Oregon Health Authority

2019 CCO Readiness Review

for

Umpqua Health Alliance

September 2019

Interim Report

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Overview

Background

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

Methodology

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

Table 1-1—Readiness Review Activities and Timing

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

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

Medicare & Medicaid Services' (CMS') regulations specified by the federal Medicaid managed care final rule published November 1, 2018, and select OHA CCO 2.0 contractual requirements. RRs do not assume that all processes must be fully implemented at the time of review. Therefore, HSAG assigned one of the following ratings to each element in the RR Tool:

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

Phase 1—Critical Areas Readiness Review

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

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

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

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

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

Phase 2—Operations Policy Readiness Review

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

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

Results

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

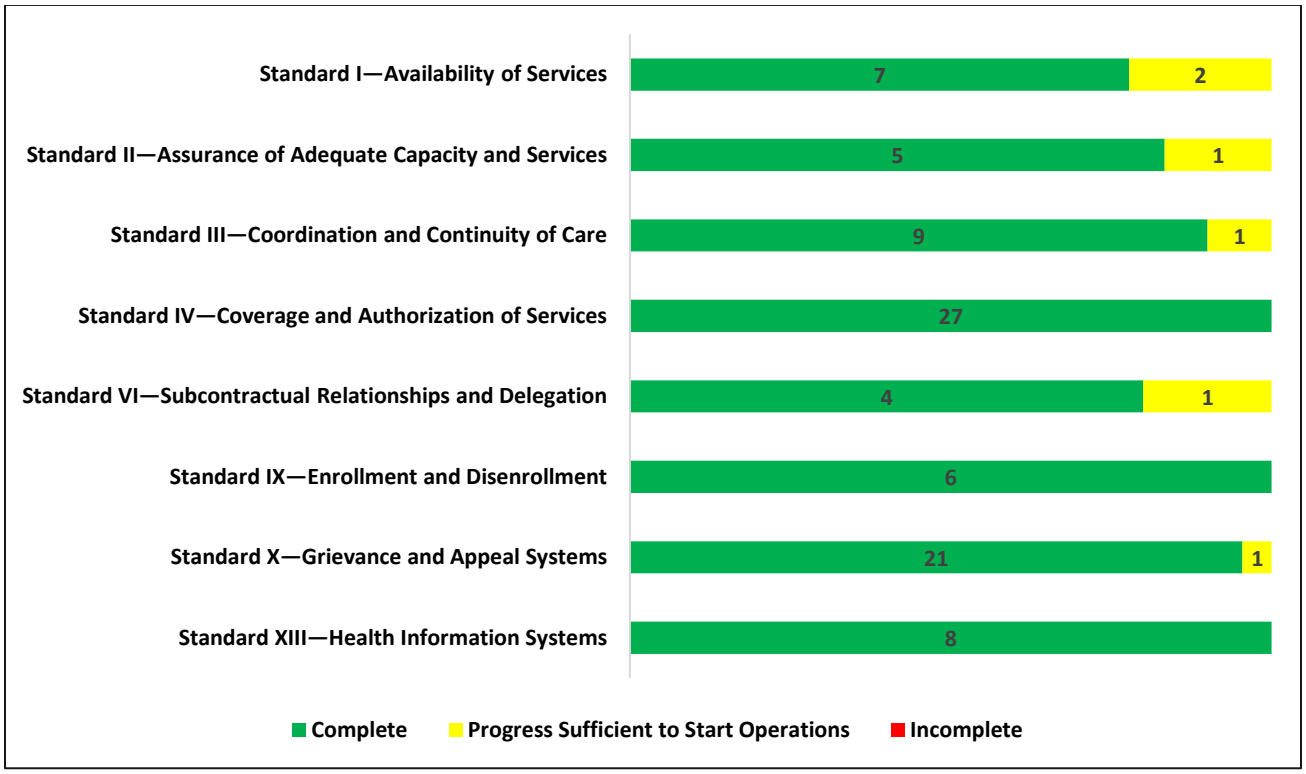
2. Phase 1 Results

Across all eight standards, UHA's overall percentage of complete elements is 93.6 percent. The CCO demonstrated:

- *Complete* ratings for 87 of the 93 total elements.
- *Progress Sufficient to Start Operations* ratings for six elements across five standards.
- No *Incomplete* ratings were identified for any elements across eight standards.

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—UHA Phase 1—Critical Areas Readiness Review Results



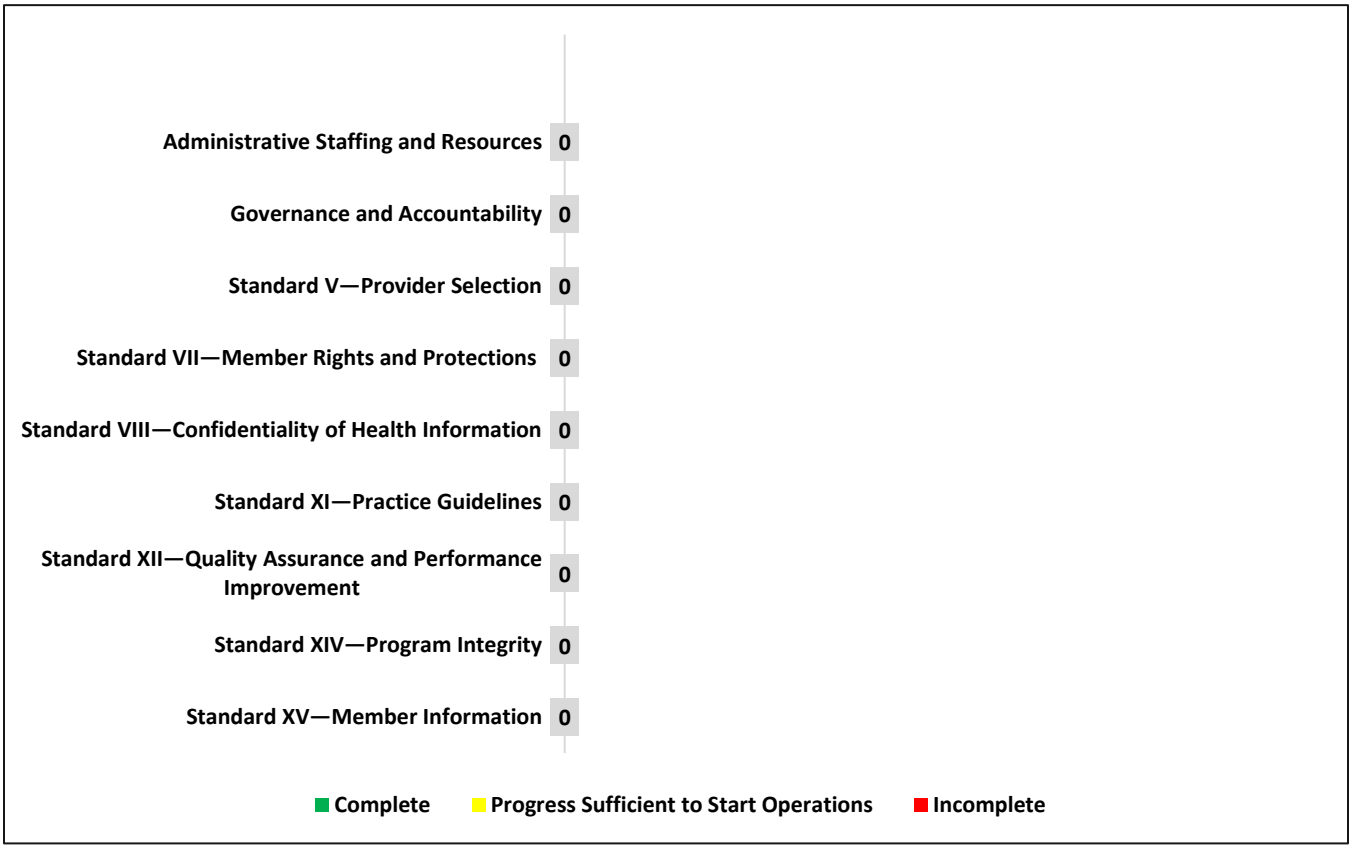
3. Phase 2 Results

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

Across all eight standards, UHA'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—UHA 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 UHA'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)*	• CE11 Out-of-Network Services • CE15 Specialty HealthCare Services • CE17 Single Case Agreement • PN7 Network Adequacy • PN8 Monitoring Network Availability • PN9 Monitoring Network Access • 2019 Network Adequacy Survey, • DSN Provider Report for CCO 2.0 (08.2019) FINAL 080119 UHA has a robust Provider Network Department who works in close collaboration with Clinical Engagement and Member Services to ensure covered services to members are provided in a timely manner. The Compliance Department works with individual departments to complete the P&P process through various committees and in a formalized process.	☒ 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.	• CE11- Out-of-Network Services • CE15 - Specialty Health Care Services • CO29 - NEMT Quality Assurance Program and Plan • MS7 – Non-Emergent Medical Transportation • PN7 Network Adequacy • PN8 Monitoring Network Availability	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
42 CFR §438.206(b)(1) *Contract: Exhibit B Part 4 (3)(a)(1)*	• PN9 Monitoring Network Access • 2019 Network Adequacy Study • Access and Availability Report 7.02.19 • Geomapping MH_Time & Distance • Geomapping_Hospital_Time & Distance • Geomapping_PCPA Time & Distance • Geomapping_PCPCH_Time & Distance • Geomapping_PCPP_Time & Distance • Geomapping_Pharmacy_Time & Distance • Geomapping_SPA_Time & Distance • Geomapping_SPP_Time & Distance • Geomapping_SUD_Time & Distance • KPIs Geomapping June '19_Dental • KPIs Geomapping June '19_OBGyn (60min.mi) • KPIs UHA Internal Items (see Subcontractual Relationship Tool, deliverable UHA KPIs – Dental, for sample of external items). • DSN Provider Report for CCO 2.0 (08.2019) FINAL 080119	
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.	UHA has an adequate network of women's health specialist; WHCNP embedded into 3 OB/GYN practice groups (Harmony Health, Accent on Women's & Roseburg Women's Health Care) who are not PCP designated. UHA would not limit	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
42 CFR §438.206(b)(2) *Contract: Exhibit B Part 4 (2)(m)*	participation for new specialist providers identified to meet this need. • CE15 – Specialty Health Care Services • PN7- Network Adequacy • PN8 - Monitoring Network Availability • PN9 - Monitoring Network Access • 2019 Network Adequacy Study • Geomapping_PCPA Time & Distance • Geomapping_PCPCH_Time & Distance • Geomapping_PCPP_Time & Distance • KPIs Geomapping June '19_OBGyn (60min.mi) • Provider Handbook_July 2019 (Section 4.5.1,7.8,7,17.1) • Provider Directory • UHA Member Handbook 2019	
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)*	• CE10 - Second Opinion for Health Care Services (Section 1, 3, 4) • UHA Member Handbook 2019 (see pg. 50 & 56) • Provider Handbook_July 2019 • Second Opinion PA Utilization Review Report YTD	☒ 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	• CE11 - Out of Network Services under procedures (Pg. 1 – (1))	☒ Complete

