Oregon Health Authority

2019 CCO Readiness Review

for

Yamhill Community Care Organization

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 clinical guidelines

Results

This report documents results of the Phase 1—Critical Areas Readiness Review and (pending completion of Phase 2 of the RR) Phase 2—Operations Policy Readiness Review for Yamhill Community Care Organization (YCCO), 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.

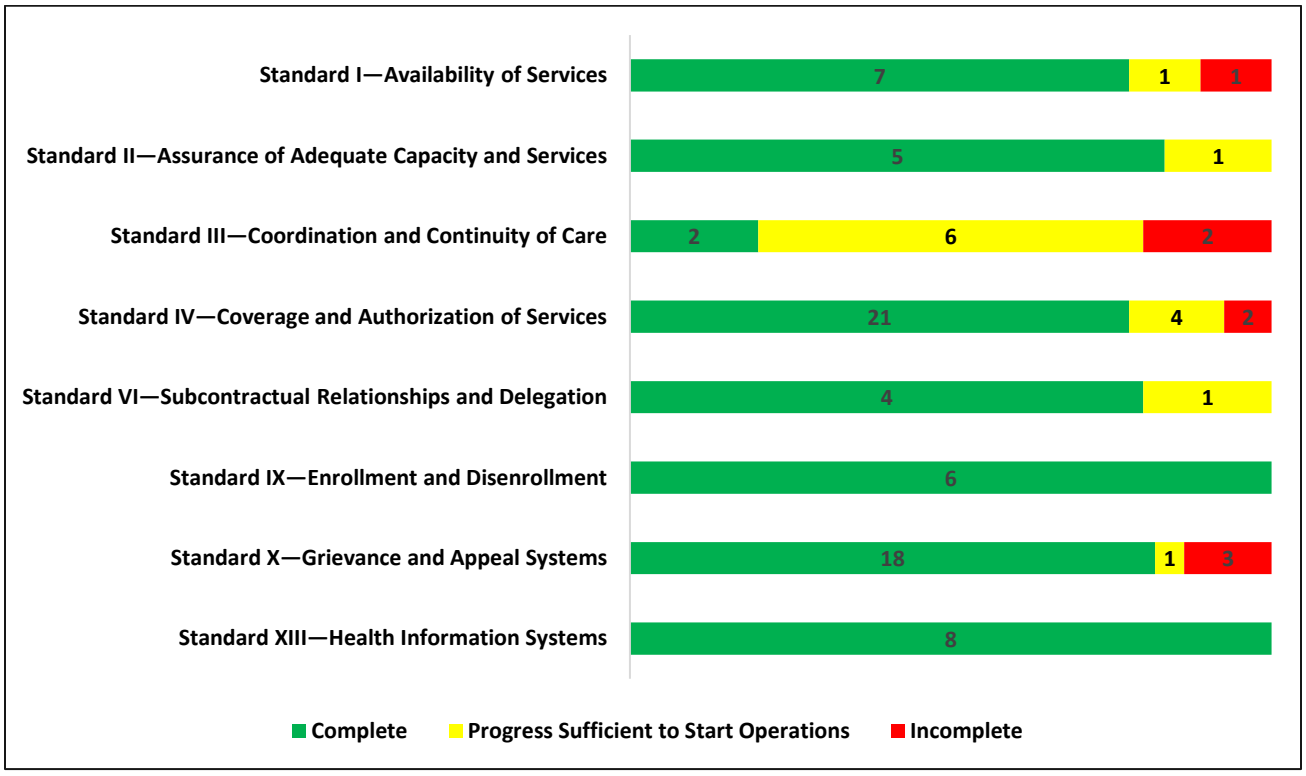
2. Phase 1 Results

Across all eight standards, YCCO's overall percentage of complete elements is 75.3 percent. The CCO demonstrated:

- *Complete* ratings for 71 of the 93 total elements.
- *Progress Sufficient to Start Operations* ratings for 14 elements across six standards.
- *Incomplete* ratings for eight elements across four standards, indicating areas of greater deficiency. These areas *require action* to ensure readiness prior to providing services.

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

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



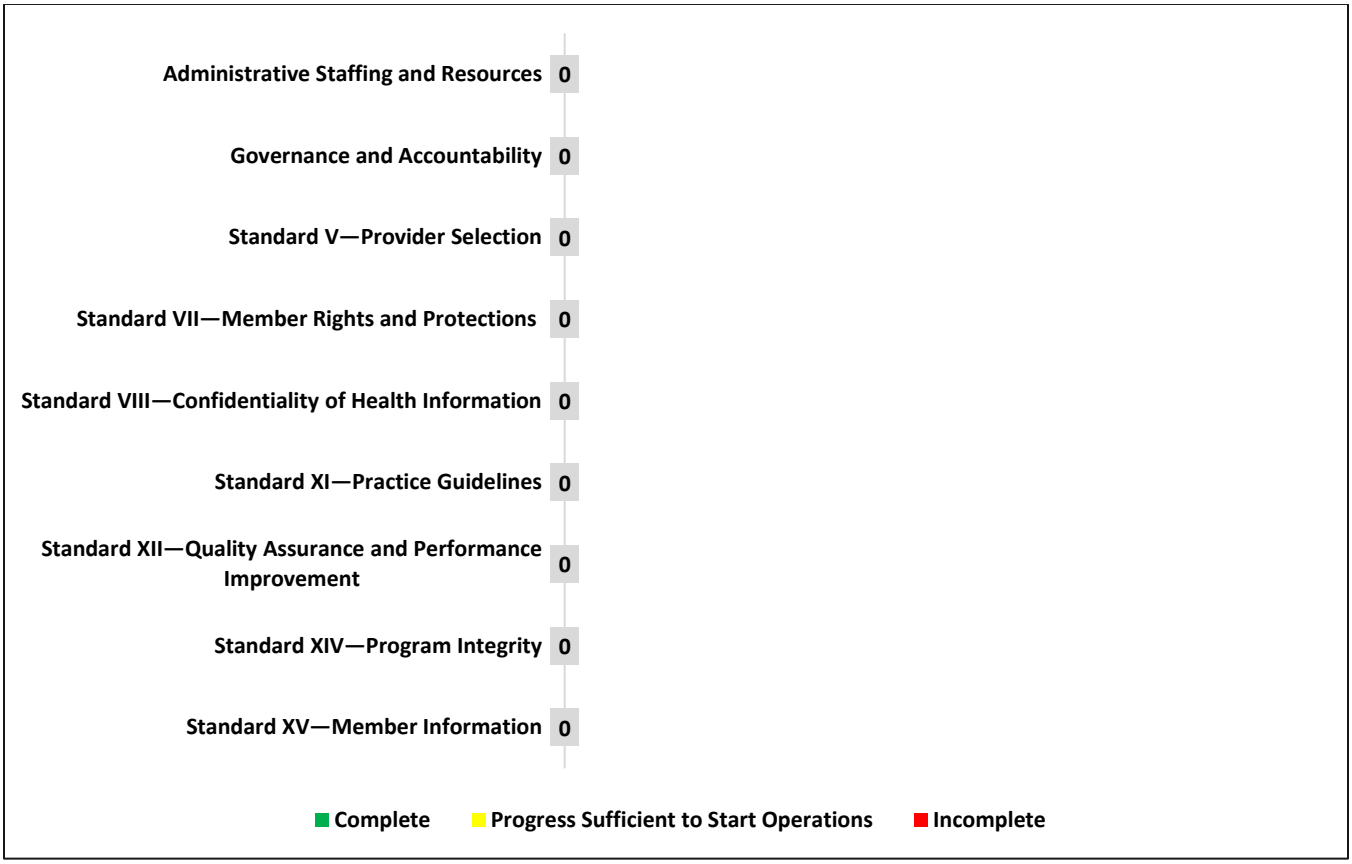
3. Phase 2 Results

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

Across all eight standards, YCCO'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—YCCO 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 YCCO'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)*	• SVC-004 Network Capacity, Service Adequacy and Availability, pg. 2, 3, 5 • Member Handbook with Insert 010719, pg. 25 • Providence Individual Practitioner Contract Template with OHP Compliance Provisions • Website screenshot- Provider Directory • 2018 YCCO EQR Report_Final_08282018, pg.21	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
2. The CCO maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract (inclusive of non-emergent medical transportation, alternative therapies [e.g., acupuncture, chiropractic medicine, massage, yoga], and access to traditional health care workers) for all members, including those with limited English proficiency, physical or mental disabilities, or special health care needs. *42 CFR §438.206(b)(1)* *Contract: Exhibit B Part 4 (3)(a)(1)*	• SVC-004 Network Capacity, Service Adequacy and Availability, pg. 2, 3 • 2019 DSN Provider Capacity and Narrative Report FINAL, Tab 1 DSN Capacity Report • Member Handbook with Insert 010719, pg. 25 • Website screenshot- Provider Directory • 2018 YCCO EQR Report_Final_08282018, pg.21	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
3. The CCO provides female members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the female member's designated source of primary care if that source is not a woman's health specialist. *42 CFR §438.206(b)(2)* *Contract: Exhibit B Part 4 (2)(m)*	• SVC-004 Network Capacity, Service Adequacy and Availability, pg. 5 • Member Handbook with Insert 010719, pg. 27	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
4. The CCO has a mechanism to allow members to obtain a second opinion from a network provider or arrange for the member to obtain one outside the network, at no cost to the member. *42 CFR §438.206(b)(3)* *Contract: Exhibit B Part 4 (2)(n)*	• MM-001 Second Opinion, pg. 2 • Member Handbook with Insert 010719, pg.23	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
5. If the CCO is unable to provide medically necessary covered services to a particular member using contract providers, the CCO shall adequately and timely cover these services for that member using non-contract providers for as long as the CCO's provider network is unable to provide them. a. The CCO shall coordinate payment with out-of-network providers and ensure that the cost to the member is no greater than it would be if services were provided within the network. *42 CFR §438.206(b)(4-5)* *Contract: Exhibit B Part 4 (4)(g)*	• SVC-004 Network Capacity, Service Adequacy and Availability, pg. 5, 6 • Member Handbook with Insert 010719, pg.22	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
6. The CCO demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services: a. In accordance with 42 CFR §431.51(b)(2), members shall not be restricted in freedom of choice of providers of family planning services. b. Therefore, members are permitted to self-refer to any provider for the provision of family planning services, including those not in the CCO's network. *42 CFR §431.51(b)(2)* *42 CFR §438.206(b)(7)* *Contract: Exhibit B Part 2 (6)(b)*	• SVC-004 Network Capacity, Service Adequacy and Availability, pg. 5 • Website screenshot- Provider Directory • Member Handbook with Insert 010719, pg.28	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
7. The CCO ensures its provider network observe the timely access to services provisions and complies with the following requirements: a. Meet and require its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services. b. Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid Fee for Service (FFS), if the provider serves only Medicaid enrollees. c. Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary. d. Establish mechanisms to ensure compliance by network providers. e. Monitor network providers regularly to determine compliance. f. Take corrective action if there is a failure to comply by a network provider. *42 CFR §438.206(c)(1)* *Contract: Exhibit B Part 4 (2)(a)* *Contract: Exhibit B Part 4 (13)(b)(3), (4)*		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		
8. The CCO demonstrates that its network includes sufficient specialty behavioral health providers to ensure timely access to covered specialty behavioral health services for the following priority populations in accordance with the timeframes below,	• SVC-004 Network Capacity, Service Adequacy and Availability, pg. 4, 5	☒ Complete ☐ Progress Sufficient to Start Operations

