievances, Appeals, Contested Case Hearings Policy and Procedure • Procedure, Continuation of Benefits Section 3-4 (Pg. 15) Notice of Appeal Resolution Letter (TEMPLATE) • (Pg. 4) Notice of Adverse Benefit Determination Letter • (Pg. 2)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
22. Effectuation of Reversed appeal resolutions: • If the CCO or the State fair hearing (contested case hearing) officer reverses a decision to deny, limit, or delay	OR.QMI.111 Grievance System – Grievances, Appeals, Contested Case Hearings Policy and Procedure	☒ Complete ☐ Progress Sufficient to Start Operations

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

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• Name of the covered person for whom the appeal or grievance was filed, member ID number, and date the member filed the grievance or appeal; • Notations of oral and written communications with the member; and • Notations about appeals and grievances the member decides to resolve in another way if the CCO is aware of this. *42 CFR §438.416* *Contract: Exhibit I (9)*		
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		
24. The CCO provides the information about the grievance appeal, and fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing (contested case hearing) after the CCO has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. • The member's right to have a provider or authorized representative file a grievance and/or an appeal on his or her behalf, provided he or she has provided written consent • The toll-free numbers to file a grievance or an appeal	OR.QMI.111 Grievance System – Grievances, Appeals, Contested Case Hearings Policy and Procedure • Procedure, Section D.2 (Pg. 6) Trillium OHP Provider Manual • Pg. 37 - 39	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• The fact that, when requested by the member: – Services that the CCO seeks to reduce or terminate will continue if the appeal or request for State fair hearing (contested case hearing) is filed within the time frames specified for filing. – The member may be required to pay the cost of services furnished while the appeal or State fair hearing (contested case hearing) is pending, if the final decision is adverse to the member. *42 CFR §438.414* *42 CFR §438.10(g)(xi)* *Contract: Exhibit B Part 3 (5)(b)*		

Standard X- Grievance and Appeal Systems	
	Total #
Complete	**21**
Progress Sufficient	**0**
Incomplete	**1**
Not Applicable (NA)	**2**

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. The Contractor shall maintain a health information system that collects, analyzes, integrates, and reports data sufficient to support program requirements, including but not limited to: Utilization of services a. Claims and encounters b. Grievances, appeals and hearing records c. Disenrollment for other than loss of Medicaid eligibility d. Member characteristics i. Race ii. Ethnicity iii. Preferred Language iv. Names and phone numbers of the member's PCP or clinic v. Attestation of member rights and responsibilities e. Client Process Monitoring Systems Forms data using the Measures and Outcome Tracking System (MOTS) f. LTPC Determination Forms *42 CFR §438.242(a)* *Contract: Exhibit J (1)*	Overall reporting • OR.IS.01, pg 10-11 Member and Provider Services Support • CRM - OR.IS.01, pg 28 • Component for Care and Utilization of services- • OR.IS.01, pg 8 **a.** Claims Processing and Payment, • OR.IS.01,PG 8 Encounter Processing • OR.IS.01 PG 9 **b.** Complaint and Grievance Support, • OR.IS.01-PG 2 **c**. Disenrollement • OR.IS.01, PG 1 **d.** Member characteristics • OR.IS.01, pg 5-7 • MDM, OR.IS.01, pg 3 • Provider Data Management pg 7 • Loading Our Production Member System, pg 5 Centelligence™ Engage: • Real Time Analytics for Effective Member Outreach pg 10	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• Web & Mobile Support of Members and Providers and Operating in Full Compliance, pg 11 **e.** Client Process Monitoring Systems Forms data using the Measures and Outcome Tracking System- • MOTS Policy 7.24.2019.doc, pg 1 **f.** LTPC Determination Forms • OR.MM.BH.113_LOC_Acute_and_Long_Term_Psychiatric_Hospitalization1.1.2020.doc, pg 1-2 • Procedure and Request Form LTPC Determinations Age 18-64	
2. Contractor's claims processing and retrieval systems shall collect data elements necessary to enable the mechanized claims processing and information retrieval systems operated by the State. *42 CFR §438.242(b)(1)*	OR.IS.01 Information Systems Management • Claims Processing and Payment, Pg 8 and 9	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
3. Contractor shall collect data at a minimum on: a. Member and provider characteristics as specified by OHA and in Exhibit G b. Member enrollment c. All services furnished to members through an encounter data system, pharmacy, or other methods as specified by OHA *42 CFR §438.242(b)(2)*	a. OR.IS.01 Information Systems Management • Indexing, Storing and Retrieving Electronic Document Images pg 10 • Meeting Reporting Requirements pg 10 • Data Warehousing Component pg 10 • Centelligence™ Engage: Real Time Analytics for Effective Member Outreach pg 10,11	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Contract: Exhibit J(2)	• Web & Mobile Support of Members and Providers pg 11 • Support for Providers pg 11 • Special Needs pg 12 • Provider Referral Network Data Management System Documentation pg 14,15,16 b. OR.IS.01 Information Systems Management • (Ready to Support Department Member File Processes pg 4) c. OR.IS.01 Information Systems Management • Claims Processing and Payment pg 8,9 • Encounter Processing pg 9 • Data Warehousing Component pg 10	
4. Contractor shall ensure that data received from providers, either directly or through a third party, is accurate, truthful, and complete in accordance with OAR 410-120-1280 and OAR 410-141-3420 by: a. Verifying the accuracy and timeliness of data reported b. Screening the data for completeness, logic, and consistency c. Submitting the certification to verify current member eligibility for fully dual eligible members using the AVR system or MMIS Web Portal. d. Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts in	a. OR.IT.109EDI_File_and_Data_Validation.5.16.2019_doc.doc • section 1 a-c and page 2 Claims File Validation OR.OPS.181_SVF_06_17_19.doc • whole policy b. OR.IT.109_EDI_File_and_Data_Validation.5.16.2019_doc.doc • section 1 a-c and Page 2 Claims File Validation	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
accordance with OHA Electronic Data Transmission (EDT) procedures in OAR Chapter 943 Division 120. *42 CFR §438.242(b)(3)(i-iii)* *Contract: Exhibit J(3)*	OR.IT.EBO_111_Trillium_Community_Health_Plan_Encounters_PolicyandProcedures_012819.doc • Page 4 & 5 OR.IT.109_EDI_File_and_Data_Validation.5.16.2019_doc. • pg 1, 2 c. OR.OPS.190Access_and_Monitoring_(team_comments)_4.9.2018.docx; • page 1&2 OR_OPS_175_Oregon_Health_Plan_Enrollment_Practices__002_11_19_18.doc • section 5 regarding duals OR.OPS.190_Access_and_Monitoring_(team_comments)_4.9.2018.docx, • pg1 OR_OPS_175_Oregon_Health_Plan_Enrollment_Practices__002_11_19_18.doc • pg2 d. OR.IT.109_EDI_File_and_Data_Validation.5.16.2019_doc.doc • Whole policy OR.IT.EBO_111_Trillium_Community_Health_Plan_Encounters_PolicyandProcedures_012819.doc • Page 4 & 5	