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	• PN7 - Network Adequacy (Pg. 5 – Requests for Out-of-Network Service – (1)) • CE17 - Single-Case Agreement • Out of Network Referrals (January 2019 – June 2019)	☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
6. The CCO demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services: a. In accordance with 42 CFR §431.51(b)(2), members shall not be restricted in freedom of choice of providers of family planning services. b. Therefore, members are permitted to self-refer to any provider for the provision of family planning services, including those not in the CCO's network. *42 CFR §431.51(b)(2)* *42 CFR §438.206(b)(7)* *Contract: Exhibit B Part 2 (6)(b)*	• CE05 – Medical & Pharmacy Review (see pg. 4 item 7(b)(iii)) • CE12 – Prior Authorizations (see pg. 3 item 2(a)) • UHA Member Handbook 2019 - Page 36	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
7. The CCO ensures its provider network observe the timely access to services provisions and complies with the following requirements:	Per HSAG, this is a "preview element" and no deliverable is required at this time.	☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
a. Meet and require its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. b. Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid Fee for Service (FFS), if the provider serves only Medicaid enrollees. c. Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary. d. Establish mechanisms to ensure compliance by network providers. e. Monitor network providers regularly to determine compliance. f. Take corrective action if there is a failure to comply by a network provider. *42 CFR §438.206(c)(1)* *Contract: Exhibit B Part 4 (2)(a)* *Contract: Exhibit B Part 4 (13)(b)(3), (4)*		
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. UHA works in close collaboration with Mercy Medical Center (hospital) and Compass Behavioral Health (CMHP) to provide interim services if members are placed on a waitlist. UHA continues to contract with out of area specialty behavioral health providers to ensure coverage in a timely manner for members with	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
a. If a timeframe cannot be met due to lack of capacity, the member must be placed on a waitlist and provided interim services within 72 hours of being put on a waitlist. Interim services should be as close as possible to the appropriate level of care and may include referrals, methadone maintenance, compliance reviews, HIV/AIDS testing, outpatient services for substance use disorder, risk reduction, residential services for substance use disorder, withdrawal management, and assessments or other services described in OAR 309-019-0135. b. Pregnant women, veterans and their families, women with children, unpaid caregivers, families, and children ages birth through five years, individuals with HIV/AIDS or tuberculosis, individuals at the risk of first episode psychosis and the I/DD population: Immediate assessment and intake. If interim services are necessary due to capacity restrictions, treatment at appropriate level of care must commence within 120 days from placement on a waitlist. c. IV drug users: Immediate assessment and intake. Admission required within 14 days of request, or, if interim series are necessary due to capacity restrictions, admission must commence within 120 days from placement on a waitlist. d. Opioid use disorder: Assessment and intake within 72 hours. e. Medication assisted treatment: No more than 72 hours for assessment and induction, with efforts to do such as soon as possible. f. Children with serious emotional disturbance: Any limits that the Authority may specify in the contract or in guidance.	SPMI. UHA is willing to contract with providers for specialty behavioral health care and educates providers on the process of obtaining DMAP numbers, submitting PAs and claims to ensure that services are covered and reimbursed. – PN7 Network Adequacy (section 1.d) – PN8 Monitoring Network Availability (section 1.d & e) – PN9 Monitoring Network Access (section 1 b vii) – 2019 Network Adequacy Study – Access and Availability Report 07.02.19 – Behavioral Health Network Adequacy Dashboard – Behavioral Health Monitoring Process Letter b. UHA will add the additional requirements in the updated Medicaid required language exhibits for the 2020 contracts surrounding our behavioral health providers, Compass, to ensure that our network has the sufficient specialty services for our members. UHA's Network Adequacy Study outlines the monitoring network availability to adhere to the OAR's governed by the State. Behavioral Health providers will be required to meet the standards of non-urgent appointments within 2 weeks from the date of the request. If there are no additional in-area providers of this specialty the Provider Network Department will	

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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*	work to contract with out -of -area providers to fulfill that gap for our members in order to received care. – PN7- Network Adequacy – PN8 - Monitoring Network Availability – 2019 Network Adequacy Study – Behavioral Health Network Adequacy Dashboard – Behavioral Health Monitoring Process Letter c. UHA utilizes services provided by contracts with the hospital and CMHP to provide immediate services to IV drug users. UHA continues to monitor this population to ensure adequate access and to contract with providers identified to fulfill this need. – PN7- Network Adequacy – PN8 - Monitoring Network Availability – 2019 Network Adequacy Study – Behavioral Health Network Adequacy Dashboard – Behavioral Health Monitoring Process Letter d. UHA's contract with the CMHP provides the coverage specialty behavioral health services needed for members with opioid use disorder, and provide assessment and intake within 72 hours. – PN7- Network Adequacy	

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	– PN8 - Monitoring Network Availability – 2019 Network Adequacy Study – Behavioral Health Network Adequacy Dashboard – Behavioral Health Monitoring Process Letter e. UHA has well-established contracts with Adapt, Compass and Serenity Lane to ensure sufficient and timely specialty behavioral health services for MAT treatment and additional behavioral services. – PN7- Network Adequacy – PN8 - Monitoring Network Availability – PN9 - Monitoring Network Access – Network Adequacy Study – Access and Availability Report 07 02 19, KPIs – Behavioral Health Network Adequacy Dashboard – Behavioral Health Monitoring Process Letter f. UHA contracts with Jasper Mountain, Trillium Family Services and Adapt Deer Creek for children with serious emotional disturbances. UHA continues to identify opportunities with other out of area providers willing to negotiate for contracting and routinely collaborates with out of network providers to complete SCAs. – NETWORK PROVIDER AGMT (MENTAL HEALTH) (ALL PLANS) (UHN, LLC;	

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	ADAPT dba COMPASS BEHAVIORAL HEALTH) 010119; – FACILITY AGMT (BEHAVIORAL HEALTH) (UHA; JASPER MOUNTAIN) g. UHA has a robust behavioral health network that encompasses both the CMHP as well as individual providers. Several contracted providers are embedded into medical home groups, as well as RHC and FQHCs. All behavioral health providers are monitored through quarterly Access to Care surveys as well as secret shopper calls, as needed. Grievance and Appeals, and access issues received through Member Services help identify lack of sufficient and timely services. Providers who do not meet adequate requirements are placed on a CAP and work with Compliance through remediation. Appointments are assessed through complete and detailed chart note/reviews for being therapeutic in nature. – PN7- Network Adequacy – PN8 - Monitoring Network Availability – PN9 - Monitoring Network Access – 2019 Network Adequacy Study – Access and Availability Report 07.02.19 – Geomapping MH_Time & Distance – Geomapping_SUD_Time & Distance	

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	– ACCESS TO CARE SURVEY_2Q19 – UHA Monthly Reports June 2019_sent to Dr. Carr 7-26-19 – Behavioral Health Network Adequacy Dashboard – Behavioral Health Monitoring Process Letter	
HSAG Findings: The CCO's Monitoring Network Availability policy identified general timeliness requirements (e.g., urgent care, routine dental, etc.) and adherence to timeliness provisions for priority populations in relation to providing specialty behavioral health services; however, the policy omitted a few components for the priority populations, including ensuring timeliness for intravenous drug user admission within 14 days of request, services or admissions within 120 days from request or placement if on a waitlist, and any limitations for children with serious emotional disturbance.		
Required Actions: HSAG recommends that the CCO update its Monitoring Network Availability policy to explicitly include all timeliness provisions for priority populations in relation to providing specialty behavioral health services.		
9. The CCO has written policies and procedures that ensure scheduling and rescheduling of member appointments are appropriate to the reasons for and urgency of the visit. The member shall be seen, treated, or referred within the following timeframes: a. *Well care:* Within four (4) weeks from the date of a patient's request. b. *Urgent care:* Within seventy-two (72) hours or as indicated in the initial screening for urgent care. c. *Emergency care:* Immediately or referred to an emergency department depending on the member's condition. 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.	• Access to Care Survey_BH (Adapt)_Sample • Access to Care Survey_BH_Sample • Access to Care Survey_FQHC, RHC_Sample • Access to Care Survey_PCP _Sample • Access to Care Survey_Specialist _Sample • Behavioral Health Monitoring Process Letter • Behavioral Health Network Adequacy Dashboard • CMHP & LMHA MOU a. UHA will work to revised policies to identify "re-scheduling" of appointments are appropriate to the reasons for and urgency of the visit." Quarterly Access to Care surveys assist to monitor adequate access and availability for	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	well-care visits within 4 weeks. There have been no deficiencies identified. – MS1- Member Assignment and Reassignment – MS9 Member Handbook Availability – PN7- Network Adequacy – PN8 - Monitoring Network – PN9 - Monitoring Network Access – 2019 Network Adequacy Study – Access and Availability Report 07.02.19 b. UHA identifies the applicable OAR on P&Ps and on the quarterly Access to Care surveys. Urgent Care visits being identified as not within 72 hours are issued a written CAP for the provider to bring them to remediation. – PN7- Network Adequacy – PN8 - Monitoring Network Availability – PN9 - Monitoring Network Access – 2019 Network Adequacy Study – Access and Availability Report 07.02.19 – Geomapping MH_Time & Distance – Geomapping_Hospital_Time & Distance – Geomapping_PCPA Time & Distance – Geomapping_PCPCH_Time & Distance – Geomapping_PCPP_Time & Distance – Geomapping_Pharmacy_Time & Distance	

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	– Geomapping_SPA_Time & Distance – Geomapping_SPP_Time & Distance – Geomapping_SUD_Time & Distance – KPIs Geomapping June '19_Dental • KPIs Geomapping June '19_OBGyn (60min.mi) c. UHA has policies in place to require network providers to provide immediate care to members within 24 hours. Through the credentialing process, providers are also required to have adequate call coverage service in place for after-hours emergencies. Providers are trained and train members to call their PCP first for an appt. before utilizing the urgent care and emergency room. – PN7- Network Adequacy – PN8 - Monitoring Network Availability – PN9 - Monitoring Network Access – 2019 Network Adequacy Study – Access and Availability Report 07.02.19 – KPIs & Geomapping items listed under (b) above. d. UHA has one DCO who reports on access and availability on a monthly basis. Advantage is currently on a CAP to remediate not meeting sufficient emergency oral care requirements of care within 24 hours. UHA conducts secret shopper calls and evaluates trends through their	

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Member Services and Grievance and Appeals departments. – PN7- Network Adequacy – PN8 - Monitoring Network Availability – PN9 - Monitoring Network Access – 2019 Network Adequacy Study – Access and Availability Report 07.02.19 – KPIs Geomapping June'19_Dental – Advantage Dental Access Report_June 2019 – CAP Requested - Emergency Appt Adv Dental – CAP Requested - Urgent & Routine Appts Adv Dental – CAP Response Adv Dental - Urgent & Routine Appts – CAP Status Update Requested- Urgent and Routine Appts Adv Dental – CAP Status Update Request - Adv Dental Emergency Appts – CAP Response_Adv Dental & Timely Access e. UHA contracts with one DCO who provides a monthly report on access and availability sufficient for meeting urgent oral care requirements of care within 1-2 weeks. UHA has placed DCO on a written CAP and continues to closely monitor issues identified through	

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Member Services and Grievance and Appeals departments. – PN7- Network Adequacy – PN8 - Monitoring Network Availability – PN9 - Monitoring Network Access – Network Adequacy Study – Access and Availability Report 07 02 19 – KPIs Geomapping June'19_Dental – Advantage Dental Access Report_June 2019 f. UHA ensures that its network providers have a fair approach to request member reassignment, while taking into consideration barriers, coordination of care, and a timely transition for impacted members. UHA's policy MS1 address the decision making process and necessary steps to assign and reassign a member from a provider. For routine oral care our providers provide through surveys communication surrounding the time frames of appointments and wait times. UHA monitors the access to care and conducts secret shopper calls, as needed, in the event a member files a grievance UHA follows up with the provider and our compliance department to document the issue and prepare a remediation plan to ensure the member's services continue within a timely manner according to the state's requirements. – MS1- Member Assignment and Reassignment	

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	– PN7- Network Adequacy – PN8 - Monitoring Network Availability – PN9 - Monitoring Network Access – 2019 Network Adequacy Study g. Through the quarterly Access to Care surveys, each behavioral health provider group is required to complete to identify intake assessment within 2 weeks of a request for non-urgent visits. UHA conducts secret shopper calls as needed and issues CAPs in the event that requirements are not met. – PN7- Network Adequacy – PN8 - Monitoring Network Availability – PN9 - Monitoring Network Access – 2019 Network Adequacy Study – CAP_Valley View 07.13.18 – CAP_Compass 07.13.18	
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)*	• SOP Cultural Considerations • CLAS Training_CE 050819 • 2018 Annual Training_Culture • MS2 – Nondiscrimination of Members • MS3 – Member Rights (see items 4(k), (l), (m), (n), (o), (q), (r), (s), (hh), and (mm)) • MS4 – Written Notices to Members • MS5 – Requests for Interpreter or Alternative Format Policy	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• PN6 – Provider Orientation & Training • Training Tracking Required by Office • Training Tracking_Sign-in Sheet_6.5.19 PCP Luncheon • Training Tracking_Sign-in Sheet_6.13.19 Specialist Luncheon • Training Tracking_Sign-in Sheet_6.28.19 TIC & MI CMG PULM & SLEEP • Training Tracking_Sign-in Sheet_7.1.19 CUST SVC & TIC UH Staff • Draft June 5th Power Point OM Meeting 1 • New Provider Orientation Attestation_July 2019_Sample • Umpqua PP Advance Directive Training • Advance Directive Training Sign-in Sheet Umpqua Health Alliance, through Umpqua Health Network, in agreement with CCO requirements, will continue to provide trainings that aligns with the components of cultural competence curriculum as set forth by OHA's Cultural Competency Continuing Education criteria. UHA has developed mechanisms and tools to deliver culturally competent services to members and providers in the rural area of Douglas County. UHA provides training for all contracted providers in several ways; by providing training conferences for community partners and providers, through a monthly newsletter which contains training material as well as links and schedules of	