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
with access prioritized in accordance with OAR 309-019-0135 and 410-141-3220. a. If a timeframe cannot be met due to lack of capacity, the member must be placed on a waitlist and provided interim services within 72 hours of being put on a waitlist. Interim services should be as close as possible to the appropriate level of care and may include referrals, methadone maintenance, compliance reviews, HIV/AIDS testing, outpatient services for substance use disorder, risk reduction, residential services for substance use disorder, withdrawal management, and assessments or other services described in OAR 309-019-0135. b. Pregnant women, veterans and their families, women with children, unpaid caregivers, families, and children ages birth through five years, individuals with HIV/AIDS or tuberculosis, individuals at the risk of first episode psychosis and the I/DD population: Immediate assessment and intake. If interim services are necessary due to capacity restrictions, treatment at appropriate level of care must commence within 120 days from placement on a waitlist. c. IV drug users: Immediate assessment and intake. Admission required within 14 days of request, or, if interim series are necessary due to capacity restrictions, admission must commence within 120 days from placement on a waitlist. d. Opioid use disorder: Assessment and intake within 72 hours. e. Medication assisted treatment: No more than 72 hours for assessment and induction, with efforts to do such as soon as possible.	YCCO delegates the delivery of Behavioral Health Services and ensures sufficient network through oversight and monitoring. • YCCO Delegation Matrix • P&P Audit Master • Timely Access to Services_016-102-03-03 • Availability of YCCO Behavioral Health Services_016-102-03-09 • YCCO Behavioral Health Urgent and Emergent Care_016-102-03-11 • Client Assignment and Termination_016-102-03-06	☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
f. Children with serious emotional disturbance: Any limits that the Authority may specify in the contract or in guidance. g. Routine behavioral health care for other populations: Seen for an intake assessment within seven days from date of request, with second appointment within 14 days and 4 appointments (including the second appointment) within 48 days. Appointments must be therapeutic in nature and expand beyond administrative activities. *Contract: Exhibit B Part 4 (2)* *Contract: Exhibit M*		
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. f. *Routine oral care:* Within eight (8) to twelve (12) weeks, or the community standard, whichever is less.	• SVC-004 Network Capacity, Service Adequacy and Availability, pg. 3, 4 • 2018 Availability of Services Grievance System Audit – Hours of Operations Audit Findings Sheet	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*		
HSAG Findings: The CCO's Network Capacity, Service Adequacy and Availability policy defined appointment availability standards for required visit types. However, neither the documentation nor CCO staff member responses clearly defined the CCO's mechanisms for ensuring its providers were made aware of the availability standards or how the CCO monitored the timeliness of member appointments.		
Required Actions: The CCO should update its policies and procedures to define the mechanisms used to (1) inform providers of the appointment availability standards, and (2) monitor and assess provider adherence to appointment availability standards.		
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)*	In alignment with the States efforts to delivery culturally responsive services, YCCO offers training to both providers and staff on equity, cultural agility. • EquityTraining_SignIn_2016_12_6 • Yamhill_12.06.2016_Outline_revised • Equity Stakeholder Meeting Presentation_4.22.2016A • Staff meeting equity presentation • WVMC cultural comp Flyer - final • physician slides • Yamhill Community Care Bridge 13 Training Agenda 07.28.16 • PMc_transequity YCCO also maintains policies maintaining commitment to these requirements.	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• SVC-004 Network Capacity, Service Adequacy and Availability, pg. 2 • COM-002 Communication Services, pg. 2	
HSAG Findings: While the CCO provided documentation of its efforts to promote cultural competency through training for its staff members and contracted providers, general delegate contract templates with providers did not specify provisions regarding culturally competent care and nondiscrimination.		
Required Actions: HSAG recommends that the CCO ensure its contracts with delegates and contracted providers include expectations and requirements regarding the provision of culturally competent care and nondiscrimination.		
11. The CCO ensures that network providers provide physical access, reasonable accommodations, and accessible equipment for members with physical and mental disabilities. *42 CFR §438.206(c)(3)* *Contract: Exhibit B Part 4 (3)(a)(2)(e)*		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		

Standard I- Availability of Services	
	Total #
Complete	**7**
Progress Sufficient	**1**
Incomplete	**1**
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*	YCCO 2019 submission of Delivery System Network Adequacy report and supporting documentation. • 2019 DSN Provider Capacity and Narrative Report FINAL • DSN Narrative #2 - Geo Location Analysis • SVC-004 Network Capacity, Service Adequacy and Availability pg. 2 Evaluation of 2018 DSN submission for meeting stated requirements. 2018_Yamhill_DSN Report_DRAFT	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: The CCO's Network Capacity, Service Adequacy and Availability policy defined the requirement to report network capacity information to the State and maintain a sufficient network. However, YCCO's policy did not describe the processes or mechanisms for collecting, reporting, and monitoring network capacity data, including the integration of network data from its delegates. During the remote interviews, CCO staff described the use of operational meetings and its Quality Clinical Advisory Panel to work collaboratively with its delegates to maintain a sufficient network.		
Required Actions: HSAG recommends that the CCO update its policies and procedures to include the process(es) used to collect network data and report on the CCO's compliance with network requirements. Documentation should include how data is integrated from its delegates and reported to OHA, the mechanisms used to monitor the CCO's provider network, and the staff members or committees responsible for overseeing network management.		
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:	YCCO submits documentation demonstrating compliance with the following reporting requirements a. YCCO will submit documentation of and adequate network capacity at the time of contracting b. Evidence of annual submission. • 2018_Yamhill_DSN Report_DRAFT • 2019 DSN Provider Capacity and Narrative Report FINAL	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
i. Changes in the CCO's services, benefits, geographic service area, composition of or payments to its provider network; or ii. Enrollment of a new population. *42 CFR §438.207(c)(1-3)* *Contract: Exhibit G*	• DSN Narrative #2 - Geo Location Analysis • SVC-004 Network Capacity, Service Adequacy and Availability pg. 6 c. 2019 Transition of physical health, CareOregon to PH Tech/Providence Plan Partners • DSN Letter 121318 • Yamhill Community Care Transition DSN 2018 transition from three dental care organizations to one, Capitol Dental Care • YCCO update to DSN • OHA notice letter 2017-10-03 • Capitol Dental Care Network Plan • 2018 projected CDC-YCCO_DSN+capacity_20171227	
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)*	Through oversight and monitoring, YCCO ensures the following access time/distance standards are met. OHA's evaluation of YCCO 2018 Delivery System Network report states YCCO Fully Met time and distance standards for member access to health care providers. • 2018_Yamhill_DSN Report_DRAFT, 30 • 2019 DSN Provider Capacity and Narrative Report FINAL, DSN Narrative Report tab, rows 2-16 • DSN Narrative #2 - Geo Location Analysis, pg. 5-6	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• SVC-004 Network Capacity, Service Adequacy and Availability pg. 3 • 2019 Audit Schedule Final, Q3 • P&P Audit Master	
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)*	Through oversight and monitoring, YCCO ensures the following access time/distance standards are met. OHA's evaluation of YCCO 2018 Delivery System Network report states YCCO Fully Met time and distance standards for member access to health care providers. • 2018_Yamhill_DSN Report_DRAFT, 30 • 2019 DSN- Provider Capacity and Narrative Report FINAL - Access Standards • SVC-004 Network Capacity, Service Adequacy and Availability, pg. 3 • 2019 Audit Schedule Final, Q3 • P&P Audit Master	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
5. Hospital and Emergency Services Access Standards—Hospitals—Time and Distance: a. In urban areas - Thirty (30) minutes or thirty (30) miles from the personal residences of members. b. In rural areas – Sixty (60 minutes) or sixty (60) miles from the personal residence of members. *42 CFR §438.68* *42 CFR §438.206(c)(1)(i)* *Contract: Exhibit B (2)(a)*	Through oversight and monitoring, YCCO ensures the following access time/distance standards are met. OHA's evaluation of YCCO 2018 Delivery System Network report states YCCO Fully Met time and distance standards for member access to health care providers. • 2018_Yamhill_DSN Report_DRAFT, 30 • 2019 DSN- Provider Capacity and Narrative Report FINAL - Access Standards	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• SVC-004 Network Capacity, Service Adequacy and Availability, pg. 3 • 2019 Audit Schedule Final, Q3 • P&P Audit Master	
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)*	Through oversight and monitoring, YCCO ensures the following access time/distance standards are met. OHA's evaluation of YCCO 2018 Delivery System Network report states YCCO Fully Met time and distance standards for member access to health care providers. • 2018_Yamhill_DSN Report_DRAFT, 30 • 2019 DSN- Provider Capacity and Narrative Report FINAL - Access Standards • SVC-004 Network Capacity, Service Adequacy and Availability, pg. 3 • 2019 Audit Schedule Final, Q3 • P&P Audit Master	☒ 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)*	YCCO ensures each member has access to care appropriate to their needs. • CM-002 Care Coordination, Pg. 2 • YCCO TOC Welcome Enrolled Letter • Member Handbook, Pg. 1, 2	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: YCCO's Care Coordination policy stated that members are provided information on how to contact their PCP, which is located on their identification (ID) card and welcome letter, and customer service can also provide contact information. The policy contained general statements related to member transitions; however, the CCO could not articulate a standardized approach nor was any documentation provided to explain the processes used by the CCO or the CCO's expectations of its delegates related to transition planning and follow-up. During the remote interview session, YCCO's delegate, Providence Plan Partners, was able to explain discharge planning processes it implements when a member is being transitioned out of a hospital setting.		
Required Actions: HSAG recommends that the CCO revise the Care Coordination policy or create a new policy, procedure, or process to explain the CCO's approach to transition planning and the CCO's expectations of its delegates in the transition planning process.		
2. The CCO coordinates the services it furnishes to the member: a. Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays; b. With the services the member receives from any other MCO, PIHP, or PAHP; c. With the services the member receives in FFS Medicaid; and	YCCO ensures coordination of member services • CM-002 Care Coordination, Pg. 2, 3	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*		
HSAG Findings: YCCO's Care Coordination policy stated that it will coordinate services it furnishes to members between settings of care with other health plans, fee-for-service (FFS) Medicaid, and community and social support providers. While YCCO delegates care coordination functions, the policy lacked specificity related to the CCO's expectations of its delegates. During the remote interview session, YCCO's delegate, Providence Plan Partners, was able to provide examples of care coordination activities it implements, such as multidisciplinary team meetings and transition of care subcommittee meetings.		
Required Actions: HSAG recommends that the CCO revise the Care Coordination policy or create a new policy, procedure, or process to explain the CCO's approach to the coordination of services provided to members and the expectations for its delegates regarding the care coordination process.		
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)*	YCCO conducts initial screening of member needs within 30 days of enrollment • CM-002 Care Coordination, Pg. 3 • YCCO HRA Questionnaire • YCCO HRA Postcard • YCCO HRA UTC	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: YCCO's Care Coordination policy stated that a health risk screening and assessment of each member's needs will be completed based on the time frames set by OHA. No other documentation was provided explaining the process for conducting the survey, how the survey is conducted (telephonically, on paper), how many outreach attempts are made and how attempts are documented, or how tracking and monitoring is done to ensure best efforts are made to assess each member. During the remote interview session, YCCO's delegate, Providence Plan Partners, stated that it mails a Health Risk Assessment Questionnaire to members upon enrollment. If the survey is not returned within two weeks, a postcard reminder is sent to the member; no other outreach attempts are made to get the survey completed.		
Required Actions: HSAG recommends that the CCO revise the Care Coordination policy or create a new policy, procedure, or process to explain the CCO's approach to initial screening and the expectations for its delegates regarding the initial screening of all newly enrolled members. In addition, HSAG recommends that the CCO implement procedures to ensure subsequent outreach attempts are made to get the survey completed.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	• YCCO Readiness Provider Contract • Providence Group Facility Contract Template with OHP Compliance Provisions • Providence Individual Practitioner Contract Template with OHP Compliance Provisions	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: The provider and hospital agreements submitted by the CCO contained information about the role of patient-centered primary care and processes for requesting hospital admission or specialty services. However, while the agreements included some language about medical record sharing, there was no language that specifically identified the CCO's expectations for communication and medical record sharing at the time of hospital admission and discharge. During the remote interview session, YCCO staff members were unable to articulate any expectations for provider communication.		
Required Actions: HSAG recommends that the CCO update the hospital and specialty provider agreements to include its performance expectations for communication and record sharing at the time of hospital admission and at the time of discharge to facilitate follow-up appointments and care.		
5. The CCO has processes in place to ensure that: a. Hospitals and specialty service providers are accountable for achieving successful transitions of care. b. Primary care teams are responsible for transitioning members out of hospital settings into the most appropriate, independent, and integrated care settings, including home	• CM-002 Care Coordination, Pg. 2 • Providence Group Facility Contract Template with OHP Compliance Provisions • Providence Individual Practitioner Contract Template with OHP Compliance Provisions	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
and community-based as well as hospice and other palliative care settings. *Contract: Exhibit B Part 4 (9)*		
HSAG Findings: YCCO's Care Coordination policy stated that delegates and providers are responsible for coordinating care for members transitioning between levels of care. However, the facility and individual practitioner contract templates did not include any language about transitions of care. During the remote interview session, YCCO staff members were unable to articulate any processes in place to ensure successful transitions of care.		
Required Actions: The CCO should develop and implement processes that ensure hospital and specialty service providers are accountable for achieving successful transitions of care and ensuring that primary care teams are responsible for transitioning members into the most appropriate settings.		
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)*	• CM-002 Care Coordination, Pg. 2, 3 YCCO is exploring functionality for CIM the care documentation system to include HRA data with providers and make available for the State or CMS upon request	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
7. The CCO ensures that each provider furnishing services to members maintains and shares, as appropriate, a member health record in accordance with professional standards. *42 CFR §438.208(b)(5)* *Contract: Exhibit B Part 8 (1)(d-f)*		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
8. The CCO ensures that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable. *42 CFR §438.208(b)(6)* *Contract: Exhibit B Part 4 (1)(a)*	YCCO protects member information and ensures compliance with this requirement through audit and monitoring of delegated partners. • YCCO Delegation Matrix • 2019 Audit Schedule Final • P&P Audit Master • 2017 Delegation Oversight Review Tool • Q3 Audit- HIPAA • CM-002 Care Coordination, Pg. 2 • CMPL-009 PHI Release TPO Policy, Pg. 2	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
9. The CCO implements mechanisms to comprehensively assess each member identified as needing LTSS or having special health care needs to identify any ongoing special conditions of 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)*	YCCO provides for an assessment of all members identified as LTSS or having special health care needs • CM-001 Special and Exceptional Health Care Needs, pg.# 2 • YCCO HRA Questionnaire	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: The Special & Exceptional Health Care Needs policy stated that YCCO and its delegates, with the use of appropriate healthcare professionals, will comprehensively assess each member identified as needing long-term services and supports (LTSS) or having special healthcare needs in order to identify any ongoing special conditions of the member that require a course of treatment or regular care monitoring. No other documentation was provided to explain how the CCO conducts the comprehensive assessment, timelines for completion, or tracking mechanisms to ensure timeliness. During the remote interview session, YCCO's delegate, Providence Plan Partners, stated that the assessment is conducted telephonically and that it attempts to complete the assessment within two weeks of member referral to care coordination. Providence Plan Partners demonstrated the CareAdvance care management system used to conduct the comprehensive assessment.		
Required Actions: HSAG recommends that the CCO revise its policies and procedures to include more specificity as to the process, timelines, and monitoring practices in place to ensure the completion of the comprehensive assessment.		