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	HEDIS Data Validation.docx (P&P detailing how data is validated - pg 2 HEDIS Flowchart.docx • P&P detailing how data is used for reporting, including claims data-starting pg 8 OR.IT.109_EDI_File_and_Data_Validation.5.16.2019_doc.doc, • pg 1, 2 OR.IT.EBO_111_Trillium_Community_Health_Plan_Encounters_PolicyandProcedures_012819.doc - pg 4	
5. Contractor shall make all collected and reported data available to the State and upon request to OHA and CMS. *42 CFR §438.242(b)(4)* *Contract: Exhibit J(3)(g)*	OR.IS.01_Information_Systems_Management • page 10;Meeting Reporting Requirements	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
6. Contractor shall confirm the member's responsibility for its portion of payment as stated in 42 CFR 438.10 (i.e., any cost sharing that will be imposed by the CCO, consistent with those set forth in the State plan.) *42 CFR 438.10(e)(2)(vii) and (g)(2)(C)(viii)* *Contract: Exhibit J(1)(c)(5)*	OR.OPS.182 • Section 2, 2, 4-4.1	☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
7. The CCO shall provide to OHA, upon request, verification that members were contacted to confirm that billed services were provided in accordance with 42 CFR §455.20 and 433.116 (e) and (f) by: a. Providing a notice, within 45 days of the payment of a claim, to all or a sample group of the Members who received services; b. The notice must, based on information from the Contractor's claims payment system, specify: i. The services furnished ii. The name of the provider furnishing the services iii. The date on which the services were furnished iv. The amount of the payment made by the member, if any, for the services c. The sample shall not include specially protected information such as genetic, mental health, alcohol and drug or HIV/AIDS. *42 CFR §455.20; 433.116 (e) and (f)* *Contract: Exhibit J(1)(c)(6)*	OR.OPS.181 • section 1-5	☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		
8. The CCO shall: a. Collect and maintain sufficient member encounter data to identify the provider who delivers any item(s) or service(s) to members.	OR.IT.EBO_111_Trillium_Community_Health_Plan_Encounters_PolicyandProcedures_012819.doc, • pg 1 & 3 • pg 4 & 5	☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
b. Submit member encounter data to OHA at a frequency and level of detail to be specified by CMS and OHA, based on program administration, oversight, and program integrity needs. c. Submit all member encounter data that the State is required to report to CMS under §438.818. d. Specifications for submitting encounter data to the Agency in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate. *42 CFR §438.242(c)(1-4)*		☒ NA
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		
9. Contractor shall develop IS contingency planning in accordance with 45 C.F.R. §164.308. Contingency plans shall include: a. Data Backup plans b. Disaster Recovery plans c. Emergency Mode of Operation plans d. Application and data criticality analysis and testing; and revisions procedures shall also be addressed within the required contingency plans. *45 CFR §164.308*	a. CC.IT.03 Backup Procedure and Tape Rotation Revised Layout • Entire document CC.IT.03_Backup_Procedure_and_Tape_Rotation_Revised_Layout.docx, pg 1-4 • pg 1-4 1. CC.BC.01 Business Continuity Policy • entire policy CC.SECR.17.1.A Information Security Business Continuity Standard • pgs 26-28 c. Business Continuity Plan_TCHP_HN,	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• entire policy The incident response and recovery strategy for the various Centene sites and systems during and after an event impacting shared or core systems, services or information technologies is of key importance to our customers and the viability of Centene operations enterprise wide. Centene is committed to maintaining continuity of core operations necessary to meet ongoing contractual requirements and business needs with minimal interruption, should systems or services be interrupted in any way. d. CC.SECR.17.1.A Information Security Business Continuity Standard – Plan Implement Review Revised Layout, • Pages 2-3 provides evidence of application and data criticality analysis and testing and revisions. CC.BC.01_Business_Continuity_Policy.docx • pg 1 CC.IT.29 Major Incident IT Communications Policy Revised Format, • entire policy	
10. The CCO shall develop and maintain an OHA-approved HIT Roadmap inclusive of CCO's activities, milestones and timelines. The HIT Roadmap must describe where the CCO has	a. OR HIT Roadmap rev a.xlsx • Entire document b. OR HIT Roadmap rev a.xlsx	☐ Complete ☐ Progress Sufficient to Start Operations