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	upcoming training events. Member services offers language assistance to individuals who have limited English proficiency and other needs to ensure that they have timely access to all health care services.	
HSAG Findings: The CCO's documentation provided evidence that it promotes culturally competent services through contract expectations and documented training opportunities and requirements. While nondiscrimination is clearly outlined in the CCO's member handbook, the provider manual, provider contracts, and CCO policies and procedures do not consistently include nondiscrimination language related to sexual orientation and gender identity.		
Required Actions: HSAG recommends that the CCO review its provider documents to ensure the use of consistent nondiscrimination language to ensure the CCO and its providers support 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.		
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)*	Per HSAG, this is a "preview element" and no deliverable is required at this time.	☐ 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	**7**
Progress Sufficient	**2**
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*	PN7- Network Adequacy PN8 - Monitoring Network Availability PN9 - Monitoring Network Access Network Adequacy Study Access and Availability Report 07 02 19 DSN Provider Report for CCO 2.0 (08.2019) FINAL 080119 Each year UHA develops a Network Adequacy Study and a DSN Report to provide evidence of UHA's KPI's and the network availability access and standards for our providers as outlined in UHA's policies PN8, PN7 and PN9. Additionally, UHA authorizes, out of network and out of service area, as necessary to ensure that adequate services are being provided to meet the needs of UHA' enrollees. UHA provides coverage for preventative, primary care, and specialty services. The DSN report is submitted to the State annually and it defines the network. In order to complete the DSN report, a geo mapping software is utilized to report on the adequacy of membership to specific provider types within a 30 min/mi or 60 min/mi requirement. Reporting is done on a monthly basis for KPIs and as an additional tool to assess and demonstrate compliance with maintaining a provider network sufficient in number, mix and geographic distribution to meet the needs of anticipated number of enrollees in the service area.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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*	PN7- Network Adequacy PN8 - Monitoring Network Availability PN9 - Monitoring Network Access Network Adequacy Study Access and Availability Report 07 02 19 PN12- Delivery Service Network (DSN) Workflow DSN Provider Report for CCO 2.0 (08.2019) FINAL 080119	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: The CCO's Delivery System Network Workflow policy identified quarterly and annual network report submission procedures, but it does not clearly define the processes for identifying and reporting when a significant change in the CCO's operations that would affect the adequacy of capacity and services.		
Required Actions: HSAG recommends that the CCO update its Delivery System Network Workflow policy that address how it identifies, documents, and reports when there has been a significant change in its operations that would affect the adequacy of capacity and 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)*	Access and Availability Report 07 02 19 PN7- Network Adequacy PN8 - Monitoring Network Availability PN9 - Monitoring Network Access KPIs Geomapping June'19_DENTAL KPIs Geomapping June'19_OBGyn (60min.mi) Geomapping June'19_PCPCH_TIME & DISTANCE Geomapping June'19_PCPA TIME & DISTANCE	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Geomapping June'19_PCPP_TIME & DISTANCE Geomapping SUD_TIME & DISTANCE Geomapping MH_TIME & DISTANCE Network Adequacy Study Access and Availability Report 07.02.19 PN12- Delivery Service Network (DSN) Workflow Access to Care Surveys are distributed to the provider panel to identify gaps in the provider network. Adult and Pediatric primary care, PCPCH, OB/GYN, Behavioral Health, Oral Health are monitored on a monthly utilization report. As trends are identified, UHA reaches out of area/network to contract or complete Single Case Agreement as needed.	
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)*	Access and Availability Report 07 02 19 Geomapping June'19_SPA_TIME & DISTANCE Geomapping June'19_SPP_TIME & DISTANCE CE17- Single-Case Agreement Access to Care Surveys are distributed to the provider panel to identify gaps in the provider network. Adult and Pediatric specialists are monitored on a monthly utilization report. As trends are identified, UHA reaches out of area/network to complete SCA or contracts, as needed, to provide coverage for our members. Various Committees meet on a monthly basis to discuss/review solutions such as telehealth and collaboration with community provider/resources to fulfill any identified needs.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
5. Hospital and Emergency Services Access Standards—Hospitals—Time and Distance: a. In urban areas - Thirty (30) minutes or thirty (30) miles from the personal residences of members. b. In rural areas – Sixty (60 minutes) or sixty (60) miles from the personal residence of members. *42 CFR §438.68* *42 CFR §438.206(c)(1)(i)* *Contract: Exhibit B (2)(a)*	PN7- Network Adequacy PN8 - Monitoring Network Availability PN9 - Monitoring Network Access HOSPITAL_TIME & DISTANCE Contracts are being finalized with OHSU and the PeaceHealth hospitals in Cottage Grove and Florence to continue to provide adequate coverage to membership in the northern and coastal Douglas County areas.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
6. Pharmacy—Time and Distance: a. In urban areas - Thirty (30) minutes or thirty (30) miles from the personal residences of members. b. In rural areas – Sixty (60 minutes) or sixty (60) miles from the personal residence of members. *42 CFR §438.68* *42 CFR §438.206(c)(1)(i)* *Contract: Exhibit B (2)(a)*	PN7- Network Adequacy PN8 - Monitoring Network Availability PN9 - Monitoring Network Access Geomapping June'19_PHARMACY_TIME & DISTANCE UHA contracts with MedImpact to manage our pharmacy network. MedImpact has a sufficient network. UHA has not found any need for improvement in this area.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard II—Assurance of Adequate Capacity and Services	
	Total #
Complete	**5**
Progress Sufficient	**1**
Incomplete	**0**
Not Applicable (NA)	**0**

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. The CCO ensures that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member. a. The member must be provided information on how to contact their designated person or entity. b. The CCO implements a standardized approach to effective transition planning and follow-up. *42 CFR §438.208(b)(1)* *Contract: Exhibit B Part 4 (2)(k)*	CE16 Intensive Care Coordination Services (addresses b in section 2 & 3) CE18 Integrated Care Coordination (addresses a in section 13.b.), (addresses b in sections 14-21, 24-27) CE19 Substance Use Disorder (addresses b in section 5) TC1 Transitional Care for Acute Care (addresses b in section 3,4) CE23 Inpatient Psychiatric Authorization (addresses 1 in entirety) SOP03 Intensive Case Management Care Plans (addresses a in sections 2 & 3), (addresses b in sections 5) SOP04 Interdisciplinary Team (addresses b in sections 1-5) SOP05 New Beginning Program (addresses a in sections 1.c.), (addresses b in sections 4-6) SOP07 New Day Program (addresses a in section 1.b.), (addresses b in sections 4,6 &7) SOP08 Discharge Planning and Transition (addresses b in entirety) Case Management General Letter New Beginning Welcome Letter	☒ 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;	CE16 Intensive Care Coordination Services (addresses a in sections 3 & 9), (addresses c in section 9) CE 18 Integrated Care Coordination (addresses a in sections 2,3,10), (addresses b, c & d in section 10)	☒ Complete ☐ Progress Sufficient to Start Operations

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	CE19 Substance Use Disorder (addresses a in section 2), (addresses d in section 5) TC1 Transitional Care for Acute Care (addresses a in section 3) CE23 Inpatient Psychiatric Authorization (addresses a in section 4.f.) SOP03 Intensive Case Management Care Plans (addresses a in section 5) SOP04 Interdisciplinary Team (addresses d in sections 1-5) SOP05 New Beginning Program (addresses d in sections 1-5) SOP07 New Day Program (addresses a in section 6), (addresses d in entirety) SOP08 Discharge Planning and Transition (addresses a,b,c & d in entirety) CM Discharge Planning Assessment rev.7-2019	☐ Incomplete ☐ NA
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)*	MS8 Health Risk Assessment (addressed in section 1) CE16 Intensive Care Coordination Services (addressed in section 3, 9) CE18 Integrated Care Coordination (addressed in section 5.b.) CE19 Substance Use Disorder SOP 10 Case Management Health Risk Survey Process TC1 Transitional Care for Acute Care CE23 Inpatient Psychiatric Authorization SOP08 Discharge Planning and Transition	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	SOP03 Intensive Case Management Care Plans SOP04 Interdisciplinary Team SOP05 New Beginning Program SOP07 New Day Program FINAL Health Risk Assessment.Youth DRAFT - Health Risk Assessment.Youth 2020 FINAL Health Risk Assessment.Adult (002) DRAFT - Health Risk Assessment.Adult 2020	
4. The CCO's service agreements with specialty and hospital providers must: i. Address the coordinating role of patient-centered primary care; ii. Specify processes for requesting hospital admission or specialty services; and iii. Establish performance expectations for communication and medical records sharing for specialty treatments: – At the time of hospital admission; or – At the time of Hospital discharge for the purpose of facilitating after-Hospital follow up appointments and care. *Contract: Exhibit B Part 4 (9)*	CE13 - Emergency Care and Post Stabilization; TC1- Transitional Care for acute Care AHN PARTICIPATING GROUP AGMT (GALEN INPATIENT PHYSICIANS, INC) (See section 2.8 Patient Centered Primary Care Homes (PCPCH); 2.13 Hospital Admission Authorization; 3.14 Medical Records; Plan Addendum A, Section 6) PeaceHealth - UHN Facility Agreement (1_2019)) (See section 2.6 Patient Centered Primary Care Homes ("PCPCH"); 2.7 Care Coordination and Concurrent Review; 2.9 Hospital Admissions; 3.11 Medical Records) Mercy VBP Amendment (pg. 8, Section 5)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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,	CE16 Intensive Care Coordination Services (addresses a in section 1 &4) CE18 Integrated Care Coordination (addresses a in section 13.a.,15)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	CE19 Substance Use Disorder (addresses a in section 5) SOP 08 Discharge Planning or Transition of Care, Section 1, 4(f), section 10 TC1 Transitional Care for Hospitalizations CE23 Inpatient Psychiatric Authorization PN8 - Monitoring Network Availability	☐ 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)* *Contract: Exhibit B Part 4 (2)(f)(3)*	CE18 - Integrated Care Coordination under procedures (Pg. 3 – (9)) IDT Meeting Agenda 07.18.2019	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
7. The CCO ensures that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards. *42 CFR §438.208(b)(5)* *Contract: Exhibit B Part 8 (1)(d-f)*	Per HSAG, this is a "preview element" and no deliverable is required at this time.	☐ 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.	H37 Public Health Uses and Disclosure of PHI H38 Uses and Disclosures as Required by Law or Victims of Abuse, Neglect or Domestic Violence H39 Uses and Disclosure of PFI for Health Oversight Activities and Worker's Compensation	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
42 CFR §438.208(b)(6) *Contract: Exhibit B Part 4 (1)(a)*	H1 General rules and uses and Disclosures of Protected Health Information H10 Notice of Privacy Practices H28 Uses Disclosures of PHI for Treatment, Payment, or Healthcare Operations H35 Uses Disclosures Requiring an Opportunity to Agree or Object H36 Uses Disclosures of PHI Requiring Authorization	☐ NA
9. The CCO implements mechanisms to comprehensively assess each member identified as needing LTSS or having special health care needs to identify any ongoing special conditions of 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)*	CE 16 Intensive Care Coordination Services, Section 3, section 8, Section 9(a-c) Ce 18 Integrated Care Coordination, section 2, section 3, section 5(a-d)(iii), section 6, section 8(a), Section 9)(a) CE 19 Substance Use Disorder, section 5, section 6 TC1 Transitional Care for Acute Care, Section 2, CE 23 Inpatient Psychiatric Authorization, section 4(f) SOP 08 Discharge Planning and Transition, section 2, Section 4(e), Section 4(f), Section 7, Section, 10, Section 11, Section 15, section 16 SOP 03 Intensive Case Management Care Plans, Section 4(a,b), Section 9(a-c) SOP 04 Interdisciplinary Team, section 6(a-b) SOP05 New Beginning Program SOP07 New Day Program Sample CM Discharge plan assessment Sample General Assessment Sample 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**
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)*	CE 15 Specialty Health Care Services, Section 3 CE 16 Intensive Care Coordination Services, Section 1(a-c), Section 2, Section 8 CE 18 Integrated Care Coordination, section 2, section 3, section 5(b), section 8(a-c), section 13(a-d), section 25 SOP 05 New Beginnings Program, section (a-e), Section 3, section 4 SOP 03 Intensive Case Management Care Plan, section 1, section 4(a-b), section 5, section 9(a-c) SOP 04 Interdisciplinary Team Meetings, section 4, section 5 SOP 07 New Day Program Section 1(a-b), section 3, section 4, section 5 SOP 08 Discharge Planning and Transition of Care, section 1, section 2, section 4(b), section 12, section 15 Sample General Assessment Sample Care Plan	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: While UHA had policies and procedures to identify, assess, and produce a treatment plan for members identified as having a special healthcare need, information related to the comprehensive assessment and treatment planning lacked some specificity. For example, UHA's expected time frames for completing assessments and care plans were not identified, processes for ensuring member participation in the care planning process were not defined, and how the CCO shares the care plan with providers and documents the sharing of that information was not included. During the remote interview session, UHA staff members demonstrated the care management systems, which confirmed that the CCO has processes in place to conduct care coordination activities.		
Required Actions: HSAG recommends that the CCO revise its policies and procedures to include more specificity related to the process, time frames, tracking, and monitoring of the comprehensive assessment activities. In addition, HSAG recommends that the CCO revise policies and procedures to include more specificity related to the processes, time frames, tracking, monitoring, documentation and sharing of the treatment/care planning activities.		