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)*	YCCO maintains policies and procedures for the identifying, assessing and producing a treatment plan for members with special healthcare needs. YCCO delegates this process and through oversight ensures requirements are met • CM-001 Special and Exceptional Health Care Needs, Pg. 2, 3 • YCCO Delegation Matrix • 2019 Audit Schedule Final • P&P Audit Master • YCCO Delegation Matrix • ENCC 120 Exceptional Needs Care Coordination Provider Specialty, Pg. 2 • Special Needs Referral Policy 2017.02, Pg. 1	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA
HSAG Findings: The policies submitted by YCCO were general and lacked specificity as to how care coordination activities are conducted or defined the CCO's expectations for its delegates. For example, policies did not explain who is responsible for each activity; how each activity is conducted; timeliness for completion of activities; and how activities and timelines are monitored for completeness, accuracy, and timeliness. While the CCO has decided to delegate this process, YCCO is still required to have its own written policies and procedures that adequately explain the CCO's processes for identifying, assessing, and producing a treatment plan for each member identified as having a special healthcare need. It is unclear how YCCO would conduct oversight and monitoring of its delegates when processes and performance expectations have not been clearly defined by the CCO. Providence Plan Partners demonstrated the CareAdvance care management system it uses to conduct the initial screening, comprehensive assessment, and treatment planning.		
Required Actions: The CCO should revise its policies and procedures to include specific processes and timelines for identifying, assessing, and producing a treatment plan for each member identified as having a special healthcare need.		

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

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	• CM-001 Special and Exceptional Health Care Needs, Pg. 2	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: YCCO's Special and Exceptional Care Needs policy stated that the CCO will have mechanisms to allow direct access to specialists. The CCO also submitted a Providence Health Plan Exceptional Needs Care Coordination Provider Specialty Access policy, which stated that members with special healthcare needs can directly access specialty care through a standing referral by having a qualifying condition or presenting Providence Health Plan with verification of a qualifying condition. When asked to explain what that process involved, the delegate was unable to articulate the process described in the policy. In addition, during the remote interview session, YCCO staff members stated that any member can see a specialist without a referral or authorization for the first visit; however, YCCO's Care Coordination policy only stated that members do not need a referral for mental health or substance use disorder treatment.		
Required Actions: HSAG recommends that the CCO revise policies and procedures to include more specificity related to direct access, expectations of its delegates, and the processes used to ensure members with special healthcare needs are able to see specialists, as appropriate for their condition and needs, with limited barriers.		

Standard III—Coordination and Continuity of Care	
	Total #
Complete	**2**
Progress Sufficient	**6**
Incomplete	**2**
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)*	YCCO delegates the process of coverage of services and through oversight and monitoring ensures compliance with these requirements. • SVC-004 Network Capacity, Service Adequacy and Availability, pg. 5 • SVC-002 Authorization of Services, pg. 2 • Handbook with Insert 010719, pg. 25 • YCCO Delegation Matrix • 2019 Audit Schedule Final • P_P Audit Master	☒ 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	YCCO service limitations are based on alignment with the State prioritized list and coverage guidelines. • SVC-002 Authorization of Services, pg. 2, 3 • YCCO-PA-Procedures-List-Effective-06182019 • YCCO Benefit Build_Benefit Details • DME and Supply List.FINAL.xlsm	☒ 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)*	YCCO has done a full parity assessment comparing services MH/SUD and M/S. One area of parity was identified in the and YCCO has worked to resolve. • DO-003 Mental Health Parity Policy, Pg. 1 • SVC-002 Authorization of Services, pg. 2 • YCCO BH Authorizations_016-102-10-05 • OOP Provider Expectations -Practitioner-Part Two • Yamhill_UM NQTL v7-9-18 to CCO • Yamhill_OON_OOS NQTL_7-9-18 to CCO • Mental Health Parity Action Plan - Yamhill - v 3-31-2019	☒ 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)*	YCCO has done a full parity assessment comparing MH/SUD and M/S. No parity concerns were identified when comparing treatment limits and financial requirements. • DO-003 Mental Health Parity Policy, Pg. 1 • MH Parity Submission 2017 • Yamhill_NQTL Analysis_to OHA 11-28-18	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
5. The CCO must furnish medically necessary services as defined in the Contract and in a manner that: a. Is no more restrictive than that used in the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and b. Addresses: 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)*	YCCO has done a full parity assessment comparing MH/SUD and M/S. No parity concerns were identified when comparing non-quantitative treatment limits • SVC-004 Network Capacity, Service Adequacy and Availability, pg 5 • SVC-002 Authorization of Services, pg. 2, 3 • MH Parity Submission 2017 • Yamhill_NQTL Analysis_to OHA 11-28-18	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
6. The CCO establishes and adheres to written policies and procedures for both the initial and continuing service authorization requests consistent with utilization control requirements of 42 CFR Part 456. Policies and procedures must include: a. Mechanisms to ensure consistent application of review criteria for authorization decisions; b. Consultation with the requesting provider for medical services when appropriate. c. A process to ensure that any decision to deny a service authorization request or to authorize a service in an amount,	YCCO maintains policies and procedure related to authorization request consistent with 42 CFR Part 456. YCCO delegates authorization and utilization management and through oversight ensures requirements are met. • SVC-002 Authorization of Services, pg. 2 & 3 • DO-001 Delegation Oversight Policy • DO-002 Audit and Monitoring Policy • 2019 Audit Schedule • P&P Audit Master	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs. *42 CFR §438.210(b)(1-3)* *Contract: Exhibit B Part 2 (3)(a & f)* *Contract: Exhibit B Part 2 (2)(c)*	• YCCO Delegation Matrix a. Concurrent and retrospective review are utilization management functions YCCO delegates and monitors though oversight. • YCCO Behavioral Health Authorizations _016-102-10-05, pg. 1-3 • UM 20 Standards for Review for Medical Directors, pg. 2 • UM 30 Level of UM Decision Making, pg. 2, 3 b. • Authorization Audit 2018 c. YCCO contracts with AllMed for specialty match review for those service denials that are outside of the scope of the Medical Director. • AllMed Independent Medical Review Service Agreement	
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)*	YCCO policy and contract provisions do not provide incentives for providers or individuals to deny, limit or discontinue services. • SVC-002 Authorization of Services, pg. 2 • YCCO contract with AllMed, a specialty match service • AllMed Independent Medical Review Service Agreement	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
8. The CCO operates a drug utilization review program that complies with the requirements described in section 1927(g) of the Act and 42 CFR part 456, subpart K. *42 CFR §438.3(s)(4)* *Contract: Exhibit B Part 2 (4)(g)(2)*	YCCO delegates pharmacy benefit managements and ensures • ORPTCOPS056 QA – Drug Utilization Review Program	☒ 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)*	YCCO both notifies the provider and member in cases of a decision to deny a service • SVC-002 Authorization of Services, pg. 4 • NOABD Audit Tracking 2019 • YCCO Claim NOABD • YCCO OHP 2405 NOABD CS Contact Info • Handbook with Insert 010719	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
10. The written notice of adverse benefit determination must be consistent with the provisions under 42 CFR 438.10(c) and must include: a. The date of the notice; 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;	YCCO notice of adverse benefit determination is consistent with the following provisions. • YCCO Claim NOABD • YCCO OHP 2405 NOABD CS Contact Info • NOABD Audit Tracking 2019 • GA-003 Denials, Appeals, and Contested Case Hearings, pg.3, 4 • Communication_Mailings Inventory; YCCO Mailings Initial Transition, OHA Approval Number	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
f. Date of the service or date service was requested by the provider or member; g. Name of the provider who performed or requested the service; h. Effective date of the adverse benefit determination if different from the date of the notice; i. Whether the CCO considered other conditions if the service was below the funding line of the OHP Prioritized List of Health Services; j. The reasons for the adverse benefit determination, including reference to the specific statutes and administrative rules to the highest level of specificity for each reason and specific circumstances identified in the notice that include, but is not limited to: k. The right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. l. The member's right to request an appeal with the CCO within 60 days of the CCO's adverse benefit determination, including information on exhausting the CCO's one level of appeal described at §438.402(b) and the right to request a State fair hearing (contested case hearing) within 120 days after issuance of the CCO's Notice of Appeal Resolution or where the CCO failed to meet appeal timelines as outlin4ed		