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
implemented its own HIT and where it leverages collaborative HIT solutions, as well as describe how the CCO: a. Uses HIT to achieve its desired outcomes b. Supports EHR adoption for its contracted providers c. Supports access to health information exchanges to enable sharing patient information for care coordination for its contracted providers d. Ensures access to hospital event notifications for its contracted providers e. Uses hospital event notifications in the CCO to support its care coordination and population health efforts f. Uses HIT to administer VBP arrangements, provide support to providers with VBP arrangements, and uses HIT for population health efforts *Contract: Exhibit J(2)(a, f-j)*	• Entire document c. Supports access to health information exchanges to enable sharing patient information for care coordination for its contracted providers - Provider Electronic Health Records EHR Policy and Procedure d. OR HIT Roadmap rev a.xlsx • Entire document e. OR HIT Roadmap rev a.xlsx • Entire document f. OR HIT Roadmap rev a.xlsx • Entire document	☐ Incomplete ☒ NA
HSAG Findings: This element will be reviewed by the OHA HIT for the readiness review.		
Required Actions: None.		
11. The CCO shall provide an annual HIT Roadmap update to OHA for review and approval. The HIT Roadmap update must: a. Identify any changes to the prior-approved HIT Roadmap. b. An attestation to progress made on its HIT Roadmap, including supporting documentation c. An attestation that the COO has an active, signed HIT Commons MOU, and i. Adheres to the terms of the HIT Commons MOU	• OR HIT Roadmap rev a.xlsx • Row 6 • OR HIT Roadmap rev a.xlsx • Row 7 • OR HIT Roadmap rev a.xlsx • Row 12 i. Row 14	☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
ii. Pays the annual HIT Commons assessments subject to the payment terms of the HIT Commons MOU iii. Serves, if elected, on the HIT Commons Governance Board, or one of its committees iv. Participates in OHA's HITAG, at least annually d. Report the EHR(s) vendor/product used by its contracted providers and its progress on EHR adoption targets via the Performance Expectations report e. Report the HIE tool(s) used by its contracted providers and its progress on HIE access targets via the Performance Expectations report f. Report on its use of HIT to administer VBP arrangements and support its contracted providers with VBP arrangements. g. Report on its use of HIT to support population health management *Contract: Exhibit J(2)(b, k)*	ii. Row 16 iii. Row 17 iv. Row 18 OR.OPS.02_HIT Roadmap PP Draft.docx • pg, 1 • OR HIT Roadmap rev a.xlsx • Row 26 OR.OPS.02_HIT Roadmap PP Draft.docx • pg, 1 • OR HIT Roadmap rev a.xlsx • Row 26 • OR HIT Roadmap rev a.xlsx • Row 43 • OR HIT Roadmap rev a.xlsx • Row 73 OR.OPS.02_HIT Roadmap PP Draft.docx • pg, 1 The HIT Liaison and Director of Medicaid will review the HIT Roadmap quarterly and update it no less than annually.	
HSAG Findings: This element will be reviewed by the OHA HIT for the readiness review.		
Required Actions: None.		

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
12. The CCO shall: a. Participate as a member in good standing of the HIT Commons b. Maintain an active, signed HIT Commons MOU c. Adhere to the terms of the HIT Commons MOU d. Pay the annual HIT Commons assessments subject to the payment terms of the HIT Commons MOU e. Serve, if elected, on the HIT Commons governance board or one of its committees. *Contract: Exhibit J(2)(d)*	• and c. OR.OPS.02_HIT Roadmap PP Draft.docx • Entire document The VP of Finance will be responsible for documenting annual payments made to HIT Commons. Throughout the duration of the contract, Trillium will pay the annual HIT Commons membership fee and serve on the board or committee where HIT Commons sees fit	☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element will be reviewed by the OHA HIT for the readiness review.		
Required Actions: None.		
13. The CCO shall participate in OHA's HIT Advisory Group (HITAG) at least once annually. *Contract: Exhibit J(2)(e)*	The Manager of Data Analytics and HIT Liaison will participate in the HITAG no less than once annually.	☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element will be reviewed by the OHA HIT for the readiness review.		
Required Actions: None.		
14. The CCO shall document and report to OHA, annually, on how HIT is used to support contracted providers by providing: a. Information (at least quarterly) on measures used in the VBP arrangements	OR_Trillium_HISReq15_HIS_graphic.docx e.g. a. Trillium uses HIT to enable providers to participate in VBP arrangements in a variety of ways. Trillium uses HIT to enable providers to	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
b. Accurate and consistent information on patient attribution c. Information on patients requiring intervention and the frequency of that information d. Other actionable data (e.g., risk stratification, member characteristics) to support providers' participation in VBP arrangements and implementation of interventions. e. Use of HIT to support contracted providers to participate in VBP arrangements *Contract: Exhibit J (2)(k)(7)*	participate in VBP arrangements in a variety of ways b. OR.ANA.108_Analytics_Performance_and_Quality_Improvement_Reporting_2019_07_29.docx • pg 1 ICCM Quality Reporting Documentation 2019 Trillium CPC+ 2019 05 HOTSPOT_ICCM.pdf 2020 Medicaid TCOC Template7.15.19.docx Hotspotter sample redacted • Entire document Comp Packet 190724.pdf • slide 6-10 Comp Agenda 190724.pdf • Entire document TCHP CFD 2019 ICCM Addendum FINAL - signed.pdf • Entire document c. Hotspotter sample redacted.pdf, 2019 05 HOTSPOT_ICCM.pdf • Demonstrates consistent reporting across members OR_Trillium_HIS_Req15 , v2.docx	☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• Demonstrates consistent reporting across members on various platforms - portal and Novillus), OR.ANA.108_Analytics_Performance_and_Quality_Improvement_Reporting_2019_07_29.docx, • pg 1 d. Novillus Health Net and Trillium –Data Integrations 03-22-2018.pptx • P&P detailing timing and format of reports OR.ANA.108_Analytics_Performance_and_Quality_Improvement_Reporting_2019_07_29.docx, • pg 1 2019 HOTSPOT_ICCM.pdf • Entire document CGMA_Gap_Management2019 • Entire document ICCM Monthly Utilization Reporting Process • Entire document OR.ANA.108_Analytics_Performance_and_Quality_Improvement_Reporting_2019_07_29.docx, • pg 1 e. 2019 HOTSPOT_ICCM.pdf	

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• Entire document CGMA_Gap_Management • Entire document Novillus - Health Net and Trillium - Data Integrations 03-22-2018.pptx • Novillus is referenced as the Multi-Payer Market Driven Portal (Care Gaps) OR_Trillium_HISReq15_HIS_graphic.docx • Entire document Trillium Provider Portal – Patient • Entire document Roster.docxOR_Trillium_HIS_Req15 v2.docx • Entire document HIT Roadmap row 43	
15. The CCO shall document and report to OHA, annually, on how HIT is used to support population health management, including: a. The ability to identify and report on member characteristics (e.g., past diagnoses and services) b. The capability of risk stratifying members c. The ability to provide risk stratification and member characteristics to contracted providers with VBP arrangements for the population(s) addressed in the arrangement(s).	HIT Roadmap • rows 66-73 a. OR_Trillium_HIS_Req15.docx • pg 2 b. OR_Trillium_HIS_Req15.docx,CC.CM.06_-_Predictive_Modeling_052019.docx; • pg1 HIT Roadmap • row 71	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Contract: Exhibit J (2)(k)(8)	c. OR_Trillium_HIS_Req15.docx • several screen shots included in this document demonstrate how risk stratification and other information about members is shared with providers , OR_Trillium_HIS_Req15.doc • pg 1 OR.CM.01_Case_Management_Program_Description_7.15.19 FINAL.docx; • pg 12 Program Segments MEMBER IDENTIFICATION AND ACCESS TO CARE MANAGEMENT • pg 18	