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)*	Per HSAG, this is a "preview element" and no deliverable is required at this time.	☐ 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))*	Per HSAG, this is a "preview element" and no deliverable is required at this time.	☐ 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)*	SOP 09 Special Health Care Needs, section 2, section 3 CE15 Special Healthcare Service CE16 Intensive Care Coordination Services CE18 Integrated Care Coordination CE19 Substance Use Disorder TC1 Transitional Care for Acute Care CE23 Inpatient Psychiatric Authorization SOP03 Intensive Case Management Care Plans SOP04 UHA Interdisciplinary Team SOP05 New Beginning Program SOP07 New Day Program Sample General Assessment Sample Care plan	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care	
	Total #
Complete	**9**
Progress Sufficient	**1**
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)*	CE05 - Medical and Pharmacy Review, (pg. 3, (5)(a), (7)(b)(i), and Pg.4, (8)(b).	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
2. The CCO is permitted to place appropriate limits on a service: a. On the basis of criteria applied under the State plan, such as medical necessity; or b. For the purpose of utilization control, provided that: i. The services furnished can reasonably achieve their purpose, as required in paragraph (a)(3)(i) of this section; ii. The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the member's ongoing need for such services and supports; and	CE05 - Medical and Pharmacy Review, (Pg.3, (7)(a)-(b))	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
iii. Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with §441.20 of this chapter. *42 CFR §438.210(a)(4)(i-ii)* *Contract: Exhibit B Part 2*		
3. The CCO has processes to ensure that utilization or prior authorization standards for mental health or substance used disorder benefits and access to both in-network and out-of-network providers providing these benefits are no more stringent then the standards that are applied to medical/surgical benefits. *Contract: Exhibit E (22)*	CE04 - Outpatient Behavioral Health Services Prior Authorization CE05 - Medical and Pharmacy Review, (Pg. 3, (6)) CE11 - Out of Network CE12 - Prior Authorization (Pg. 5, (10)) CE19 - Substance Use Disorder Services QI02 - Over and Under Utilization CE24 - Mental Health Parity (Pg. 2, (1)(g))	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
4. The CCO has processes to ensure that any financial requirements or treatment limits to mental health or substance use disorder benefits in any classification are no more restrictive then the financial requirements or treatment limits to medical/surgical benefits in the same classification (whether or not the benefits are furnished by the CCO). *Contract: Exhibit E (22)*	CE04 - Outpatient Behavioral Health Services Prior Authorization CE05 - Medical and Pharmacy Review CE11 - Out of Network CE12 - Prior Authorization CE19 - Substance Use Disorder Services QI02 - Over and Under Utilization CE24 - Mental Health Parity (Pg. 1 and 2, (1)(g))	☒ 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:	CE05 - Medical and Pharmacy Review under procedures (7).	☒ Complete ☐ Progress Sufficient to Start Operations

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
a. Is no more restrictive than that used in the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and b. Addresses: i. The prevention, diagnosis, and treatment of a member's disease, condition, and/or disorder that results in health impairments and/or disability. ii. The ability for a member to achieve age-appropriate growth and development iii. The ability for a member to attain, maintain, or regain functional capacity. *42 CFR §438.210(a)(5)(i-ii)* *Contract: Exhibit B Part 2 (2)(b)*		☐ Incomplete ☐ NA
6. The CCO establishes and adheres to written policies and procedures for both the initial and continuing service authorization requests consistent with utilization control requirements of 42 CFR Part 456. Policies and procedures must include: a. Mechanisms to ensure consistent application of review criteria for authorization decisions; b. Consultation with the requesting provider for medical services when appropriate. c. A process to ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an	a. CE05 - Medical and Pharmacy Review under procedures (1) SOP - CE05 - Inter-Rater Reliability b. CE05 - Medical and Pharmacy Review under procedures (4)(b) and (10). c. CE05 - Medical and Pharmacy Review under procedures (5). Inter-Rater Reliability Testing Results 7.30.19	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs. *42 CFR §438.210(b)(1-3)* *Contract: Exhibit B Part 2 (3)(a & f)* *Contract: Exhibit B Part 2 (2)(c)*		
7. The CCO's utilization management policies are not structured in a way to provide incentives for its provider network, employees or other utilization reviewers to inappropriately deny, limit or discontinue medically appropriate services to any member. *42 CFR §438.210(e)* *Contract: Exhibit B Part 2 (2)(d)*	CE04 - Outpatient Behavioral Health Services Prior Authorization CE05 - Medical and Pharmacy Review CE12 - Prior Authorization CE19 - Substance Use Disorder Services CE22 - Payment and Authorization for Hospital Admission QI05 - Performance Measurement and Reporting Requirements	☒ 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)*	P&T Charter_Version 3_7-2019; P&T Committee Minutes for last 2 quarters: Q1 2019 P&T Minutes Q2 2019 P&T Minutes	☒ 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)*	CE21 - Adverse Benefit Determinations (Pg. 3 (2))	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
10. The written notice of adverse benefit determination must be consistent with the provisions under 42 CFR 438.10(c) and must include: a. The date of the notice; b. CCO name, address, phone number; c. Name of the member's Primary Care Practitioner, Primary Care Dentist, or behavioral health practitioner, as applicable; d. Member's name, address, and ID number e. Service requested or previously provided and adverse benefit determination the CCO made or intends to make; f. Date of the service or date service was requested by the provider or member; g. Name of the provider who performed or requested the service; h. Effective date of the adverse benefit determination if different from the date of the notice; i. Whether the CCO considered other conditions if the service was below the funding line of the OHP Prioritized List of Health Services; j. The reasons for the adverse benefit determination, including reference to the specific statutes and administrative rules to the highest level of specificity for each reason and specific circumstances identified in the notice that include, but is not limited to: k. The right of the member to be provided upon request and free of charge, reasonable access to and copies of all	a-g. CE21 - Adverse Benefit Determinations procedure 2 on page 3. i-k. CE21 - Adverse Benefit Determinations procedure 2 on page 3. ABD page 1. m-o. CE21 - Adverse Benefit Determinations procedure 3 on page 4. ABD (page 2)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
documents, records, and other information relevant to the member's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. l. The member's right to request an appeal with the CCO within 60 days of the CCO's adverse benefit determination, including information on exhausting the CCO's one level of appeal described at §438.402(b) and the right to request a State fair hearing (contested case hearing) within 120 days after issuance of the CCO's Notice of Appeal Resolution or where the CCO failed to meet appeal timelines as outlin4ed in 410-141-3230; and the procedures for exercising these rights described in 410-141-3245. m. The circumstances under which an appeal process can be expedited and how to request it. n. The procedures for exercising the rights specified in this standard. o. The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the member may be required to pay the costs of these services. *42 CFR §438.404(b)* *Contract: Exhibit I (3)(b)*		
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	CE12 - Prior Authorization under procedure (8) Q2 2019 P&T Minutes Compliance KPIs June 2019	☒ Complete ☐ Progress Sufficient to Start Operations

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
service, with a possible extension of up to 14 additional calendar days: a. The member, or the provider, requests extension; or b. The CCO justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest. *42 CFR §438.210(d)(1)(i-ii)* *Contract: Exhibit B Part 2 (3)(h)*		☐ Incomplete ☐ NA
12. For cases in which a provider indicates, or the CCO determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the CCO must make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service. a. The CCO may extend the 72-hour time period by up to 14 calendar days if the member requests an extension, or if the CCO justifies (to the State agency upon request) a need for additional information and how the extension is in the member's interest. *42 CFR §438.210(d)(2)(i-ii)* *Contract: Exhibit B Part 2 (3)(i)*	CE12 - Prior Authorization under procedures (9) Compliance KPIs June 2019	☒ 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)*	CE12 - Prior Authorization, Section 6 Compliance KPIs June 2019: Compliance KPI Report shows compliance with outpatient drug authorization turnaround times, see row 9 highlighted in red.	☒ 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. *42CFR438.404(c), 42CFR431.211, 42CFR431.213(a)-(g), 42CFR431.214(a)* *Contract: Exhibit I (3)(c)*	CE21 - Adverse Benefit Determinations procedure 5 on pages 5-6. Adverse Benefit Determinations SOP CE21 Compliance KPIs June 2019	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	CE13 - Emergency Care and Post-Stabilization, - defined under definitions	☒ 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)*	CE13 - Emergency Care and Post Stabilization- defined under definitions	☒ 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.	CE13 - Emergency and Post Stabilization- section 2, Section 3, and Section 3(a)(i-iii) & section 3(b)	☒ 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)*		
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)*	CE13 - Emergency and Post-Stabilization (Prior Authorization, section 1) & (Emergency and post-stabilization, section 2)	☒ 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)*	CE13 - Emergency and Post-Stabilization (Emergency and post-stabilization, section 3)	☒ 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	CE13 - Emergency and Post-Stabilization (Emergency and post-stabilization, section 4)	☒ Complete ☐ Progress Sufficient to Start Operations

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
that determination is binding on the entities identified in paragraph (b) of this section as responsible for coverage and payment. *42 CFR §422.114(d)(3)* *Contract: Exhibit B Part 2 (4)(a)(9)*		☐ 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	CE13 - Emergency Care and Post Stabilization (Coverage & Payment, Section 5, (a-d)(i-iii) and Section 6, and section 7) (Behavior Health, Section 1-5) (Emergency and Post-Stabilization Services, section 1-5)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
iii. The CCO's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the CCO must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in §422.113(c)(3) is met. d. Must limit charges to members for post-stabilization care services to an amount no greater than what the organization would charge the member if he or she had obtained the services through the CCO's network. For purposes of cost sharing, post-stabilization care services begin upon inpatient admission. *42 CFR §438.114(e)* *42 CFR §422.113(c)(2)(i-iv)* *Contract: Exhibit B Part 2 (4)(a)(6&8)*		
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)*	CE13 - Emergency Care and Post-Stabilization (coverage and payment, section 5(a-d)(i-iv)	☒ 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)*	MS7 - Non-Emergent Medical Transportation (NEMT, section 1(a)(i-iv), Section 1(d)(i-v)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
24. The CCO maintains a NEMT Call Center with minimum operating hours Monday through Friday from 9:00am to 5:00pm. For after hours arrangements, the CCO provides an afterhours message in English and Spanish instructing the caller how to access the alternative arrangement. *Contract: Exhibit B Part 2 (4)(b)(13)*	MS7 - Non-Emergent Medical Transportation (section 1(f)(iv), section 1(f)(v)(1-2)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
25. The CCO has written policies and procedures for Emergency Dental Services and Urgent Care Services for Emergency Dental Conditions that describe when treatment of an emergency or urgent dental condition should be provided in an ambulatory dental office setting and when emergency dental services should be provided in a hospital setting. *Contract: Exhibit B Part 2 (4)(k)(2)*	CE13 - Emergency Care and Post-Stabilization, Dental Emergency/Urgent Care, Section(s) 1 through 7.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ 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)*	CE13 - Emergency Care and Post-Stabilization-Behavior Health Services section 1-5	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	CE13 - Emergency Care and Post-Stabilization-Behavior Health Services, Section 1-5	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