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
in 410-141-3230; and the procedures for exercising these rights described in 410-141-3245. m. The circumstances under which an appeal process can be expedited and how to request it. n. The procedures for exercising the rights specified in this standard. o. The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the member may be required to pay the costs of these services. *42 CFR §438.404(b)* *Contract: Exhibit I (3)(b)*		
HSAG Findings: The CCO's Denials, Appeals and Contested State Hearings policy included the required elements for a Notice of Adverse Benefit Determination letter with one exception; the document did not specify the member's time frame to request an appeal or State fair hearing. However, the sample Notice of Action Benefit Denial Letter did include the time frame information.		
Required Actions: HSAG recommends that the CCO revise its Denials, Appeals and Contested State Hearings policy to include a statement that the Notice of Adverse Benefit Determination letter must include the member's time frame to request an appeal or State fair hearing.		
11. For standard authorization decisions, the CCO shall provide notice as expeditiously as the member's condition requires and within 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days: a. The member, or the provider, requests extension; or	YCCO follows the required timeline for providing notice of a standard authorization decision. • SVC-002 Authorization of Services, pg. 3 • Yamhill SLA Report 201906 • YCCO Quality Performance Metrics_07252019 • CDC Service Level Reporting	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
b. The CCO justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest. *42 CFR §438.210(d)(1)(i-ii)* *Contract: Exhibit B Part 2 (3)(h)*		
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)*	YCCO follows the required timeline for providing notice of an expedited authorization decision. • SVC-002 Authorization of Services, pg. 4 • Yamhill SLA Report 201906 • YCCO Quality Performance Metrics_07252019 • CDC Service Level Reporting	☒ 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)*	YCCO follows the required timeline for providing notice of the coverage of outpatient drug authorizations. • ORPTCOPS010 Notification of Standard Coverage Determinations • YCCO Quality Performance Metrics_07252019	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: The CCO submitted the Providence Health Plan Pharmacy Operational Policy for this requirement. It indicated at the top of the policy that it "Applies to commercial/health insurance and Marketplace/Medicaid." However, the policy did not include Medicaid-specific information regarding the required time frame for providing a response within 24 hours of a request for prior authorization. The YCCO Quality Performance Metrics document included a performance measure for pharmacy prior authorization processing standard requests.		
Required Actions: HSAG recommends that the CCO document in its policy that, for all covered outpatient drug authorization decisions, it provide a response by telephone or other telecommunication device within 24 hours of request.		
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.	• SVC-002 Authorization of Services, pg. 4 • YCCO CLAIM NOABD • YCCO OHP 2405 NOABD CS Contact Info • NOABD Audit Tracking 2019	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
– 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)*		
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)*	• SVC-002 Authorization of Services, pg.1 • MM-002 Emergency Urgent and Post-Stabilization Services, pg. 1	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: The policies submitted by the CCO for this element contained two different definitions for "emergency services."		
Required Actions: HSAG recommends that the CCO update the definition in its Emergency, Urgent and Post-Stabilization Services policy to match the definition in its Authorization of Services policy.		
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)*	• MM-002 Emergency Urgent and Post-Stabilization Services, pg. 1	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
17. The CCO: a. Covers and pays for emergency services regardless of whether the provider that furnishes the services has a contract with the CCO; and b. Does not deny payment for treatment obtained under either of the following circumstances: i. A member had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in paragraphs (a), (b), and (c) of the definition of emergency medical condition in paragraph (a) of this section. ii. A representative of the CCO instructs the member to seek emergency services. *42 CFR §438.114(c)(1)* *Contract: Exhibit B Part 2 (4)(a)(3,5&11)*	• MM-002 Emergency Urgent and Post-Stabilization Services, pg. 1 • Section III-A - Claims Adjudication Procedure • Section III-A - Claim Payment Accuracy Monitoring	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
18. The CCO does not: a. Limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms; and b. Refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider, MCO, PIHP, PAHP or applicable State entity of the Member's screening and treatment within 10 calendar days of presentation for emergency services. *42 CFR §438.114(d)(1)* *Contract: Exhibit B Part 2 (4)(a)(1&10)*	• MM-002 Emergency Urgent and Post-Stabilization Services, pgs. 2, 3	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
19. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42 CFR §422.114(d)(2)* *Contract: Exhibit B Part 2 (4)(a)(9)*	• MM-002 Emergency Urgent and Post-Stabilization Services, pg. 2	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
20. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in paragraph (b) of this section as responsible for coverage and payment. *42 CFR §422.114(d)(3)* *Contract: Exhibit B Part 2 (4)(a)(9)*	• MM-002 Emergency Urgent and Post-Stabilization Services, pgs. 2, 3	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
21. Poststabilization care services are covered and paid for in accordance with provisions set forth at 42 C.F.R. §422.113(c). a. The CCO is financially responsible (consistent with §422.214) for post-stabilization care services obtained 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;	• MM-002 Emergency Urgent and Post-Stabilization Services, pg. 2	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
c. The CCO is financially responsible for post-stabilization care services obtained within or outside the CCO's network that are not pre-approved by a plan provider or other organization representative, but administered to maintain, improve, or resolve the member's stabilized condition if: i. The CCO does not respond to a request for pre-approval within 1 hour; ii. The CCO cannot be contacted; or iii. The CCO's representative and the treating physician cannot reach an agreement concerning the member's care and a plan physician is not available for consultation. In this situation, the CCO must give the treating physician the opportunity to consult with a plan physician and the treating physician may continue with care of the patient until a plan physician is reached or one of the criteria in §422.113(c)(3) is met. d. Must limit charges to members for post-stabilization care services to an amount no greater than what the organization would charge the member if he or she had obtained the services through the CCO's network. For purposes of cost 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)*		
HSAG Findings: The CCO's Emergency, Urgent and Post-Stabilization Services policy did not include the detailed financial responsibility requirements as outlined in this element. The policy referenced 42 CFR and the applicable State contract references instead.		
Required Actions: HSAG recommends that the CCO update its Emergency, Urgent and Post-Stabilization Services policy to include the required post-stabilization payment language.		

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	• MM-002 Emergency Urgent and Post-Stabilization Services, pg. 3	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
23. The CCO has written policies and procedures that describe the process for receiving member requests, approving non-emergent medical transportation (NEMT) services, and scheduling, assigning, and dispatching providers. *Contract: Exhibit B Part 2 (4)(b)*	YCCO ensures NEMT delegate maintains policies and procedures describing the process of delivering services. • Wellride Reimbursement Program Guide 09.18.15 • ATTACHMENT 8 - Transportation Provider Policies and Procedures Manual - Yamhill 06 25 2015 • NEMT - 2014-2015 Questions- responses	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA
HSAG Findings: The CCO did not submit policies and procedures that addressed non-emergent medical transportation (NEMT) services. The document labeled "Attachment 8—Transportation Provider Policies and Procedures Manual" is the manual that First Transit drivers receive from their employer. None of the documents submitted included the necessary information for this element, nor did the CCO submit its own organizational policies related to NEMT.		
Required Actions: The CCO should develop organizational policies regarding NEMT services that describe the requirements and the CCO's expectations for its NEMT vendor. In addition, it should require its NEMT vendor to have the appropriate policies and procedures.		