Standard XIII—Health Information Systems	
	Total #
Complete	**8**
Progress Sufficient	**0**
Incomplete	**0**
Not Applicable (NA)	**7**

Appendix B. Delivery System Network (DSN)

The DSN Provider Capacity Report is an inventory of each individual provider (i.e., physician, mid-level practitioner, or other practitioner), facility, or business, whether employed by or under subcontract with a CCO, or paid fee-for-service, that agrees to provide the described services, or items, to Medicaid and fully dual-eligible CCO members. Containing an inventory of the provider categories and service categories outlined in Exhibit G of the CCO contract, HSAG evaluated the data to assess general capacity of each CCO's existing and proposed DSN. Specifically, HSAG evaluated the DSNs on four key domains:

- Quality of DSN Provider Capacity Reporting
- Provider Network Capacity
- Provider Accessibility
- Geographic Distribution

Quality of DSN Provider Capacity Reporting

The quality of DSN provider capacity reporting domain assessed the CCO's ability to provide complete provider network data in the required format. Key measures included:

- Percent Present—the percent of key data fields that are populated
- Percent Valid Format—the percent of key fields where data are submitted in the required format (e.g., dates as dates)
- Percent Valid Values—the percent of key data fields containing valid data

Table B-1 and Figure B-2 contain the quality metric results for the individual practitioner and facility and service provider capacity reports, respectively. Overall, the quality of TCHP's Provider Capacity Reports were good with minor errors associated with the individual practitioner file.

Table B-1—TCHP Phase 1—Individual Practitioner DSN Provider Capacity File Quality Metrics

DSN Data Field	DSN Quality Metrics		
	% Present	% Valid Format	% Valid Values
Accepting New Medicaid Enrollees	88.5	99.6	
Address #1	100.0		
Provider's Capacity	15.2	100.0	
City	100.0		
Status of Medicaid Contract	100.0	0.0	
County	100.0		
Credentialing Date	61.5	100.0	100.0
DMAP (Medicaid ID)	99.7	99.8	

DSN Data Field	DSN Quality Metrics		
	% Present	% Valid Format	% Valid Values
Provider First Name	100.0		
Group/Clinic Name	100.0		
Non-English Language 1	7.6		
Non-English Language 2			
Non-English Language 3			
Provider Last Name	100.0		
Provider Network Status	100.0	0.0	
Provider NPI	100.0	100.0	99.9
Number of Members Assigned to PCPs	1.6	99.6	
PCP Indicator	100.0	100.0	
PCPCH Tier	7.3	99.9	
Phone Number	100.0		
Provider Category	100.0	100.0	100.0
Provider Service Category	100.0	100.0	98.0
Provider TIN	100.0	99.0	
Provider Taxonomy	100.0	100.0	100.0
Zip Code	100.0		

In general, all key DSN data fields in the individual practitioner capacity report were populated except for Credentialing Date for which only 61.5 percent of the records contained a value. However, although infrequently populated, the data in the credentialing date field was formatted correctly and contained valid values (i.e., date within three years). Of note, only 7.6 percent of providers were associated with a non-English language.

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

DSN Data Field	DSN Quality Metrics		
	% Present	%Valid Format	% Valid Values
Address #1	100.0		
Facility or Business Name	100.0		
City	100.0		
Status of Medicaid Contract	100.0	64.1	
County	100.0		
DMAP (Medicaid ID)	92.7	99.8	

DSN Data Field	DSN Quality Metrics		
	% Present	%Valid Format	% Valid Values
Facility NPI	100.0	99.9	99.8
Phone Number	96.3		
Provider Category	100.0	99.9	99.9
Provider Service Category	100.0	100.0	99.2
Facility TIN	100.0	99.9	
Facility or Business Taxonomy	100.0	99.9	99.9
Zip Code	100.0		

Overall, key DSN data fields in the facility and service provider capacity report were present and populated with valid values with an overall average completeness of 99.2 percent across all data fields. Of note, only 64.1 percent of the records populated with a Contract Status were in a valid format.

Provider Network Capacity

The provider network capacity domain addressed the underlying infrastructure of the CCO's provider network and assessed whether or not required health services were available to beneficiaries through a sufficient supply and variety of providers. Table B-3 provides the number and percent of providers by provider specialty category and contract status. All providers presented in the DSN were contracted or had a contract pending at the time of submission except for one community prevention services provider and five DME providers.

Table B-3—TCHP Phase 1—Individual and Facility/Service Provider Capacity[1] by Specialty Category[2] and Contract Status

Provider Specialty Category	Total		Contract Status = Yes		Contract Status = PEND	
	Number	Percent	Number	Percent	Number	Percent
Individual Practitioners						
Primary Care Provider	1,607	16.4	1,034	64.3	573	35.7
Specialty Provider	5,338	54.5	3,739	70.0	1599	30.0
Dental Service Provider	762	7.8	743	97.5	19	2.5
Mental Health Provider	1,971	20.1	1,644	83.4	327	16.6
SUD Provider	42	0.4	39	92.9	3	7.1
Certified or Qualified Health Care Interpreters	0	0.0	0	0.0	0	0.0
Traditional Health Workers	63	0.6	59	93.7	4	6.3
Alcohol/Drug	1	0.0	1	100.0	0	0.0

Provider Specialty Category	Total		Contract Status = Yes		Contract Status = PEND	
	Number	Percent	Number	Percent	Number	Percent
Health Education, Health Promotion, Health Literacy	0	0.0	0	0.0	0	0.0
Palliative Care	3	0.0	3	100.0	0	0.0
Facility/Service Practitioners						
Hospital, Acute Psychiatric Care	8	3.6	4	50.0	4	50.0
Ambulance and Emergency Medical Transportation	4	1.8	2	50.0	2	50.0
Federally Qualified Health Centers	31	14.0	14	45.2	17	54.8
Home Health	10	4.5	8	80.0	2	20.0
Hospice	0	0.0	0	0.0	0	0.0
Hospital	14	6.3	7	50.0	7	50.0
Imaging	0	0.0	0	0.0	0	0.0
Indian Health Service and Tribal Health Services	1	0.5	0	0.0	1	100.0
Mental Health Crisis Services	3	1.4	3	100.0	0	0.0
Community Prevention Services	14	6.3	11	78.6	2	14.3
Non-Emergent Medical Transportation	2	0.9	1	50.0	1	50.0
Pharmacies	20	9.0	20	100.0	0	0.0
Durable Medical Providers	68	30.8	62	91.2	1	1.5
Post-Hospital Skilled Nursing Facility	33	14.9	30	90.9	3	9.1
Rural Health Centers	6	2.7	5	83.3	1	16.7
School-Based Health Centers	2	0.9	1	50.0	1	50.0
Urgent Care Center	5	2.3	5	100.0	0	0.0

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

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

In general, TCHP's individual provider capacity demonstrated network coverage of required physical health (primary and specialty), oral health, and mental health and substance use providers. Provider data, however, did not include documentation of certified or qualified health care interpreters or health education, health promotion, health literacy providers. Additionally, of the 17 required facilities and services, only one provider service category had a count of zero—i.e., imaging services.