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)*	CO10- Evaluation of Subcontractor (pg. 2, #1) CO35- Subcontractor- General Requirement Standards (pg. 2, #6) CO35 & CO36 Policy Approval Process Letter Subcontractor Monitoring Matrix PN10 –Agreements and Contract Workflow (pg. 2, #2) SOP- Contracts to Submit to OHA	☒ 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).	CO10 - Evaluation of Subcontractor CO35 - Subcontractor - General Requirement Standards CO36 - Subcontractor - Written Agreement Requirement Standards CO35 & CO36 Policy Approval Process Letter Subcontractor Monitoring Matrix PN10 - Agreements and Contract Workflow Subcontractor Narrative SAMPLE - Required OHP Contract Provisions (Subcontractor_Provider) (CCO 2.0) SAMPLE - EXHIBIT A - Delegated Services (Dental) SAMPLE - EXHIBIT A - Delegated Services (NEMT) SAMPLE - EXHIBIT A - Delegated Services (SUD) SAMPLE - EXHIBIT A - Delegated Services (PBM)	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

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)*	SAMPLE- EXHIBIT A - Delegated Services (Credentialing) SAMPLE: Delegated Services Exhibit – Mental Health Services SAMPLE - Att A to OHP Plan Ex A-1 Delegated Mental Health Services (Adapt) DELEGATED CREDENTIALING AGREEMENT (UHN; CMG EAST DBA EFM) EFF. 100118 SAMPLE - v. 7 SECOND AMENDED AND RESTATED MANAGEMENT SERVICES AND WORKER LEASING AGREEMENT 7-5-19(102244466.7)	
HSAG Findings: UHA's Subcontractor Written Agreement Requirement Standards policy was missing the following requirements for written agreements: delegated activities or obligations, reporting responsibilities, the subcontractor agreement to perform the delegated activities and reporting responsibilities, and the obligations and time frames for remedying deficiencies in subcontractor performance. During the remote interview session, UHA staff members stated that they will revise policies and execute addendums to subcontractor agreements once the contract with OHA is finalized.		
Required Actions: HSAG recommends that UHA revise policies to ensure that all requirements for subcontractor agreements are included. In addition, HSAG recommends that UHA review and update the subcontractor agreements to ensure that all required language and any citations to the CCO contract are consistent with the final CCO contract.		
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)*	CO10 - Evaluation of Subcontractor SOP-CO10 - Evaluation of Subcontractor EFM PreDelegation Letter EFM PreDelegation Results	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
4. The CCO has a process to monitor the subcontractor's performance on an ongoing basis. • Formal reviews shall be conducted by the CCO at least annually. *Contract: Exhibit B Part 4(13)(a)(12-14)*	CO7 - Monitoring CO10 - Evaluation of Subcontractor SOP-CO10 - Evaluation of Subcontractor UHA KPIs - Dental CAP Requested - Emergency Appt Adv Dental CAP Requested - Urgent & Routine Appts Adv Dental CAP Response Adv Dental - Urgent & Routine Appts CAP Status Update Requested- Urgent and Routine Appts Adv Dental CAP Status Update Request - Adv Dental Emergency Appts CAP Response_Adv Dental & Timely Access 01 - January UHA-Ph Tech SLA Report 201901 02- February UHA-Ph Tech SLA Report 201902 03 - March UHA-Ph Tech SLA Report 201903 04 - April UHA-Ph Tech SLA Report 201904 05 - May UHA-Ph Tech SLA Report 201905 06 - June UHA-Ph Tech SLA Report 201906 Delegated Serv Admin - Narrative Delegated Services Administrator JD Adv Dental 2018 - UHA Audit Letter - Deliverables Adv Dental 2018 - UHA Audit Letter - Results Bay Cities 2018 - UHA Audit Letter - Deliverables Bay Cities 2018 - UHA Audit Letter - Results Audit Notification_MedImpact 2018	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Audit Results_MedImpact 2018 Vituity(CEP and Galen)_UHA Audit Letter - Deliverables Vituity(CEP and Galen)_UHA Audit Letter - Results and Closure	
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)*	Per HSAG, this is a "preview element" and no deliverable is required at this time.	☐ 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;	SOP Provider Network Contract Submitted to OHA CO30 - CO34 Approval Process Letter CO30 - Disclosure of Ownership and Control CO31 - Disclosure Pertaining to Business Transaction CO33 - Prohibited Affiliations CO34 - Disclosure of Information Regarding Crime Convictions	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• Any ownership stake between the Contractor and Subcontractor. *Contract: Exhibit B Part 4(13)(a)(5-6)*		
7. The Contractor must notify OHA in writing within 30 days of terminating any Subcontractor and provide an updated Subcontractors and Delegated Entities report. The Contractor must notify OHA in writing within 30 days of terminating any Participating Provider contract when such termination is a for-cause termination, including but not limited to: • Failure to meet requirements under the contract; • For reasons related to fraud, integrity, or quality; • Deficiencies identified through compliance monitoring of the entity; or • Any other for-cause termination. *Contract: Exhibit B Part 4(13)(b)(4)*	Per HSAG, this is a "preview element" and no deliverable is required at this time.	☐ 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)*	MS10 - Member Enrollment and Disenrollment	☒ 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)*	MS10 - Member Enrollment and Disenrollment	☒ 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)*	MS10 - Member Enrollment and Disenrollment	☒ 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.	MS10 - Member Enrollment and Disenrollment - pages 3 & 4	☒ 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)*	MS10 - Member Enrollment and Disenrollment	☒ 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	MS10 - Member Enrollment and Disenrollment	☒ 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*	CE01 - Grievances, (Page 1 for failure to adhere to required timeframes) CE20 - Appeals and Hearings, (Page 3 for levels and pages 3-4 for failure to adhere to required timeframes) CE21 - Adverse Benefit Determination, (Page 2 definitions for one level of appeal) SOP - Appeals SOP - Hearings Adverse Benefit Determinations SOP CE21 SOP - Grievance log quarterly reporting Sample 2019Q1 quarterly grievance and appeals log	☒ 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)*	CE01 - Grievances (Page 1 for failure to adhere to required timeframes) CE20 - Appeals & Hearings (Page 3 for levels and pages 3-4 for failure to adhere to required timeframes) CE21 - Adverse Benefit Determination (Page 2 definitions for one level of appeal) ABD sample (Page 2 for appeal and hearing information)	☒ 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)*	CE01 - Grievances (Page 1-5) CE20 - Appeals & Hearings (Pages 1-7) CE21 - Adverse Benefit Determinations (Pages 1-2) Adverse Benefit Determinations SOP CE21	☒ 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)*	CE20 - Appeals & Hearings (Page 2)	☒ 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)*	CE01 - Grievances, (Page 2) CE20 - Appeals and Hearings, (Page 2) CE21 - Adverse Benefit Determination, (Page 2)	☒ 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)*	CE01 - Grievances (Page 4)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
7. A member may file an appeal within 60 calendar days from date on the notice of adverse benefit determination.	CE20 - Appeals and Hearings (Page 5) CE21 - Adverse Benefit Determinations (Page 4-5)	☒ Complete ☐ Progress Sufficient to Start Operations

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• 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)*		☐ 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)*	CE01_Grievances (Page5, item 11) CE20 - Appeals and Hearings UHA Daily Referral Report 6.6.19 - Grievance Tracking Sample 2019Q1 quarterly grievance and appeals log	☒ 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)*	CE20 - Appeals and Hearings CE21 - Adverse Benefit Determination	☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element was a duplicate of element #7.		
Required Actions: None.		

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	CE01 - Grievances SOP - Grievances Compliance KPIs June 2019	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
11. In handling grievances and appeals, the CCO must give members any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. *42 CFR §438.406(a)* *Contract: Exhibit I (1)(c)(4)*	CE20 Appeals & Hearings (Page 3) CE01 - Grievances (Page 3) MS5 - Requests for Interpreter or Alternative Format Sample 2019Q1 quarterly grievance and appeals log January 2020 - UHA Handbook vs 20.2 - DRAFT (Page 2 and 20)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	CE01 Grievances (Page 5) CE20 Appeals & Hearings (Page 7) SOP – Appeals SOP – Grievances Sample 2019Q1 quarterly grievance and appeals log	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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.	CE20 - Appeals and Hearings (Page 3-8) SOP - Appeals	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*		
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.	CE20 - Appeals and Hearings (Page 9) SOP – Appeals (Page 3) Compliance KPIs June 2019 Sample 2019Q1 quarterly grievance and appeals log	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• 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)*		
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. – 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.	CE01 - Grievances (Page 4-5) CE20 - Appeals and Hearings (Page 4) SOP – Appeals Sample 2019Q1 quarterly grievance and appeals log	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• If the CCO 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)*	CE20 - Appeals and Hearings Sample - NOAR SOP - Appeals	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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	CE20 - Appeals and Hearings Sample - NOAR	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
her representative or the representative of a deceased member's estate. *42 CFR §438.408(f)* *Contract: Exhibit I (5)*		
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 follow-up within two calendar days with a written notice. *42 CFR §438.410* *Contract: Exhibit I (4)(c)(3)(e)*	CE20 - Appeals and Hearings Sample - NOAR SOP - Appeals	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	CE20- Appeals and Hearings Sample - NOAR SOP - Appeals	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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:	CE20 - Appeals and Hearings (Page 7 item 18)	☒ Complete ☐ Progress Sufficient to Start Operations

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• 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)*		☐ 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)*	CE20 - Appeals & Hearings (Page 11)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
22. Effectuation of Reversed appeal resolutions: • If the CCO or the State fair hearing (contested case hearing) officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the CCO must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than seventy-two (72)	CE20 - Appeals and Hearings (Pages 8-11)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
hours from the date it receives notice reversing the determination. • If the CCO or the State fair hearing (contested case hearing) officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the CCO or the State must pay for those services, in accordance with State policy and regulations. *42 CFR §438.424* *Contract: Exhibit I (7)*		
23. The CCO maintain records of all member grievances and appeals. The record must be accurately maintained in a manner accessible to the State and available upon request to CMS. The record of each member grievance or appeal must contain, at a minimum, all of the following information: • A general description of the reason for the appeal or grievance; • The date received; • The date of each review or, if applicable, review meeting; • Resolution at each level of the appeal or grievance, if applicable; • Date of resolution at each level, if applicable; • Name of the covered person for whom the appeal or grievance was filed, member ID number, and date the member filed the grievance or appeal;	Per HSAG, this is a "preview element" and no deliverable is required at this time.	☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• Notations of oral and written communications with the member; and • Notations about appeals and grievances the member decides to resolve in another way if the CCO is aware of this. *42 CFR §438.416* *Contract: Exhibit I (9)*		
24. The CCO provides the information about the grievance appeal, and fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals. • The right to a State fair hearing (contested case hearing) after the CCO has made a decision on an appeal which is adverse to the member. • The availability of assistance in the filing processes. • The member's right to have a provider or authorized representative file a grievance and/or an appeal on his or her behalf, provided he or she has provided written consent • The toll-free numbers to file a grievance or an appeal • The fact that, when requested by the member: – Services that the CCO seeks to reduce or terminate will continue if the appeal or request for State fair hearing (contested case hearing) is filed within the time frames specified for filing.	DRAFT - January 2020 - UHA Handbook vs 20.2 Sample – ABD Sample – NOAR MS9 - Member Handbook MS5 - Requests for Interpreter or Alternative Format CE01 - Grievances CE 20 – Appeals and Hearings OHP 3302 Appeals and Hearings form	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
– 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)*		
HSAG Findings: The CCO's New Provider Attestation form is signed by a provider at the time of contract to attest that he or she has received the CCO's grievance, appeals, and State fair hearing policies. HSAG reviewed the CCO's provider manual and found that the grievance and appeals section had limited information on the applicable processes and did not contain information such as filing time frames or information on the State fair hearing process. The applicable CCO policies are not referenced in the manual.		
Required Actions: HSAG recommends that the CCO revise its provider manual to include all of the required grievance, appeals, and State fair hearing information or reference the applicable policies in the manual.		