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	YCCO NEMT call center operates during the required hours and follows both language access and call center quality and performance standards. • SVC-004 Network Capacity, Service Adequacy and Availability, pg. 3 • NEMT Quality SLA	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA
HSAG Findings: The documentation submitted by the CCO did not include a description of NEMT minimum operating hours or after-hours arrangements.		
Required Actions: The CCO should develop organizational policies regarding NEMT services describing the minimum operating hours or after-hours arrangements for its NEMT vendor. In addition, it should require its NEMT vendor to have the appropriate policies and procedures.		
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)*	YCCO subcontracts dental service coverage to Capitol Dental Care. • YCCO Delegation Matrix • CDC Emergency Services Policy 2017.09, pg. 1, 2, 3 • CDC Service Level Reporting	☒ 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)*	• YCCO Behavioral Health Urgent and Emergent Care_016-102-03-11 • YCCO BH Mobile Crisis Services_016-102-03-14	☒ 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)*	• YCCO BH Mobile Crisis Services_016-102-03-14 • Handbook with Insert 010719, pg. 31 • Yamhill CCOA Welcome ID Card English, pg. 2 • Yamhill CCOA Welcome ID Card Spanish, pg. 2	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services	
	Total #
Complete	**21**
Progress Sufficient	**4**
Incomplete	**2**
Not Applicable (NA)	**0**

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. Notwithstanding any relationship(s) that the CCO may have with any subcontractor, the CCO maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. *42 CFR §438.230(b)(1)* *Contract: Exhibit B Part 4(13)*	YCCO delegates select functions and retains ultimate responsibility for ensuring compliance with all term, rules and regulations. • DO-001 Delegation Oversight Policy, Pg.2 • YCCO Delegation Matrix • P&P Audit Master • 2019 Audit Schedule Final • Audit Findings Sheet • CDC - Dental Delegation Agreement • CO Delegation Agreement • FT - NEMT Delegation Agreement • PHT Delegation Agreement • YCHHS - BH Delegation Agreement	☒ 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.	All written agreements with subcontractors will be submitted to OHA within 30 days of execution and contain the following provisions. • DO-001 Delegation Oversight Policy, Pg.2, 3, 4 • YCCO Delegation Matrix • CDC Delegation Contract_DCO_7-01-14-Executed • Redacted YCCO - CareOregon Management Services Agreement Final Nov1 2012 • Redacted 9 30 15 Executed NEMT FT Contract	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• 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). *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)*	• Redacted PH Tech - YCCO ASA - 12-14-18 – Executed • Redacted BH Delegation Agreement_YCCO-YCHHS_01-01-15 Delegated activities and reporting • CDC Delegation Contract_DCO_7-01-14_EXECUTED (05-07-14); Delegated activities: Pages 3, 7, 8, 12, 14, 16-19, Exhibit H, Exhibit I. Reporting responsibilities: Pages 1, 16, 19, 20, 40, Exhibit G, Exhibit L, • Redacted 9 30 15 Executed NEMT FT Contract. Delegated activities: Pages 2-4. Reporting responsibilities: Pages 3-5, Exhibit A, Exhibit C • Redacted PH Tech - YCCO ASA - 12-14-18 – Executed. Delegated activities: Pages 3-4, Exhibit A, Exhibit B. Reporting responsibilities: Pages 7-8, 11, 23, Exhibit B, Exhibit D • Redacted BH Delegation Agreement_YCCO-YCHHS_01-01-15. Delegated activities: Pages 4-7, Exhibit B. Reporting responsibilities: Pages 1, 5, 7, Exhibit B, Exhibit C, Exhibit G. • Redacted YCCO - CareOregon Management Services Agreement Final Nov1 2012. Delegated activities: Pages 2-4. Reporting responsibilities: Pages 2-3, 5. Compliance with CCO obligations	

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• CDC Delegation Contract_DCO_7-01-14_EXECUTED. Pages 1, 3, • Redacted 9 30 15 Executed NEMT FT Contract. Pages 1-5 • Redacted PH Tech - YCCO ASA - 12-14-18 – Executed. Pages 3, 7-8, 15, 23-24, 27 • Redacted BH Delegation Agreement_YCCO-YCHHS_01-01-15. Pages 3-7, Exhibit B, Exhibit C, Exhibit G • Redacted YCCO - CareOregon Management Services Agreement Final Nov1 2012. Pages 2-6, Revocation and Remediation • CDC Delegation Contract_DCO_7-01-14_EXECUTED. Page 28 • Redacted 9 30 15 Executed NEMT FT Contract. Pages 6-7, Exhibit C • Redacted PH Tech - YCCO ASA - 12-14-18 – Executed. Pages 19-21, 69, • Redacted BH Delegation Agreement_YCCO-YCHHS_01-01-15. Pages 7-8, Exhibit C. • Redacted YCCO - CareOregon Management Services Agreement Final Nov1 2012. Pages 9-10 Written agreements • CDC Delegation Contract_DCO_7-01-14_EXECUTED. Pages 12, 15, 34-36	

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• Redacted 9 30 15 Executed NEMT FT Contract. Pages 2, 4, 12, 42, Exhibit C. • Redacted PH Tech - YCCO ASA - 12-14-18 – Executed. Pages 11, 40 • Redacted BH Delegation Agreement_YCCO-YCHHS_01-01-15. Pages: 18-19, Redacted YCCO - CareOregon Management Services Agreement Final Nov1 2012. Pages 3, 5	
HSAG Findings: The CCO provided several subcontract agreements (2012–2018) with various delegates. Upon review of the written agreements, some of the OHA-required provisions were omitted. For example, the agreements were missing the subcontractor's requirement to report any other primary, third-party insurance to the CCO and the time frame for reporting (as the CCO is required to report this information to OHA within 30 days of the subcontractor becoming aware); the subcontractor's requirement to document, maintain, and provide to the CCO all encounter data records that document the subcontractor's reimbursement to Federally Qualified Health Centers (FQHCs), Rural Health Centers, and Indian Health Care Providers; and the fact that, if the CCO is not paid or is not eligible for payment by OHA for services provided, the subcontractor will not be paid or eligible for payment either. During the remote interview session, YCCO staff members stated that they are in the process of updating the subcontractor agreements and anticipate completion by January 1, 2020.		
Required Actions: HSAG recommends that the CCO update the subcontractor agreements to ensure they include all requirements for written agreements as outlined in the CCO's contract with OHA. In addition, HSAG recommends that the CCO update citations to the CCO contract throughout the subcontractor agreements.		
3. The CCO evaluates the prospective subcontractor's readiness and ability to perform the scope of work outlined in the written agreement prior to the effective date of the contract. • Copies of the evaluation must be provided to OHA any time the CCO enters into a new subcontractor agreement. *Contract: Exhibit B Part 4(13)(a)(1)*	Per YCCO policy and procedure, all prospective subcontractors are assessed for readiness and ability to perform the delegated scope of work prior to constraint execution. These assessments and copies of the delegation agreements will be submitted to OHA within 30 days of execution. • DO-001 Delegation Oversight Policy, Pg. 2	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	– Policy & Procedure Oversight for Capitol-predelegation Delegation of NEMT services • YCCO NEMT scoring sheet First Transit • NEMT - 2014-2015 Questions- responses Change in delegation of plan and physical health services • Moda vs PH tech Draft of Board presentation • Oversight of PH TECH	
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)*	YCCO has a process for monitoring subcontractor performance. In the 2018 EQR audit, YCCO Substantially met (3.0 score) Subcontractual relationships and delegation. • Quality Program structure • DO-001 Delegation Oversight Policy, pg. 3, 4 • DO-002 Audit and Monitoring Policy, pg. 2, 3 • 2019 Audit Schedule Final • 2018 YCCO EQR Report_Final_08282018, pg.33 Sample desk audit tools • 2018 Care Coordination Review Form – TEMPLATE • 2018 Credentialing and Recredentialing File Review Tool 1.29.18 • 2018 Service Authorizations File Review Tool-02212018	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• NEMT Audit Template • P&P Audit Master • Audit Findings Sheet Ongoing monitoring • Yamhill SLA Report 201906 • YCCO Quality Performance Metrics_07252019 • CDC Service Level Reporting • NEMT Quality SLA Annual review • Yamhill CCO Annual delegation review 2018 • 2017 Delegation Review	
5. Whenever deficiencies or areas of improvement are identified, the CCO and subcontractor shall take corrective action. *Contract: Exhibit B Part 4(13)(a)(15-17)*		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		
6. The Contractor must provide to OHA, annually and within 30 days of any change in subcontractor, the Subcontractors and Delegated Entities Report. The report should identify any activities the Contractor has agreed to perform under the contract that have been subcontracted or delegated, and include information related to the subcontracted work including:	Notification to OHA of a subcontractor change with accompanying written agreements with subcontractors will be submitted to OHA within 30 days of execution and contain the following provisions.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• The legal name of the Subcontractor; • The scope of work being subcontracted; • Copies of ownership disclosure form, if applicable; • Copies of all written agreements with Subcontractors to ensure all contracts meet the requirements outlined in 42 CFR 438.230; • Any ownership stake between the Contractor and Subcontractor. *Contract: Exhibit B Part 4(13)(a)(5-6)*	• RFA4690-YCCO-Att 6 Delegated Entities • YCCO Delegation Matrix • CDC Delegation Contract_DCO_7-01-14_Executed • Redacted YCCO - CareOregon Management Services Agreement Final Nov1 2012 • Redacted 9 30 15 Executed NEMT FT Contract • Redacted PH Tech - YCCO ASA - 12-14-18 – Executed • Redacted BH Delegation Agreement_YCCO-YCHHS_01-01-15 Change in delegation of dental services • OHA notice letter 2017-10-03 Change in delegation of plan and physical health services • FW_ Material changes to Yamhill CCO network • Material Change and Intent to Transfer Members Letter 09_28_2018 (signed)	
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;		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• 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)*		
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)*	YCCO complies with the referenced enrollment criteria. YCCO delegates the processing of enrollment and disenrollment services and ensures compliance with requirements through the oversight of policies and procedures. • ENR-005 Enrollment and Disenrollment, Pg. 2 • YCCO Delegation Matrix • P&P Audit Master • 2019 Audit Schedule Final • Oregon Medicaid 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)*	YCCO complies with the referenced enrollment criteria. YCCO delegates the processing of enrollment and disenrollment services and ensures compliance with requirements through the oversight of policies and procedures. • ENR-005 Enrollment and Disenrollment, Pg. 4 • Oregon Medicaid 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)*	YCCO does not request disenrollment for reasons other than what is permitted under the contract. • ENR-005 Enrollment and Disenrollment, Pg. 4	☒ 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.	YCCO allows members to request disenrollment • ENR-005 Enrollment and Disenrollment, Pg. 4, 5, 6 • Member Handbook with Insert 010719, pg. 42	☒ 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)*	Per YCCO policy and Member handbook, a member can request disenrollment • ENR-005 Enrollment and Disenrollment, Pg. 6 • Member Handbook with Insert 010719, pg. 42	☒ 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	Per YCCO policy and Member handbook, a member can request disenrollment • ENR-005 Enrollment and Disenrollment, Pg. 4, 5 • Member Handbook with Insert 010719, pg. 42	☒ 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*	YCCO delegates grievance and appeal systems and ensures the system follows all requirements including the notification of members of adverse benefit determination in a timely manner through oversight and monitoring. YCCO 2017 EQR audit found Grievance System substantially met system requirements. • GA-001 Grievance System • GA-002 Member Complaints and Grievances • GA-003 Denials, Appeals, and Contested Case Hearings • Visio-Final Adjudication Road Map 2018 • YCCO Delegation Matrix • P&P Audit Master • NOABD Audit Tracking 2019 • NOA Audit Findings Sheet Q1 2018 • 2017 YCCO EQR Report_FINAL_01302018, pg.17	☒ 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.	YCCO delegates grievance and appeal systems and ensures the system follows all requirements and makes available an appeal or challenge of an adverse benefit determination through oversight and monitoring. YCCO 2017 EQR audit fully met this requirement • GA-003 Denials, Appeals, and Contested Case Hearings, pg. 3, 4, 9,	☒ 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 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)*	• YCCO Delegation Matrix • P&P Audit Master • 2017 YCCO EQR Report_FINAL_01302018, pg. 18	
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,	YCCO policies define adverse benefit determination • GA-001 Grievance System, pg. 1 • GA-002 Member Complaints and Grievances, pg.1 • GA-003 Denials, Appeals, and Contested Case Hearings, pg.1	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
deductibles, coinsurance, and other member financial liabilities. *42 CFR §438.400(b)* *42 CFR §438.52(b)(2)(ii)* *RFA: Appendix A (C)*		
4. The CCO defines Appeal as a review by the CCO of an Adverse Benefit Determination. *42 CFR §438.400(b)* *RFA: Appendix A (H)(11)*	YCCO policies define appeal • GA-001 Grievance System, pg. 1 • GA-002 Member Complaints and Grievances, pg.1 • GA-003 Denials, Appeals, and Contested Case Hearings, pg.1	☒ 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)*	YCCO policies define grievance • GA-001 Grievance System, pg. 1 • GA-002 Member Complaints and Grievances, pg.1	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: The documents submitted by the CCO defined "grievance" as an expression of dissatisfaction about any matter other than an adverse benefit determination. However, examples of grievances (i.e., quality of care or services provided) were not included. In addition, the definition did not include reference to a grievance including a member's right to dispute an extension proposed by the CCO to make an authorization decision.		
Required Actions: HSAG recommends that the CCO expand its definition of "grievance" in its applicable policies to include examples of types of grievances and a member's right to dispute an extension proposed by the CCO to make an authorization decision.		