Provider Accessibility

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

Table B-4—TCHP Phase 1—Provider Accessibility by Service Category[2]

Provider Specialty Category	Total Providers[1]	Accepting New Patients		Speak Non-English Language	
		Number	Percent	Number	Percent
Primary Care Provider	1,607	994	61.9	107	6.7
Specialty Provider	5,338	3,313	62.1	271	5.1
Dental Service Provider	762	264	34.6	296	38.8
Mental Health Provider	1,971	1,620	82.2	27	1.4
SUD Provider	42	2	4.8	1	2.4
Certified or Qualified Health Care Interpreters	0	0	0.0	0	0.0
Traditional Health Workers	63	44	69.8	0	0.0
Alcohol/Drug	1	0	0.0	0	0.0
Health Education, Health Promotion, Health Literacy	0	0	0.0	0	0.0
Palliative Care	3	3	100.0	0	0.0
TOTAL	**9,787**	**6,240**	**63.8**	**702**	**7.2**

Note: Provider counts are based on all providers regardless of contract status.

[1] Provider counts are based on unique providers deduplicated by NPI and Service Category.

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

Overall, only 63.8 percent of the TCHP's provider network was accepting new patients according to the CCO's DSN submission, including TCHP's core providers (i.e., physical, oral, and mental health). Less than 50 percent of dental providers (34.6 percent) and SUD providers (4.8 percent) reported accepting new patients while primary care and specialty providers exhibited acceptance percentages of 61.9 percent and 62.1 percent, respectively. Of its individual practitioners, only 7.2 percent noted speaking a language other than English with all core specialty categories reporting less than 10 percent of the providers speaking a non-English language except for dental service providers (38.8 percent).

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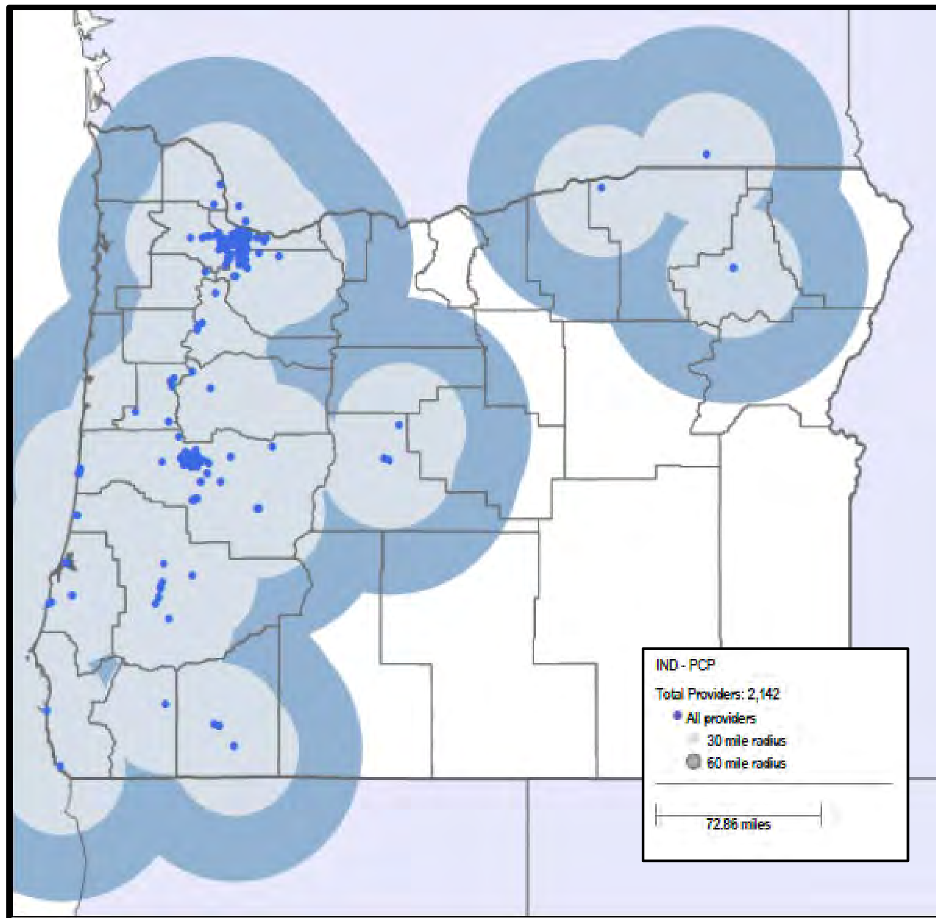
Geographic Distribution