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

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. The Contractor shall maintain a health information system that collects, analyzes, integrates, and reports data sufficient to support program requirements, including but not limited to: Utilization of services a. Claims and encounters b. Grievances, appeals and hearing records c. Disenrollment for other than loss of Medicaid eligibility d. Member characteristics i. Race ii. Ethnicity iii. Preferred Language iv. Names and phone numbers of the member's PCP or clinic v. Attestation of member rights and responsibilities e. Client Process Monitoring Systems Forms data using the Measures and Outcome Tracking System (MOTS) f. LTPC Determination Forms *42 CFR §438.242(a)* *Contract: Exhibit J (1)*	CA1 – Health Information Systems Management (page 1, section 1) and page 4, Enrollee Encounter data - addresses item a and d) CA2 - Encounter Data Submission and Validation (page 5, Capability of Systems - addresses item a) UHA Data Flow Diagram v3 (addresses item a) CE01 – Grievances (page 5, sections 12 and 13 - addresses item b) CE20 - Appeals and Hearings (page 10, Documentation, section 2 - addresses item b) UHA Appeal, Hearing, and Grievance Systems Workflow diagram (address item b) MS10 - Member Enrollment and Disenrollment (page 1, Member Enrollment, and page 3, Member Disenrollment - addresses item c) MS8 - Health Risk Assessment (page 2, Data Collected, section 1 - addresses item d - i through iv, also item f) MS3 - Member Rights (page 6, section pp - addresses item d – v) UHA Data Collection Process diagram (addresses item d) MOTS_Active Treatment_v1 (addresses item e)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	PH TECH's Community Integration Manager policy Claims Adjudication Procedure policy Encounter Data Submission policy UHA Data Collection Process Medical & Dental Encounter Chart Pharmacy Encounter Chart UHA Data Flow Diagram v3	☒ 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)* *Contract: Exhibit J(2)*	PH TECH's Community Integration Manager policy, Claims Adjudication Procedure policy, Encounter Data Submission policy CA1 - Health Information System Management QI04 - Data Validation Policy 2019 Encounter Data Tracking Sheet	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
4. Contractor shall ensure that data received from providers, either directly or through a third party, is accurate, truthful, and complete in accordance with OAR 410-120-1280 and OAR 410-141-3420 by: a. Verifying the accuracy and timeliness of data reported b. Screening the data for completeness, logic, and consistency c. Submitting the certification to verify current member eligibility for fully dual eligible members using the AVR system or MMIS Web Portal.	CA1 - Health Information System Management, CA2 - Encounter Data Submission and Validation, page 6-8 CA3 - Claims Processing, QI04 - Data Validation Policy, 2019 Encounter Data Tracking Sheet Claims Adjudication Procedure Medical & Dental Encounter Chart UHA Data Collection Process	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
d. Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts in accordance with OHA Electronic Data Transmission (EDT) procedures in OAR Chapter 943 Division 120. *42 CFR §438.242(b)(3)(i-iii)* *Contract: Exhibit J(3)*	Pharmacy Encounter Chart UHA Data Flow Diagram v3	
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)*	PH TECH's Community Integration Manager policy Claims Adjudication Procedure policy Encounter Data Submission policy CA1 - Health Information System Management, page 4 Medical & Dental Encounter Chart UHA Data Collection Process Pharmacy Encounter Chart UHA Data Flow Diagram v3	☒ 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)*	Per HSAG, this is a "preview element" and no deliverable is required at this time.	☐ 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)*	Per HSAG, this is a "preview element" and no deliverable is required at this time.	☐ 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.	Per HSAG, this is a "preview element" and no deliverable is required at this time.	☐ 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*	H19 - Data Backup and Storage (addresses item a) Jobs Backup Summary July 24 2019 (addresses item a) Jobs Restore Summary (addresses items a and b) H9 - Disaster Recovery and Business Continuity (addresses item b and c) Umpqua Health Business Continuity & Disaster Recovery Plan July 2019 (addresses item b and c) Umpqua Health Business Continuity & Disaster Recovery Plan Testing April 2019 (addresses item b and c) H20 - Data and Application Criticality Analysis (addresses item d) H21 - Evaluation Plan (addresses item d)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Contingency Plans Testing and Revision Log.xlsx (addresses item d)	
10. The CCO shall develop and maintain an OHA-approved HIT Roadmap inclusive of CCO's activities, milestones and timelines. The HIT Roadmap must describe where the CCO has implemented its own HIT and where it leverages collaborative HIT solutions, as well as describe how the CCO: a. Uses HIT to achieve its desired outcomes b. Supports EHR adoption for its contracted providers c. Supports access to health information exchanges to enable sharing patient information for care coordination for its contracted providers d. Ensures access to hospital event notifications for its contracted providers 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)*	This element will be reviewed by the OHA HIT for the readiness review.	☐ 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.		

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
11. The CCO shall provide an annual HIT Roadmap update to OHA for review and approval. The HIT Roadmap update must: a. Identify any changes to the prior-approved HIT Roadmap. b. An attestation to progress made on its HIT Roadmap, including supporting documentation c. An attestation that the COO has an active, signed HIT Commons MOU, and i. Adheres to the terms of the HIT Commons MOU ii. Pays the annual HIT Commons assessments subject to the payment terms of the HIT Commons MOU iii. Serves, if elected, on the HIT Commons Governance Board, or one of its committees iv. Participates in OHA's HITAG, at least annually d. Report the EHR(s) vendor/product used by its contracted providers and its progress on EHR adoption targets via the Performance Expectations report 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)*	This element will be reviewed by the OHA HIT for the readiness review.	☐ 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.		

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)*	This element will be reviewed by the OHA HIT for the readiness review.	☐ 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)*	This element will be reviewed by the OHA HIT for the readiness review.	☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element will be reviewed by the OHA HIT for the readiness review.		
Required Actions: None.		
14. The CCO shall document and report to OHA, annually, on how HIT is used to support contracted providers by providing: a. Information (at least quarterly) on measures used in the VBP arrangements b. Accurate and consistent information on patient attribution	Network Risk Pool MS1- Member Assignment and Reassignment Multiple Gap List Continuity of Care UHA Members Assigned to Dr SMITH	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	Umpqua Health Alliance (UHA) currently utilizes and continuously works to expand its utilization of HIT to support our contracted providers. UHA currently utilizes HIT in the following ways: 14.a UHA has developed and will deploy prior to year-end 2019 the Network Risk Pool Report (NRPR) that will be shared with contracted primary care providers on a monthly basis detailed down to the member level reports at the provider and vendor level. The report will categorize costs within health care service categories such as Inpatient, Outpatient, ED, Specialist, PCP, Behavioral Health, etc. Each contracted primary care provider will be measured against their peers as well as medical loss ratios to achieve global health plan goals. Additionally, individually contracted VBP arrangements outside of the NRPR that have specific quality metrics such as Substance Use Disorders or NEMT performance measures will be validated through claims data from UHA's business intelligence platform and further validated annually through OHA's encounter and member data. Any information on specific quality metrics that UHA has with specialty providers will be shared quarterly to keep them apprised of the current year's performance. 14.b Each week after receipt of OHA's 834 files UHA attributes new members to contracted PCP's within 7 days. Member Services then sends a weekly report to each contracted PCP including the member	☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	information for newly assigned and terminated members. These reports are reconciled against the year-end membership files. 14.c Separate from the reporting tool mentioned in 14.a above, UHA's provider portal allows providers to login into a secure website at any time to view their membership details including costs by health care category. Providers are able to view specific costs by member; utilization by member i.e. ED utilization down to the claim date, CPT and diagnosis codes. The report has been in place for several years and is reviewed with providers to ensure they understand the usefulness of the report in managing members who may require intervention. Furthermore, UHA provides monthly CCO metrics gap lists to providers on the gaps in care for a provider's assigned members. This further empowers providers to address those members that may be in need of intervention. 14.d The Continuity of Care (CoC) report, developed by UHA, includes individual member MARA risk stratification through Milliman, and takes into account dual members, large claim threshold, capitation cost allocations, cost neutrality and other areas to ensure providers are not unfairly impacted due to high-cost member attributions. This report in conjunction with the Network Risk Pool Report (14.a) is an example of providers participation in VBP arrangements that affect the entire contracted provider network risk withhold program under the VBP. Additionally,	

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	UHA's gap list reports (14.c) include actionable data for the providers. For example, a provider can see those members assigned that have excessive ED utilization, then access the Provider Portal (14.c) to find the reason for those visits, including diagnosis codes, CPT codes, dates of service, and more. Furthermore, UHA can provide ad-hoc reports on the diversification of a provider's membership and stratify those members into various data sets for the provider to take action on (e.g. providers could request information on members assigned to them that are over 55 with a diagnosis of diabetes). 14.e Individually contracted VBP arrangements outside of the NRPR and CoC that have specific quality metrics such as Substance Use Disorders or NEMT performance measures will be validated through claims data from UHA's business intelligence platform and further validated annually through OHA's encounter and member data and reported to the specialty providers on a quarterly basis.	
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	CCOMetricsManager User Guide Provider Portal User Guide IT13 - Health Information Technology Roadmap Network Risk Pool Multiple Gap List Continuity of Care	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
arrangements for the population(s) addressed in the arrangement(s). *Contract: Exhibit J (2)(k)(8)*		

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 Table B-2 contain the quality metric results for the individual practitioner and facility and service provider capacity reports, respectively. Overall, no major issues were identified with UHA's DSN submission.

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

DSN Data Field	DSN Quality Metrics		
	% Present	% Valid Format	% Valid Values
Accepting New Medicaid Enrollees	100.0	100.0	
Address #1	100.0		
Provider's Capacity	99.6	100.0	
City	100.0		
Status of Medicaid Contract	100.0	100.0	
County	100.0		
Credentialing Date	75.6	100.0	100.0
DMAP (Medicaid ID)	99.1	100.0	
Provider First Name	100.0		

DSN Data Field	DSN Quality Metrics		
	% Present	% Valid Format	% Valid Values
Group/Clinic Name	100.0		
Non-English Language 1	7.8		
Non-English Language 2			
Non-English Language 3			
Provider Last Name	100.0		
Provider Network Status	100.0	100.0	
Provider NPI	100.0	99.8	99.7
Number of Members Assigned to PCPs	12.4	100.0	
PCP Indicator	100.0	99.9	
PCPCH Tier	18.9	100.0	
Phone Number	100.0		
Provider Category	100.0	100.0	100.0
Provider Service Category	100.0	100.0	100.0
Provider TIN	100.0	99.9	
Provider Taxonomy	100.0	99.7	99.7
Zip Code	100.0		

In general, key DSN data fields in the individual practitioner capacity report were populated with valid values. The overall average completeness was 87.5 percent across both required and conditional[B-1] fields and jumped to 100 percent when excluding conditional fields. Of note, only 7.8 percent of providers were associated with a non-English language.

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

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

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

DSN Data Field	DSN Quality Metrics		
	% Present	%Valid Format	% Valid Values
County	100.0		
DMAP (Medicaid ID)	96.8	100.0	
Facility NPI	96.9	99.0	99.0
Phone Number	100.0		
Provider Category	100.0	100.0	100.0
Provider Service Category	100.0	100.0	98.6
State			
Facility TIN	100.0	99.4	
Facility or Business Taxonomy	97.5	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 99.3 percent across all data fields.