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
6. A member may file a grievance with the CCO at any time, either orally or in writing. Grievances can be submitted to the State or the CCO. *42 CFR §438.402(c)(2)(i), (c)(3)(i)* *Contract: Exhibit I (2)(a)*	YCCO 2017 EQR fully met this requirement • GA-001 Grievance System, pg. 3 • GA-002 Member Complaints and Grievances, pg. 2, 4 • 2017 YCCO EQR Report_FINAL_01302018, pg. 24	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
7. A member may file an appeal within 60 calendar days from date on the notice of adverse benefit determination. • The member may request an appeal either orally or in writing. Unless the member requests an expedited resolution, an oral appeal must be followed by a written, signed appeal. *42 CFR §438.402(c)(2)(ii), (c)(3)(ii)* *Contract: Exhibit I (1)(b)(2), (1)(c)(2-3)*	YCCO 2017 EQR fully met this requirement • GA-001 Grievance System, pg. 6 • GA-003 Denials, Appeals, and Contested Case Hearings, pg. 5, 8 • YCCO Logo OHP 2405 NOABD • 2017 YCCO EQR Report_FINAL_01302018, pg. 24	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
8. The CCO must acknowledge receipt of each grievance and appeal. *42 CFR §438.406(b)(1)* *Contract: Exhibit I (4)(a)(1)*	YCCO 2017 EQR fully met this requirement • GA-003 Denials, Appeals, and Contested Case Hearings, pg. 5, 8 • YCCO Grievance Extension Request - for grievances requiring more than 5 business days • 2017 YCCO EQR Report_FINAL_01302018, pg. 24	☒ 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	YCCO 2017 EQR fully met this requirement • GA-001 Grievance System, pg. 6 • GA-003 Denials, Appeals, and Contested Case Hearings, pg. 5, 8	☐ Complete ☐ Progress Sufficient to Start Operations

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
resolution, an oral appeal must be followed by a written, signed appeal. *42 CFR §438.402(c)(2)(ii), (c)(3)(ii)* *Contract: Exhibit I (1)(b)(2), (1)(c)(2-3)*	• YCCO Logo OHP 2405 NOABD 2017 YCCO EQR Report_FINAL_01302018, pg. 24	☐ Incomplete ☒ NA
HSAG Findings: This element was a duplicate of element #7.		
Required Actions: None.		
10. The CCO resolves each grievance in writing and provides notice as expeditiously as the member's health condition requires. Within five (5) business days from the date of the CCO's receipt of the grievance, the CCO: a. Notifies the member that a decision on the grievance has been made and what the decision is; or b. Acknowledges receipt of the grievance and notifies the member that there will be a delay in the CCO's decision of up to 30 days. c. Notice to the member must be in a format and language that may be easily understood by the member. *42 CFR §438.408(a)-(b)(1), (d)(1)* *Contract: Exhibit I (2)(h)*	YCCO 2017 EQR fully met this requirement • GA-002 Member Complaints and Grievances, pg. 4 • YCCO Grievance Extension Request – for grievances requiring more than 5 business days • YCCO Grievance Resolution • 2017 YCCO EQR Report_FINAL_01302018, pg. 26	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA
HSAG Findings: The CCO submitted its Member Complaints and Grievances policy, which met the requirements for this element with one exception: the policy had not been updated to meet the new contract requirement (effective January 1, 2020) that the CCO respond to each grievance in writing (for both oral and written grievances). During the remote session with HSAG, the CCO indicated that it had a process in place to meet the new requirement in a timely manner.		
Required Actions: The CCO should revise its Member Complaints and Grievances policy, prior to January 1, 2020, to reflect the contract requirement that it respond in writing to all grievances.		

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	• GA-001 Grievance System, pg. 4 • GA-002 Member Complaints and Grievances, pg. 2 • GA-003 Denials, Appeals, and Contested Case Hearings, pg. 2 • Member Handbook, pg. 40, 41	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
12. The CCO ensures that the individuals who make decisions on grievances and appeals are individuals who: • Were not involved in any previous level of review or decision-making nor a subordinate of any such individual. • Have the appropriate clinical expertise, as determined by the State, in treating the member's condition or disease if deciding any of the following: • An appeal of a denial that is based on lack of medical necessity. • A grievance regarding the denial of expedited resolution of an appeal. • A grievance or appeal that involves clinical issues. • Take into account all comments, documents, records, and other information submitted by the member or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination. *42 CFR §438.406(b)(2)* *Contract: Exhibit I (1)(c)(6-7)*	• GA-002 Member Complaints and Grievances, pg. 3,4 • GA-003 Denials, Appeals, and Contested Case Hearings, pg. 5,6	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
13. The CCO's appeal process must provide: a. That oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the member or the provider requests expedited resolution. b. The member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The CCO must inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in §438.408(b) and (c) in the case of expedited resolution. c. The member and his or her representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the CCO (or at the direction of the CCO) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for appeals. d. That included, as parties to the appeal, are: i. The member and his or her representative, or ii. The legal representative of a deceased member's estate. *42 CFR §438.406(b)(3-6)* *Contract: Exhibit I (4)(b)*	• GA-001 Grievance System, pg. 3, 6 • GA-003 Denials, Appeals, and Contested Case Hearings, pg. 4, 5, 6 • YCCO Logo OHP 2405 NOABD • OHA 3302 Appeal and Hearing Request	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
14. The CCO must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, no later than 16 days from the day the CCO receives the appeal. • For expedited resolution of an appeal and notice to affected parties, within 72 hours after the CCO receives the appeal. • For notice of an expedited resolution, the CCO must also make reasonable efforts to provide oral notice of resolution. • Written notice of appeal resolution must be in a format and language that may be easily understood by the member. *42 CFR §438.408(b)(2)-(3)* *Contract: Exhibit I (4)(c)(2)*	• GA-001 Grievance System, pg. 3, 6 • GA-003 Denials, Appeals, and Contested Case Hearings, pg. 4, 5, 6 • YCCO Logo OHP 2405 NOABD • OHA 3302 Appeal and Hearing Request	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
15. The CCO may extend the time frames for resolution of grievances or appeals (both expedited and standard) by up to 14 calendar days if: • The member requests the extension; or • The CCO shows (to the satisfaction of the State, upon request) that there is need for additional information and how the delay is in the member's interest. • If the CCO extends the timeframes, it must—for any extension not requested by the member: – Make reasonable efforts to give the member prompt oral notice of the delay.	YCCO 2017 EQR fully met this requirement • GA-003 Denials, Appeals, and Contested Case Hearings, pg. 7, 8 • YCCO Appeal Acknowledgement and Extension Request • 2017 YCCO EQR Report_FINAL_01302018, pg. 26	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
– Within 2 calendar days, give the enrollee written notice of the reason for the delay and inform the enrollee of the right to file a grievance with the CCO if he or she disagrees with that decision. – Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. • If the CCO fails to adhere to the notice and timing requirements for extension of the appeal resolution timeframe, the member may initiate a State fair hearing (contested case hearing). *42 CFR §438.408(c)* *Contract: Exhibit I (4)(c)(1)(c), (4)(c)(2)*		
16. The written notice of appeal resolution must include: The results of the resolution process and the date it was completed. • For appeals not resolved wholly in favor of the member: – The right to request a State fair hearing (contested case hearing), and how to do so. – The right to request that benefits/services continue while the hearing is pending, and how to make the request. – That the member may be held liable for the cost of these benefits if the hearing decision upholds the CCO's adverse benefit determination. *42 CFR §438.408(e)* *Contract: Exhibit I (4)(c)(4)*	• GA-003 Denials, Appeals, and Contested Case Hearings, pg. 7, 8 • YCCO Logo OHA 2406 NOAR • OHA 3302 Appeal and Hearing Request	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
17. The member may request a State fair hearing (contested case hearing) after receiving notice that the CCO is upholding the adverse benefit determination. The member may request a State fair hearing within 120 calendar days from the date of the notice of resolution. • The parties to the State fair hearing (contested case hearing) include the CCO, as well as the member and his or her representative or the representative of a deceased member's estate. *42 CFR §438.408(f)* *Contract: Exhibit I (5)*	• GA-003 Denials, Appeals, and Contested Case Hearings, pg. 9 • YCCO Logo OHA 2406 NOAR • OHA 3302 Appeal and Hearing Request	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
18. The CCO maintains an expedited review process for appeals, when the CCO determines, or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. The CCO's expedited review process includes: • The CCO ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. • If the CCO denies a request for expedited resolution of an appeal, it must: – Transfer the appeal to the time frame for standard resolution. – Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and	• GA-003 Denials, Appeals, and Contested Case Hearings, pg. 2, 6, 7 • YCCO Response to Request for Expedited Appeal	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
follow-up within two calendar days with a written notice. *42 CFR §438.410* *Contract: Exhibit I (4)(c)(3)(e)*		
19. The CCO provides for continuation of benefits/services while the CCO-level appeal and the State fair hearing (contested case hearing) are pending if: • The member files timely* for continuation of benefits—defined as on or before the later of the following: – Within 10 days of the CCO mailing the notice of adverse benefit determination. – The intended effective date of the proposed adverse benefit determination. • The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. • The services were ordered by an authorized provider. • The original period covered by the original authorization has not expired. • The member requests an appeal in accordance with required timeframes. **Note: This definition of timely filing only applies when the member requests continuation of benefits for previously authorized services proposed to be terminated, suspended, or reduced. The provider may not request continuation of benefits on behalf of the member.* *42 CFR §438.420(a)-(b)* *Contract: Exhibit I (6)(a)-(b)*	YCCO 2017 EQR audit fully met this requirement • GA-003 Denials, Appeals, and Contested Case Hearings, pg. 11 • OHA Appeal and Hearing Request • YCCO Logo OHA 2406 NOAR • 2017 YCCO EQR Report_FINAL_01302018, pg.29	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
20. If, at the member's request, the CCO continues or reinstates the member's benefits while the appeal or State fair hearing (contested case hearing) is pending, the benefits must be continued until one of following occurs: • The member withdraws the appeal or request for State fair hearing. • The member fails to request a State fair hearing and continuation of benefits within 10 calendar days after the CCO sends the notice of an adverse resolution to the member's appeal. • A State fair hearing officer issues a hearing decision adverse to the member. *42 CFR §438.420(c)* *Contract: Exhibit I (6)(c)*	YCCO 2017 EQR audit fully met this requirement • GA-003 Denials, Appeals, and Contested Case Hearings, pg. 11 • YCCO Logo OHA 2406 NOAR • 2017 YCCO EQR Report_FINAL_01302018, pg. 29	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
21. If the final resolution of the appeal is adverse to the member, that is, upholds the CCO's adverse benefit determination, the CCO may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section. *42 CFR §438.420(d)* *Contract: Exhibit I (6)(d)*	CCO 2017 EQR audit fully met this requirement • GA-003 Denials, Appeals, and Contested Case Hearings, pg. 10 • 2017 YCCO EQR Report_FINAL_01302018, pg. 29	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA
HSAG Findings: The CCO's Denials, Appeals and Contested Case Hearings policy indicated that members must be provided a statement that, if they choose to continue services while an appeal is pending, they may be liable for payment. The policy did not; however, include specific language that the CCO may recover the cost of services furnished to the member while an appeal was pending, if the appeal resolution is adverse to the member.		