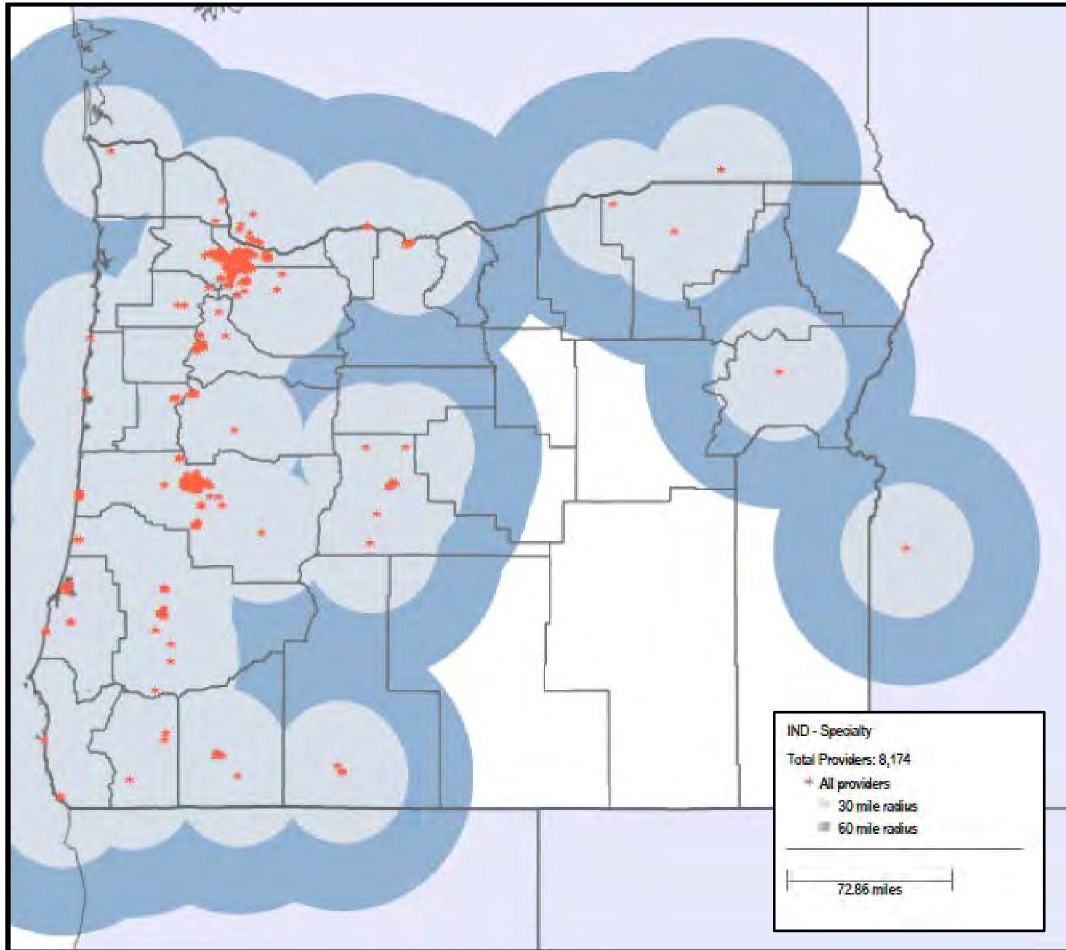
The geographic distribution of providers relative to member populations assessed whether or not the practitioner and facility locations were spread proportionately across the beneficiary population. Since beneficiary data was not available at the time of this analysis, the geospatial maps display the coverage areas around each provider location based on pre-defined distance thresholds (i.e., 30 miles and 60 miles) in alignment with OHA's current access standards. Graphic representations are provided for key individual and facility providers. The zip codes within TCHP's service areas (i.e., Clackamas County, Lane County, Multnomah County, Washington County and parts of Douglas County and Linn County) represent a mix of urban and rural areas.

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



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

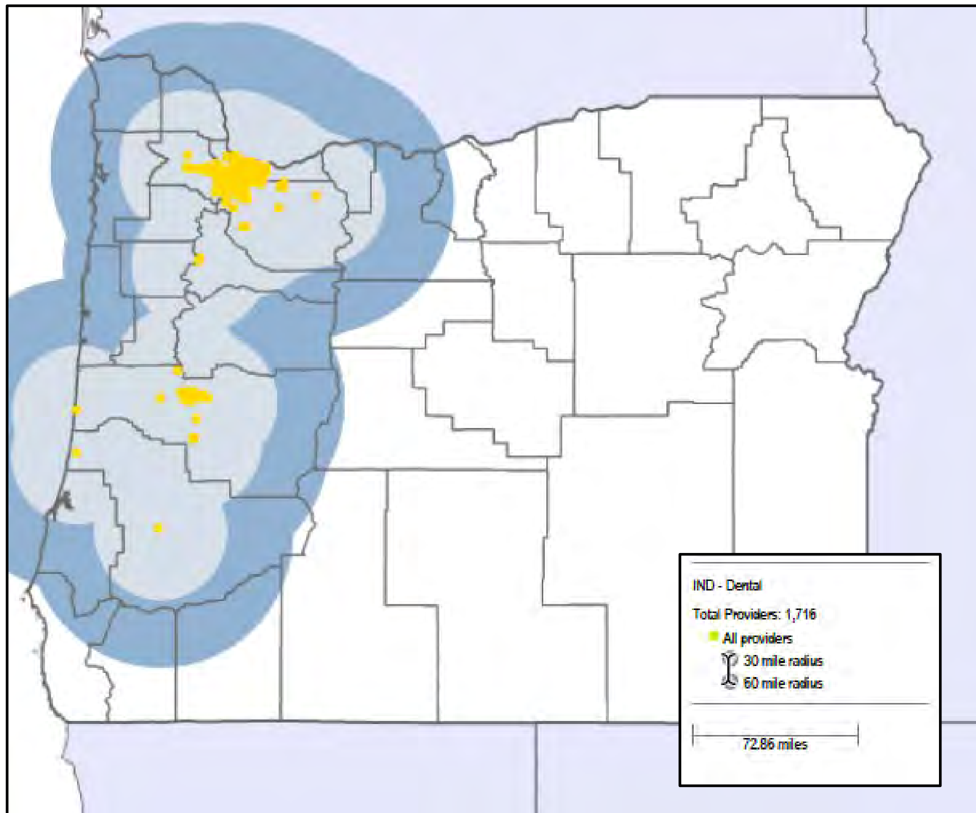
Figure B-2—TCHP Phase 1—Geographic Distribution of Specialty Providers



As shown in Most of the regions in the CCO's service area are within 30 miles of a primary care provider, except for rural parts of eastern Clackamas County where provider coverage is within 60 miles of the nearest primary care provider.