Provider Network Capacity

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

Table B-3—UHA 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	161	21.3	161	100.0	0	0.0
Specialty Provider	325	43.0	325	100.0	0	0.0
Dental Service Provider	56	7.4	56	100.0	0	0.0
Mental Health Provider	155	20.5	143	92.3	12	7.7
SUD Provider	56	7.4	56	100.0	0	0.0
Certified or Qualified Health Care Interpreters	0	0.0	0	0.0	0	0.0

Provider Specialty Category	Total		Contract Status = Yes		Contract Status = PEND	
	Number	Percent	Number	Percent	Number	Percent
Traditional Health Workers	3	0.4	3	100.0	0	0.0
Alcohol/Drug	0	0.0	0	0.0	0	0.0
Health Education, Health Promotion, Health Literacy	0	0.0	0	0.0	0	0.0
Palliative Care	0	0.0	0	0.0	0	0.0
Facility/Service Practitioners						
Hospital, Acute Psychiatric Care	1	0.2	1	100.0	0	0.0
Ambulance and Emergency Medical Transportation	4	0.6	4	100.0	0	0.0
Federally Qualified Health Centers	5	0.8	5	100.0	0	0.0
Home Health	1	0.2	1	100.0	0	0.0
Hospice	0	0.0	0	0.0	0	0.0
Hospital	5	0.8	5	100.0	0	0.0
Imaging	0	0.0	0	0.0	0	0.0
Indian Health Service and Tribal Health Services	2	0.3	2	100.0	0	0.0
Mental Health Crisis Services	3	0.5	3	100.0	0	0.0
Community Prevention Services	4	0.6	4	100.0	0	0.0
Non-Emergent Medical Transportation	5	0.8	5	100.0	0	0.0
Pharmacies	586	92.9	586	100.0	0	0.0
Durable Medical Providers	6	1.0	6	100.0	0	0.0
Post-Hospital Skilled Nursing Facility	2	0.3	2	100.0	0	0.0
Rural Health Centers	3	0.5	3	100.0	0	0.0
School-Based Health Centers	1	0.2	1	100.0	0	0.0
Urgent Care Center	3	0.5	3	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, UHA'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; alcohol/drug; health education, health promotion, health literacy; or palliative care providers. Additionally, of the 17 required facilities and services, only one provider service categories had a count of zero—i.e., hospice.

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—UHA 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	161	140	87.0	19	11.8
Specialty Provider	325	320	98.5	32	9.8
Dental Service Provider	56	56	100.0	4	7.1
Mental Health Provider	155	155	100.0	1	0.6
SUD Provider	56	56	100.0	1	1.8
Certified or Qualified Health Care Interpreters	0	0	0.0	0	0.0
Traditional Health Workers	3	3	100.0	0	0.0
Alcohol/Drug	0	0	0.0	0	0.0
Health Education, Health Promotion, Health Literacy	0	0	0.0	0	0.0
Palliative Care	0	0	0.0	0	0.0
TOTAL	**756**	**730**	**96.6**	**57**	**7.5**

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

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

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

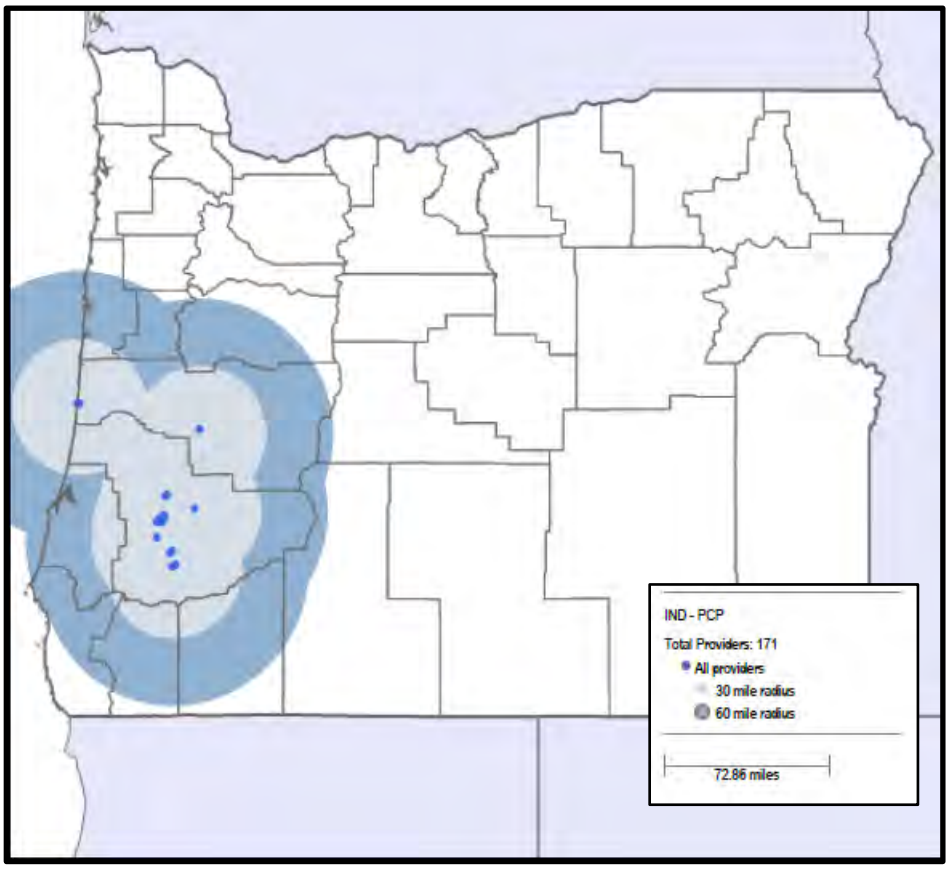
Overall, 96.6 percent of the UHA's provider network was accepting new patients with 96.5 percent of UHA's core providers (i.e., physical, oral, and mental health) indicating they were accepting new patients. Of its individual practitioners, only 7.5 percent noted speaking a language other than English

with primary care providers, specialty providers, and dental service providers reporting 11.8 percent, 9.8 percent, and 7.1 percent of the physicians, respectively, speaking a non-English language.

Geographic Distribution

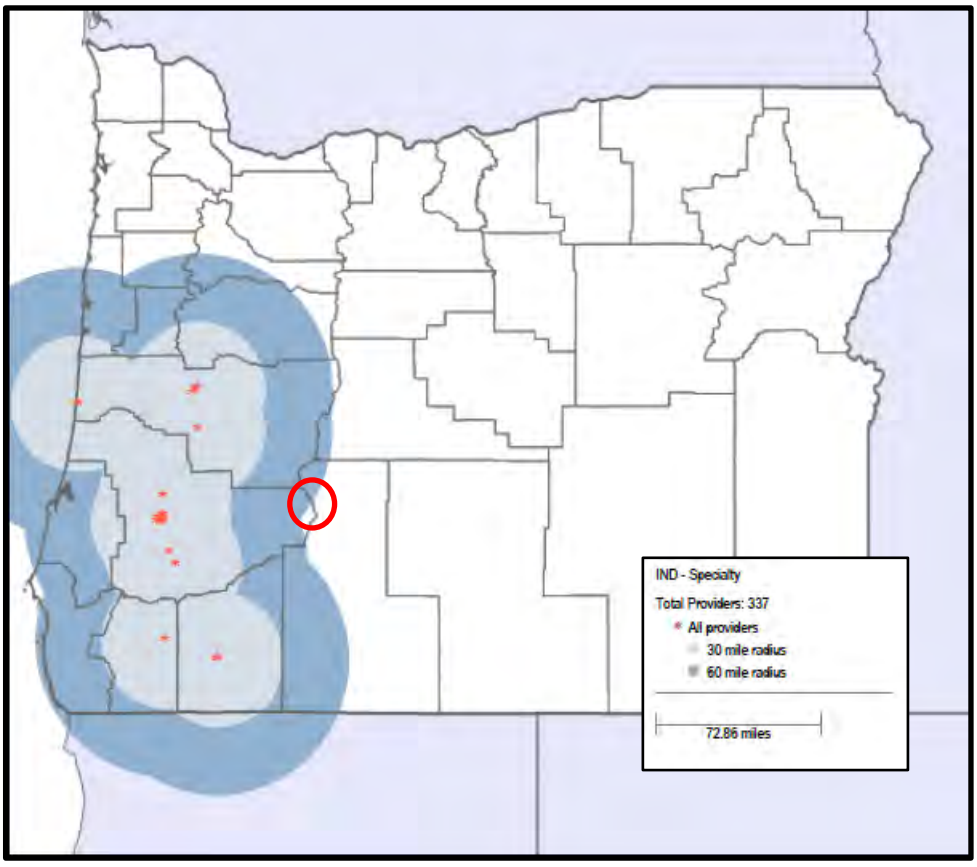
The geographic distribution of providers relative to member populations assessed whether or not the practitioner and facility locations were spread proportionately across the beneficiary population. Since beneficiary data was not available at the time of this analysis, the geospatial maps display the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

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



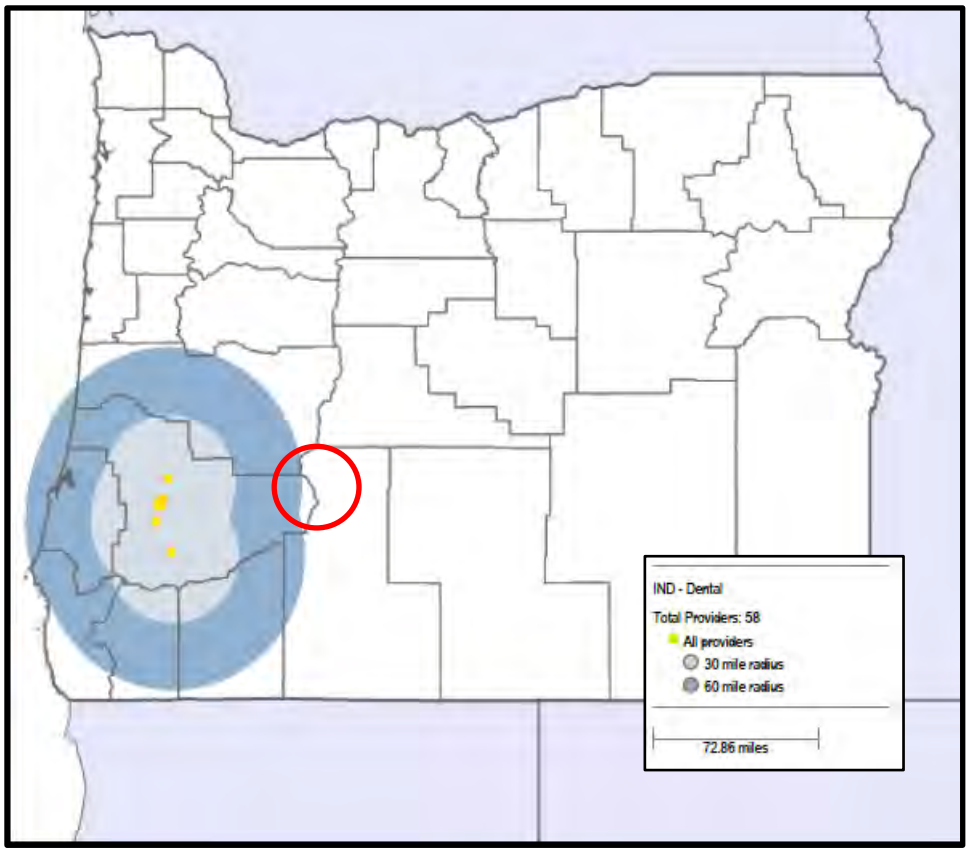
As shown in Figure B-1, the distribution of UHA's PCP providers is sufficient to cover the CCO's service area. All regions of the service area are within 60 miles of a primary care provider.