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Required Actions: The CCO should revise its Denials, Appeals and Contested Case Hearings policy to include specific language that, if a final resolution of an appeal is adverse to a member, that the CCO may recover the cost of the services furnished to the member while the appeal was pending.		
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) 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)*	• GA-003 Denials, Appeals, and Contested Case Hearings, pg. 10, 11	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
23. The CCO maintain records of all member grievances and appeals. The record must be accurately maintained in a manner accessible to the State and available upon request to CMS. The record of each member grievance or appeal must contain, at a minimum, all of the following information:		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• 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; • Notations of oral and written communications with the member; and • Notations about appeals and grievances the member decides to resolve in another way if the CCO is aware of this. *42 CFR §438.416* *Contract: Exhibit I (9)*		
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		
24. The CCO provides the information about the grievance appeal, and fair hearing system to all providers and subcontractors at the time they enter into a contract. The information includes: • The member's right to file grievances and appeals. • The requirements and time frames for filing grievances and appeals.	YCCO shares policies and oversight requirements with subcontractors at the time of contracting. Provider networks are delegated and YCCO ensures grievance system information is shared with providers through oversight and monitoring. • YCCO Delegation Matrix • P&P Audit Master	☐ Complete ☐ Progress Sufficient to Start Operations ☒ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• 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. – 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)*	• PRM 2019, pg. 17-19	
HSAG Findings: The documentation submitted by the CCO did not demonstrate that it provided information about the grievance appeal and State fair hearing system to all providers and subcontractors at the time they enter into a contract. The Providence Health Plan provider manual included a member appeals and grievance section, but it was specific to Medicare members. The CCO also submitted the provider manual of its dental delegate, Capital Dental. This manual included a Denials, Appeals, Administrative Hearings manual that had limited information on the processes. The YCCO and Yamhill County Health & Human Services Behavioral Health Provider Manual had a section titled "Member Complaints and Grievances," which		

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
had a description of a grievance but no further information. Instead, it directed the reader to see its Complaints, Grievances and Appeals policy for further information. During the remote session with HSAG, the CCO stated that it is in the process of developing a system-wide provider manual.		
Required Actions: The CCO should require that Providence Health Plan revise its provider manual to include Medicaid-specific grievance and appeals information. In addition, the provider manuals of its dental and behavioral health delegates should have the required, complete information regarding grievances, appeals, and the State fair hearing process.		

Standard X- Grievance and Appeal Systems	
	Total #
Complete	**18**
Progress Sufficient	**1**
Incomplete	**3**
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)*	YCCO contracts with PHTECH to maintain a data warehouse (DW) hosted by Amazon Redshift (cloud-based) by which plan data is integrated and stored. These data include claims and encounter; enrollment and disenrollment; member demographics including race, ethnicity, language, age, and PCP attribution and contact information. Duplicate data is also maintained in Clinical Integration Manager (CIM) through a delegation agreement with PHTECH. • YCCO Delegation Matrix • PHT Delegation Agreement; Redacted PH Tech - YCCO ASA - 12-14-18 – Executed, pg 57, 59 Ancillary to the data warehouse (DW), data is also maintained through local data storage (LOC) and can be integrated for the purpose of analytics and reporting.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Data	DW	CIM	LOC
Claims and encounters	X	X	
Grievances, appeals and hearing records		X	X
Enrollment/Disenrollment	X	X	X
Member Characteristics: Race	X	X	X

Standard XIII—Health Information Systems			
Requirement	**Evidence as Submitted by the CCO**		**Score**
	Member Characteristics: Ethnicity		
	Member Characteristics: Language	X X X	
	Member Characteristics: PCP name; phone number	X X X	
	Member Characteristics: Member Rights & Respon.	X X	
	MOTS	X	
	LTPC	X	
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)*	YCCO contracts with PHTECH to manage and maintain a claims processing and retrieval system. Through oversight and monitoring of PHTECH policies and procedures as well as transparency reports and SLA reporting, YCCO assures that the claims system collects, processes and retrieves claims with the State. • YCCO Delegation Matrix • PHT Delegation Agreement; Redacted PH Tech - YCCO ASA - 12-14-18 – Executed • PH TECH Data Integration Flow Chart – generic • 150410- CMT- Yamhill CCO- PreManage Agreement [EXECUTED] 4-10-2015 • CCO_Metrics_Manager • Claim_Import.vsd	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

<table>
<tr><th colspan="3">Standard XIII—Health Information Systems</th></tr>
<tr><th>Requirement</th><th>Evidence as Submitted by the CCO</th><th>Score</th></tr>
<tr><td></td><td>• 11-10-17 PH Tech Life of a Claim
• Encounter Submission Process
• Working 999 Errors
• Yamhill SLA Report 201906
• Transparency Reports-PHTECH</td><td></td></tr>
<tr><td>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)</td><td>Member and provider data are collected and stored in the data warehouse, in CIM, and local data storage. These data are aggregated for the purposes of reporting characteristics to OHA for Exhibit G
<table><tr><th>Data</th><th>DW</th><th>CIM</th><th>LOC</th></tr><tr><td>Exhibit G-DSN</td><td>X</td><td>X</td><td>X</td></tr><tr><td>Enrollment</td><td>X</td><td>X</td><td>X</td></tr><tr><td>Encounter, pharmacy</td><td>X</td><td>X</td><td>X</td></tr></table>• 2019 DSN Provider Capacity and Narrative Report FINAL
• YCCO Delegation Matrix
• PHT Delegation Agreement; Redacted PH Tech - YCCO ASA - 12-14-18 – Executed
• Screenshots_Data warehouse and SQL Workbench</td><td>☒ Complete
☐ Progress Sufficient to Start Operations
☐ Incomplete
☐ NA</td></tr>
<tr><td>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:</td><td>YCCO delegates encounter data processing and submission and retains authority over certifying that data received is accurate, truthful and complete.
• YCCO Delegation Matrix</td><td>☒ Complete
☐ Progress Sufficient to Start Operations
☐ Incomplete</td></tr>
</table>

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
a. Verifying the accuracy and timeliness of data reported b. Screening the data for completeness, logic, and consistency c. Submitting the certification to verify current member eligibility for fully dual eligible members using the AVR system or MMIS Web Portal. d. Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for State Medicaid quality improvement and care coordination efforts in accordance with OHA Electronic Data Transmission (EDT) procedures in OAR Chapter 943 Division 120. *42 CFR §438.242(b)(3)(i-iii)* *Contract: Exhibit J(3)*	• EHR Data Reporting Template • PHT Delegation Agreement; Redacted PH Tech - YCCO ASA - 12-14-18 – Executed • OHA Encounter Reports • Must Correct Encounter Data Corrections • Encounter Submission Process • Encounter Submission Flow Diagram • Encounter Receipt and Reconciliation Flow Diagram • Encounter Data Submission • Encounter 999 Errors (Rejected Claims) • CVF Validation SOP	☐ NA
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)*	YCCO will share data with OHA and CMS upon request per Exhibit J(3)(g) of the CCO Health Services contract.	☒ 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)*		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		
7. The CCO shall provide to OHA, upon request, verification that members were contacted to confirm that billed services were provided in accordance with 42 CFR §455.20 and 433.116 (e) and (f) by: a. Providing a notice, within 45 days of the payment of a claim, to all or a sample group of the Members who received services; b. The notice must, based on information from the Contractor's claims payment system, specify: i. The services furnished ii. The name of the provider furnishing the services iii. The date on which the services were furnished iv. The amount of the payment made by the member, if any, for the services 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)*		☐ 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**
8. The CCO shall: a. Collect and maintain sufficient member encounter data to identify the provider who delivers any item(s) or service(s) to members. b. Submit member encounter data to OHA at a frequency and level of detail to be specified by CMS and OHA, based on program administration, oversight, and program integrity needs. c. Submit all member encounter data that the State is required to report to CMS under §438.818. d. Specifications for submitting encounter data to the Agency in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate. *42 CFR §438.242(c)(1-4)*		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		
9. Contractor shall develop IS contingency planning in accordance with 45 C.F.R. §164.308. Contingency plans shall include: a. Data Backup plans 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*	YCCO maintains contingency plan in the cases where business is interrupted. Through delegation oversight and monitoring, YCCO ensured delegated partners also maintain plans. • YCCO Disaster Recovery and Business Continuity Plan_DRAFT • YCCO Delegation Matrix • 2019 Audit Schedule Final • P&P Audit Master	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	• PHT_DR_Final 2016 • EHR System Backup and Recovery Process • 2016P- Electronic Health Record Disaster Recovery Procedures • InterDent Disaster Recovery Plan_v3 • 2016F- CDC_DRBCPlan_3_17_2016 • 2017P- Interdent- Data Backup and Recovery Policy	
10. The CCO shall develop and maintain an OHA-approved HIT Roadmap inclusive of CCO's activities, milestones and timelines. The HIT Roadmap must describe where the CCO has 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)*		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: This element will be reviewed by the OHA HIT for the readiness review.		
Required Actions: None.		
11. The CCO shall provide an annual HIT Roadmap update to OHA for review and approval. The HIT Roadmap update must: a. Identify any changes to the prior-approved HIT Roadmap. b. An attestation to progress made on its HIT Roadmap, including supporting documentation c. An attestation that the COO has an active, signed HIT Commons MOU, and i. Adheres to the terms of the HIT Commons MOU ii. Pays the annual HIT Commons assessments subject to the payment terms of the HIT Commons MOU iii. Serves, if elected, on the HIT Commons Governance Board, or one of its committees iv. Participates in OHA's HITAG, at least annually d. Report the EHR(s) vendor/product used by its contracted providers and its progress on EHR adoption targets via the Performance Expectations report 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)*		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: This element will be reviewed by the OHA HIT for the readiness review.		
Required Actions: None.		
12. The CCO shall: a. Participate as a member in good standing of the HIT Commons b. Maintain an active, signed HIT Commons MOU c. Adhere to the terms of the HIT Commons MOU d. Pay the annual HIT Commons assessments subject to the payment terms of the HIT Commons MOU e. Serve, if elected, on the HIT Commons governance board or one of its committees. *Contract: Exhibit J(2)(d)*	YCCO participates in the HIT Commons. a. Jennifer Jackson is the Primary Point of Contact for YCCO and participates in good standing. b. SIGNED HIT Commons Amended and Restated MOU_01_2018_Yamhill_SRO Sig c. YCCO adheres to terms of the HIT MOU d. Effective 1/1/2020, YCCO will pay assessments as required by its contract with OHA e. Not applicable at this time	☐ 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)*		☐ 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**
14. The CCO shall document and report to OHA, annually, on how HIT is used to support contracted providers by providing: a. Information (at least quarterly) on measures used in the VBP arrangements b. Accurate and consistent information on patient attribution c. Information on patients requiring intervention and the frequency of that information d. Other actionable data (e.g., risk stratification, member characteristics) to support providers' participation in VBP arrangements and implementation of interventions. e. Use of HIT to support contracted providers to participate in VBP arrangements *Contract: Exhibit J (2)(k)(7)*	YCCO will document and report to OHA, annually HIT used to support contracted providers. a. YCCO will follow VBP reporting requirements for submission of measures. • 2019 APM Application Template b. Bi-monthly PCP assignment reporting • YCCO PCP Member Assignment Roster_2019_07_15_060213 Information provided to LAN annually • Section IV F-7 -LAN APM Submission_2019_FINAL c. Complex Care Report d. YCCO is adopting two risk scoring models: John Hopkins ACG and Wakely • Yamhill Community Care Organization - ACG Internal License Agreement FULLY EXECUTED (reduced size) 08012019 JWF e. EHR Data Reporting Template	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
15. The CCO shall document and report to OHA, annually, on how HIT is used to support population health management, including: a. The ability to identify and report on member characteristics (e.g., past diagnoses and services) b. The capability of risk stratifying members c. The ability to provide risk stratification and member characteristics to contracted providers with VBP	YCCO will document and report to OHA, annually HIT used to support contracted providers. a. Redacted PH Tech_inteligenz_YCCO CCOMM Customer Subscription Agreement 121718_Executed b. YCCO is adopting two risk scoring models: John Hopkins ACG and Wakely	☒ 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)*	Yamhill Community Care Organization - ACG Internal License Agreement FULLY EXECUTED (reduced size) 08012019 JWF Complex Care Report c. 150410- CMT- Yamhill CCO- PreManage Agreement [EXECUTED] 4-10-2015	