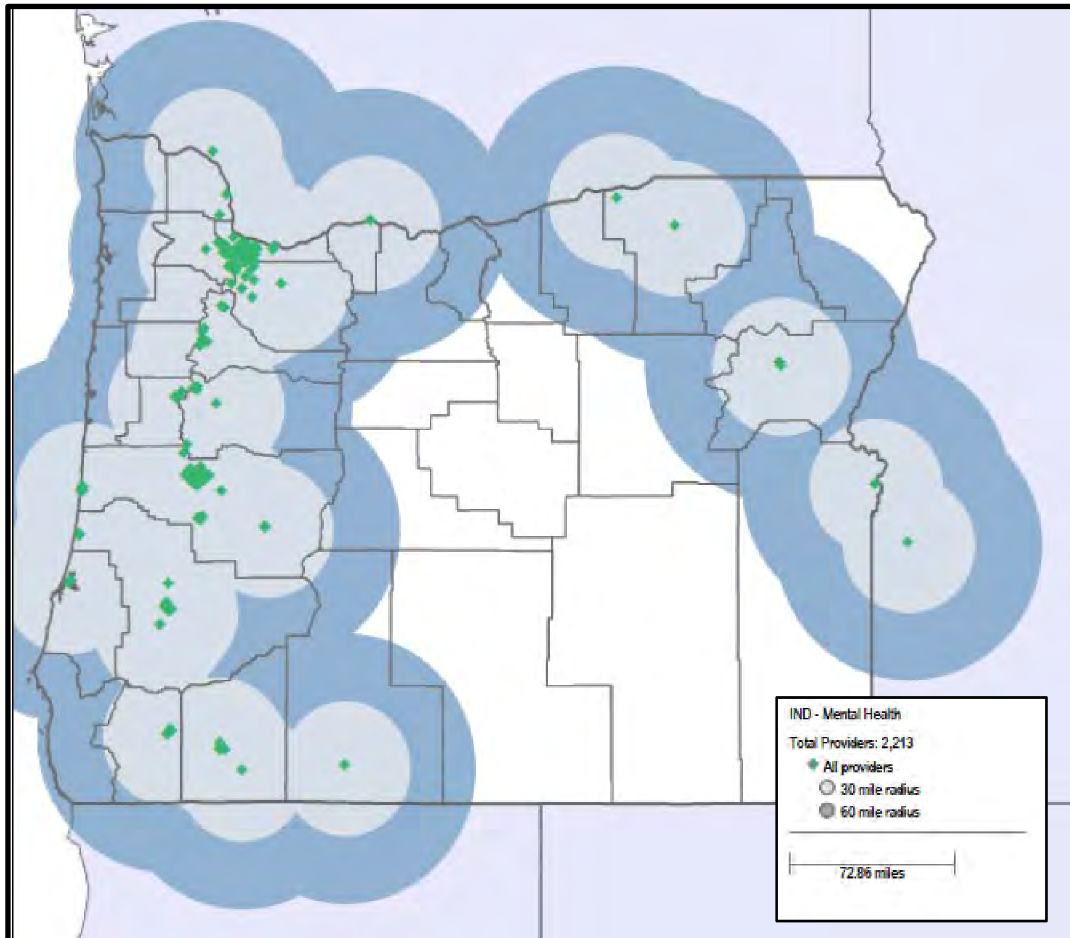
Figure B-2, the distribution of TCHP's specialty providers is sufficient to cover the CCO's service area. Most of the regions in the CCO's service area are within 30 miles of a specialty provider, except for rural parts of eastern Clackamas County and portion of northeastern Lane County where provider coverage is within 60 miles.

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



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

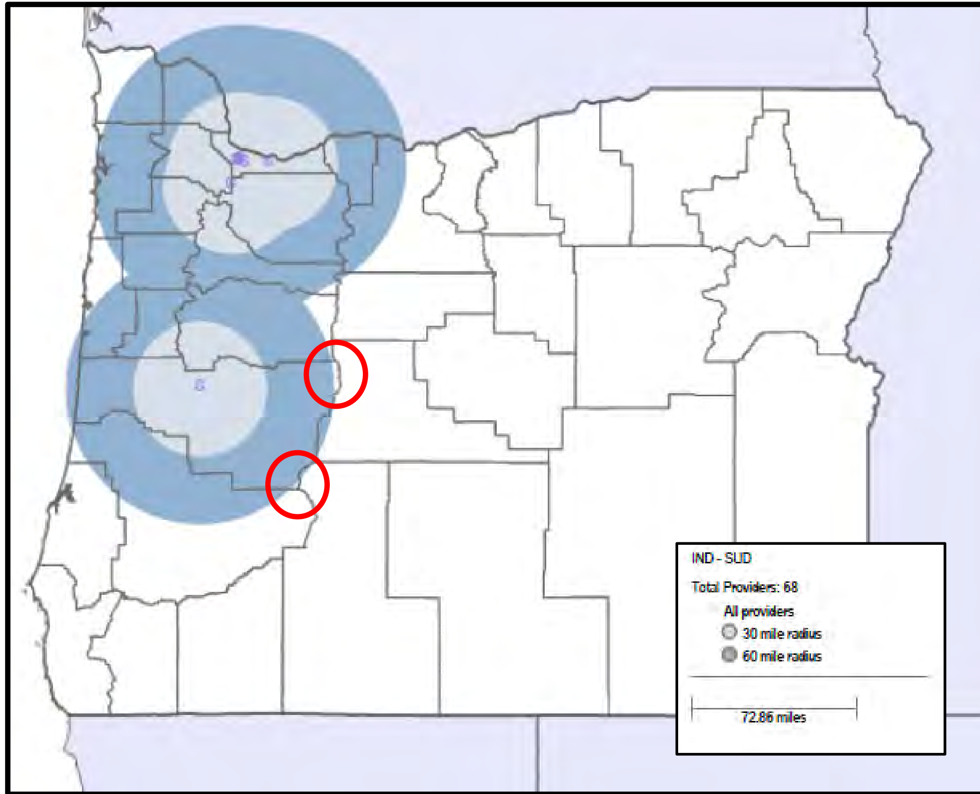
Figure B-4—TCHP Phase 1—Geographic Distribution of Mental Health Providers



As shown in the distribution of TCHP's dental service providers is sufficient to cover the CCO's service area. Most of the regions in the CCO's service area are within 30 miles of a dental provider, except for rural parts of southeastern Clackamas County and the eastern portion of Lane County where provider coverage is within 60 miles.