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



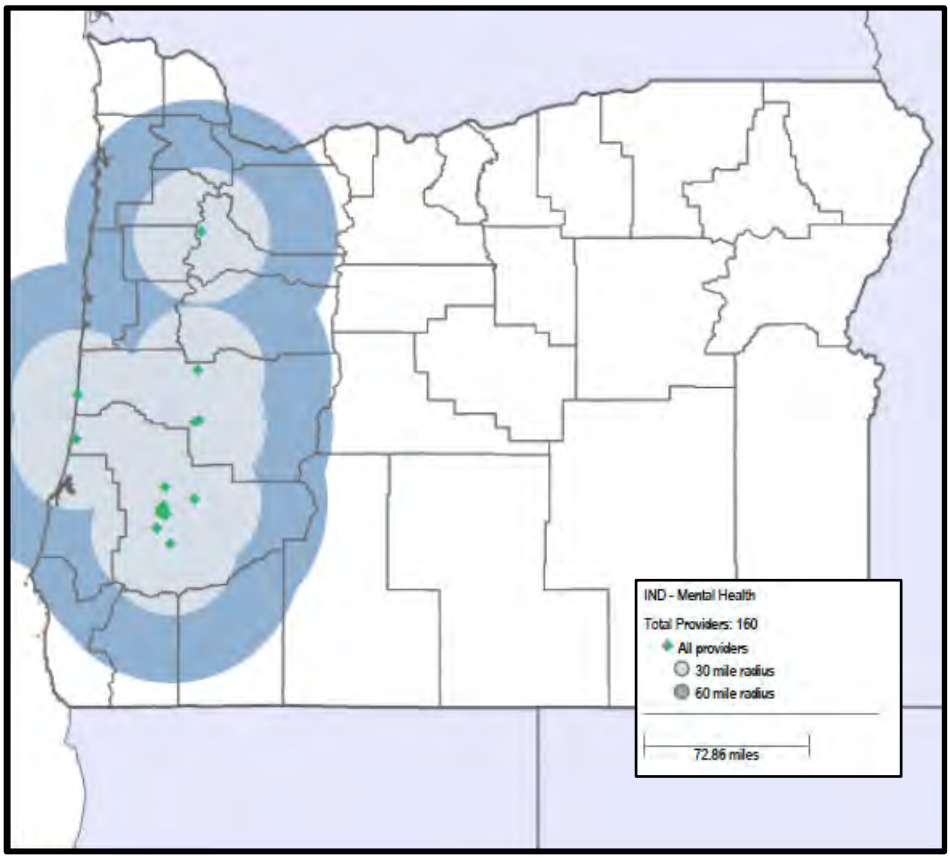
As shown in Figure B-2, the distribution of UHA's specialty providers is sufficient to cover the majority of the CCO's service area, with nearly all of the service area being within 60 miles of a specialty provider. Only a small region on the eastern edge of Douglas County lies beyond 60 miles of the nearest specialty provider.

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



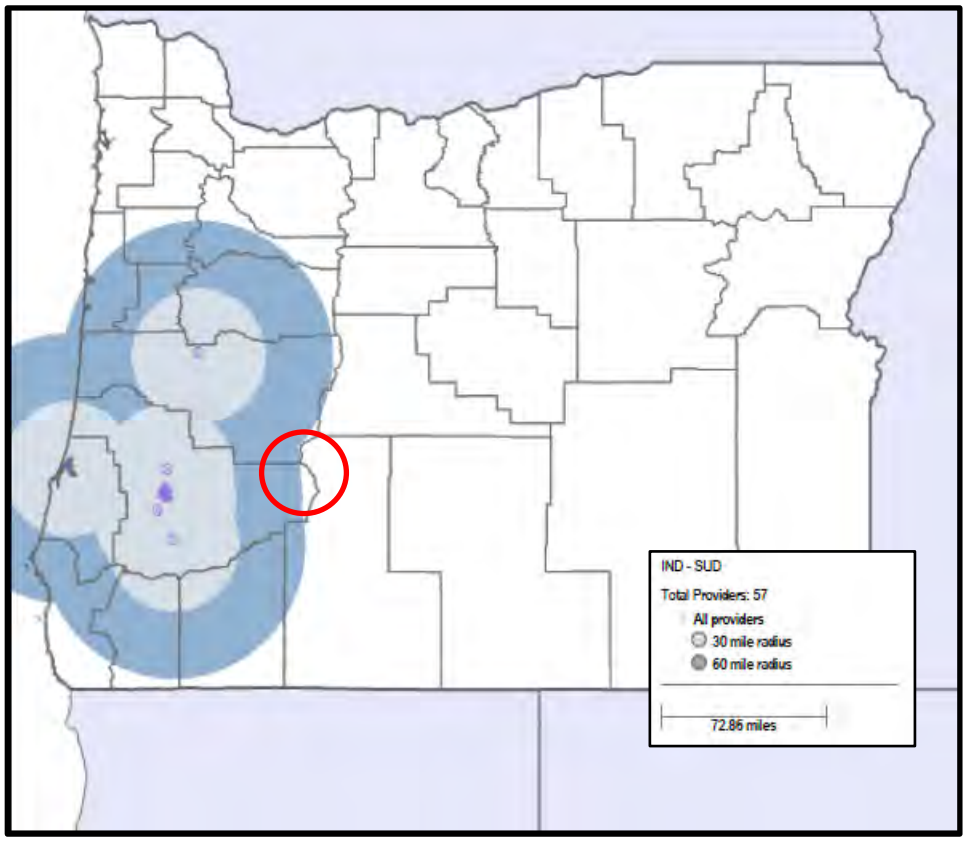
As shown in Figure B-3, the distribution of UHA's dental providers is sufficient to cover the majority of the CCO's service area, with nearly all of the service area being within 60 miles of a dental provider. Only a small region on the eastern edge of Douglas County lies beyond 60 miles of the nearest dental provider.

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



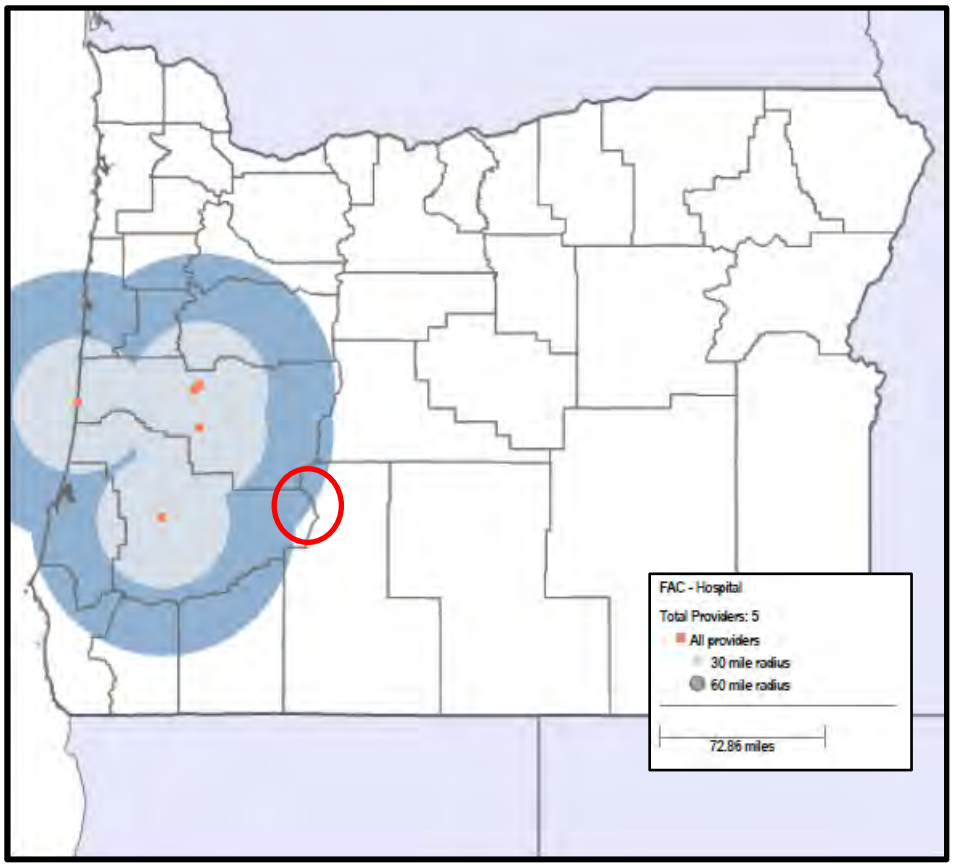
As shown in Figure B-4, the distribution of UHA's mental health providers is sufficient to cover the CCO's service area. All regions of the service area are within 60 miles of a mental health provider.

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



As shown in Figure B-5, the distribution of UHA's SUD providers is sufficient to cover the majority of the CCO's service area, with nearly all of the service area being within 60 miles of a SUD provider. Only a small region on the eastern edge of Douglas County lies beyond 60 miles of the nearest SUD provider.

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



As shown in Figure B-6, the distribution of UHA's hospital facilities is sufficient to cover the majority of the CCO's service area, with nearly all of the service area being within 60 miles of a hospital. Only a small region on the eastern edge of Douglas County lies beyond 60 miles of the nearest hospital.

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

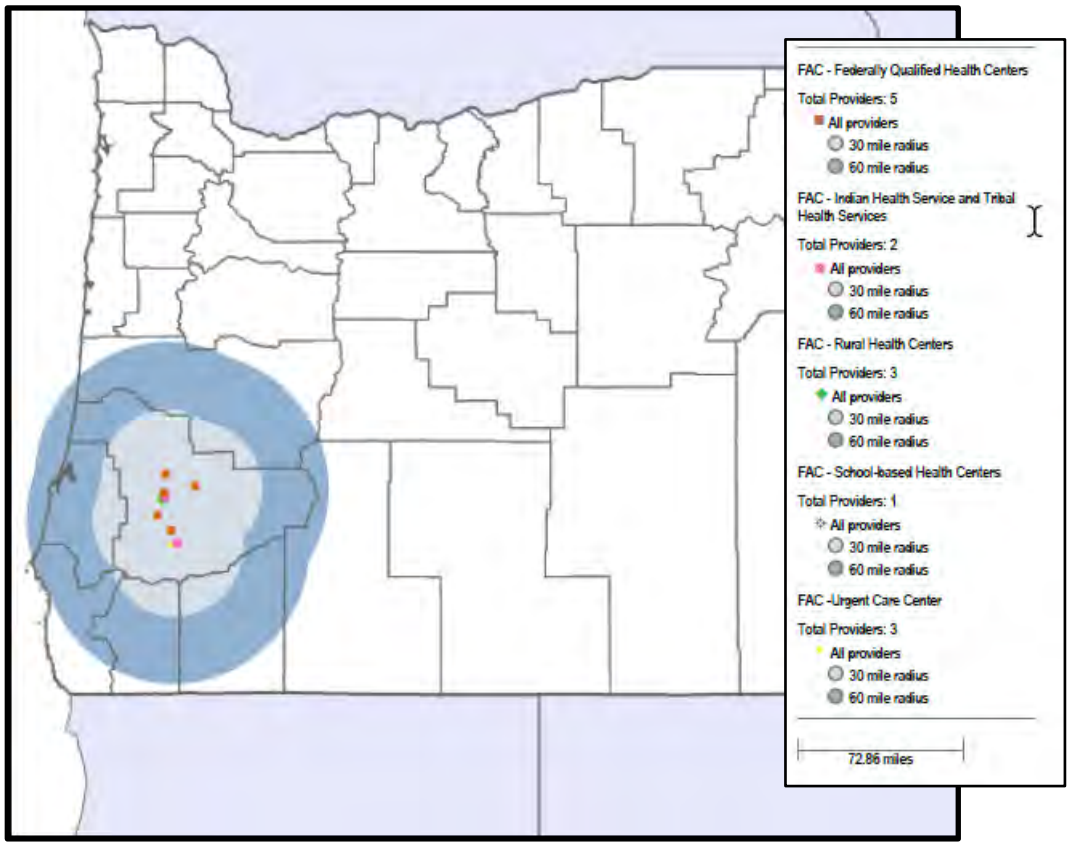


Figure B-7 displays the distribution of several clinic-based facilities within UHA's service areas, including FQHCs, Indian Health Services and Tribal Health Services, Rural Health Centers, School-Based Health Centers, and Urgent Care Centers. The map shows that the distribution of clinic-based facilities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

Appendix C. Phase 2 Evaluation Tool

[Pending completion of the Phase 2 RR]