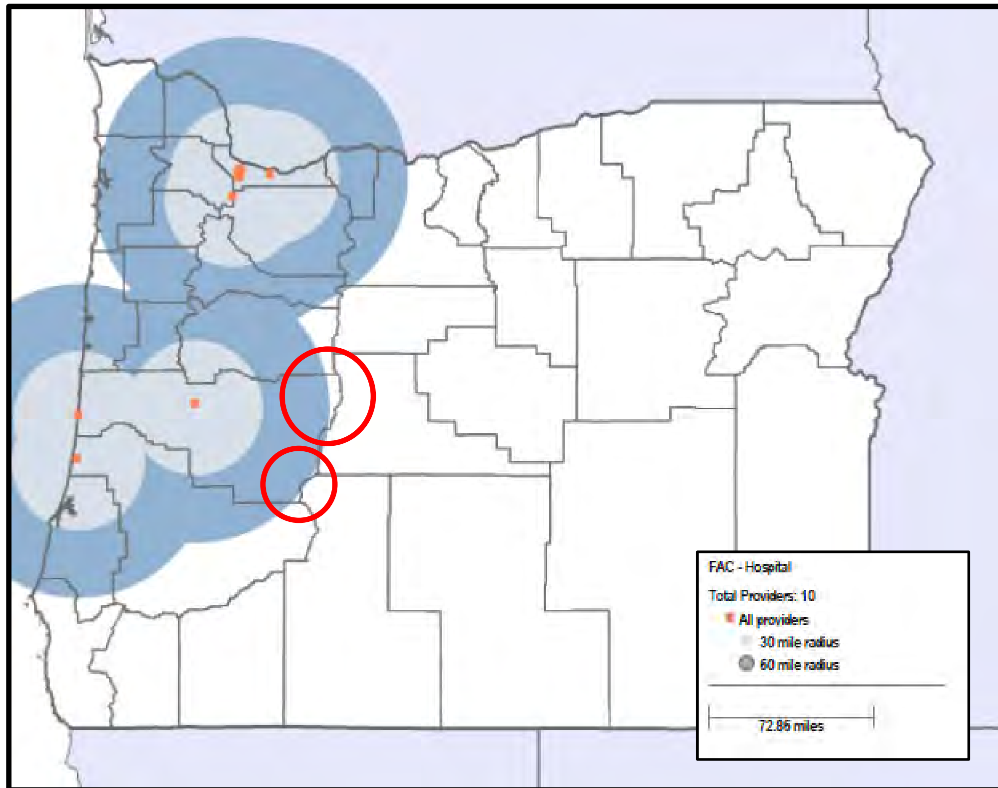
Figure B-4, the distribution of TCHP's mental health providers is sufficient to cover the CCO's service area. Most of the regions in the CCO's service area are within 30 miles of a mental health provider, except for rural parts of eastern Clackamas County and portion of northeastern Lane County where provider coverage is within 60 miles.

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



As shown in Figure B-5, the distribution of TCHP's SUD providers is generally sufficient to cover the CCO's service area with most of the regions in the CCO's service area being within 60 miles of a SUD provider. Only two small rural areas in northeastern and southeastern corners of Lane County include coverage beyond 60 miles.

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



As shown in Figure B-6, the distribution of TCHP's hospital facilities is generally sufficient to cover the CCO's service area with most of the regions in the CCO's service area being within 60 miles of a hospital facility. Only two small rural areas in northeastern and southeastern corners of Lane County include coverage beyond 60 miles.

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

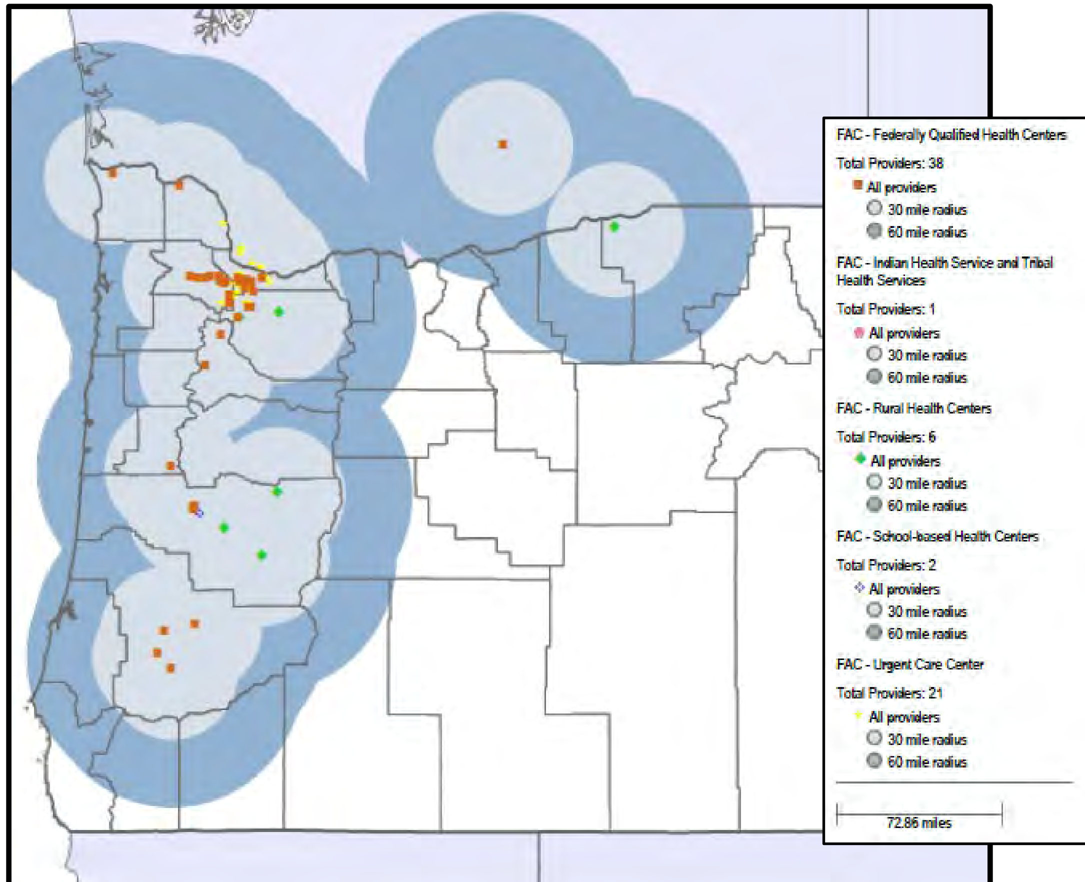


Figure B-7 displays the distribution of several clinic-based facilities within TCHP's service areas, including FQHCs, Indian Health Services and Tribal Health Services, Rural Health Centers, School-Based Health Centers, and Urgent Care Centers. The map shows that the distribution of clinic-based facilities is sufficient to cover the CCO's service area. Most of the regions inside the service area are within 30 miles of a clinic-based facility excluding rural areas in western Lane County and southeastern Clackamas County which are within 60 miles from the nearest facility.

Appendix C. Phase 2 Evaluation Tool

[Pending completion of the Phase 2 RR]