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, the quality of YCCO's Provider Capacity Reports were good with minor errors associated with the individual practitioner file.

Table B-1—YCCO 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	3.3	100.0	
Address #1	100.0		
Provider's Capacity	3.3	100.0	
City	100.0		
Status of Medicaid Contract	44.7	4.4	
County	100.0		
Credentialing Date	100.0	91.2	88.3
DMAP (Medicaid ID)	100.0	99.9	
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	3.7		
Non-English Language 2			
Non-English Language 3			
Provider Last Name	100.0		
Provider Network Status	26.6	20.1	
Provider NPI	100.0	100.0	100.0
Number of Members Assigned to PCPs	3.3	100.0	
PCP Indicator	89.8	100.0	
PCPCH Tier	1.9	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	100.0	
Provider Taxonomy	100.0	100.0	100.0
Zip Code	100.0		

In general, while most key DSN data fields on the individual practitioner capacity report were populated, several fields were less frequently populated—i.e., Contract Status (44.7 percent), Network Status (26.6 percent), and PCP Indicator (89.8 percent). Additionally, only 4.4 percent of the records with a populated Contract Status were in a valid format, and just under 90 percent of the credentialing dates were populated with valid dates (88.3 percent). The overall average completeness was 72.9 percent across both required and conditional[B-1] fields and increased to 86.9 percent when excluding conditional fields. Of note, only 3.7 percent of providers were associated with a non-English language.

Table B-2—AllCare 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		

[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
Status of Medicaid Contract	100.0	0.0	
County	100.0		
DMAP (Medicaid ID)	98.6	98.7	
Facility NPI	96.2	99.2	99.2
Phone Number	100.0		
Provider Category	100.0	100.0	100.0
Provider Service Category	100.0	100.0	100.0
Facility TIN	100.0	99.9	
Facility or Business Taxonomy	99.9	12.6	12.6
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 100.0 percent across all data fields. Of note, only 12.6 percent of the records were populated with a taxonomy code in a valid format and with valid values.

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. Only 52 percent of the providers presented in the DSN were contracted or had a contract pending at the time of submission.

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

Provider Specialty Category	Total		Contract Status = Yes		Contract Status = PEND	
	Number	Percent	Number	Percent	Number	Percent
Individual Practitioners						
Primary Care Provider	1,909	18.1	921	48.2	0	0.0
Specialty Provider	6,837	64.8	3,239	47.4	0	0.0
Dental Service Provider	50	0.5	19	38.0	0	0.0
Mental Health Provider	1,395	13.2	701	50.3	0	0.0
SUD Provider	305	2.9	153	50.2	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	51	0.5	26	51.0	0	0.0
Alcohol/Drug	3	0.0	3	100.0	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	12	7.7	12	100.0	0	0.0
Ambulance and Emergency Medical Transportation	0	0.0	0	0.0	0	0.0
Federally Qualified Health Centers	19	12.3	19	100.0	0	0.0
Home Health	5	3.2	5	100.0	0	0.0
Hospice	0	0.0	0	0.0	0	0.0
Hospital	36	23.2	36	100.0	0	0.0
Imaging	0	0.0	0	0.0	0	0.0
Indian Health Service and Tribal Health Services	1	0.6	1	100.0	0	0.0
Mental Health Crisis Services	30	19.4	30	100.0	0	0.0
Community Prevention Services	0	0.0	0	0.0	0	0.0
Non-Emergent Medical Transportation	4	2.6	3	75.0	1	25.0
Pharmacies	1	0.6	1	100.0	0	0.0
Durable Medical Providers	4	2.6	4	100.0	0	0.0
Post-Hospital Skilled Nursing Facility	34	21.9	34	100.0	0	0.0
Rural Health Centers	1	0.6	1	100.0	0	0.0
School-Based Health Centers	5	3.2	5	100.0	0	0.0
Urgent Care Center	3	1.9	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, YCCO'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; health education, health promotion, health literacy providers; or palliative care providers. Additionally, of the 17 required facilities and services, four provider service categories had a count of zero—i.e., ambulance and emergency medical transportation, hospice, imaging services, and community prevention services.

Provider Accessibility

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

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

Provider Specialty Category	Total Providers[1]	Accepting New Patients		Speak Non-English Language	
		Number	Percent	Number	Percent
Primary Care Provider	1,909	170	8.9	104	5.4
Specialty Provider	6,837	35	0.5	229	3.3
Dental Service Provider	50	6	12.0	16	32.0
Mental Health Provider	1,395	0	0.0	7	0.5
SUD Provider	305	0	0.0	5	1.6
Certified or Qualified Health Care Interpreters	0	0	0.0	0	0.0
Traditional Health Workers	51	0	0.0	1	2.0
Alcohol/Drug	3	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	**10,550**	**211**	**2.0**	**362**	**3.4**

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

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

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

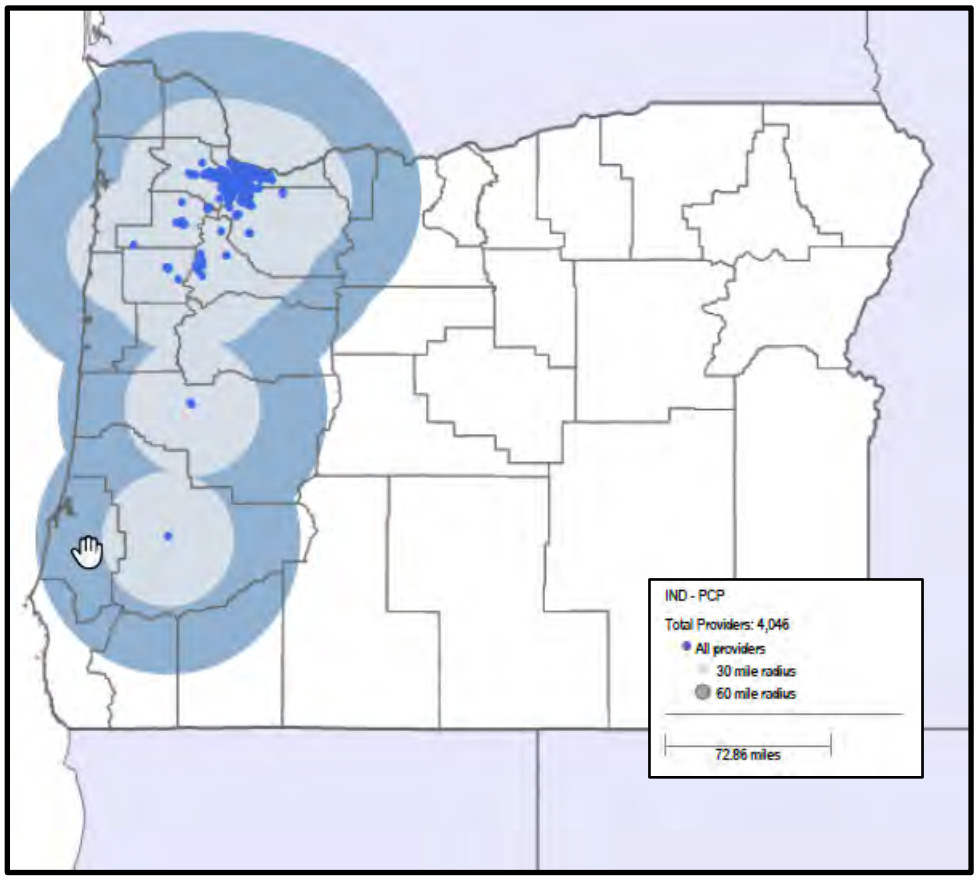
Overall, only 2.0 percent of the YCCO's provider network was accepting new patients according to the CCO's DSN submission, including YCCO's core providers (i.e., physical, oral, and mental health). Less than 15 percent of PCPs (8.9 percent), specialty providers (0.5 percent), and dental service providers (12.0 percent) reported accepting new patients. Zero percent of the mental health or SUD providers reported they were accepting new patients. Of its individual practitioners, only 3.4 percent noted

speaking a language other than English with all core specialty categories reporting less than six percent of the providers speaking a non-English language except for dental service providers (32.0 percent).

Geographic Distribution

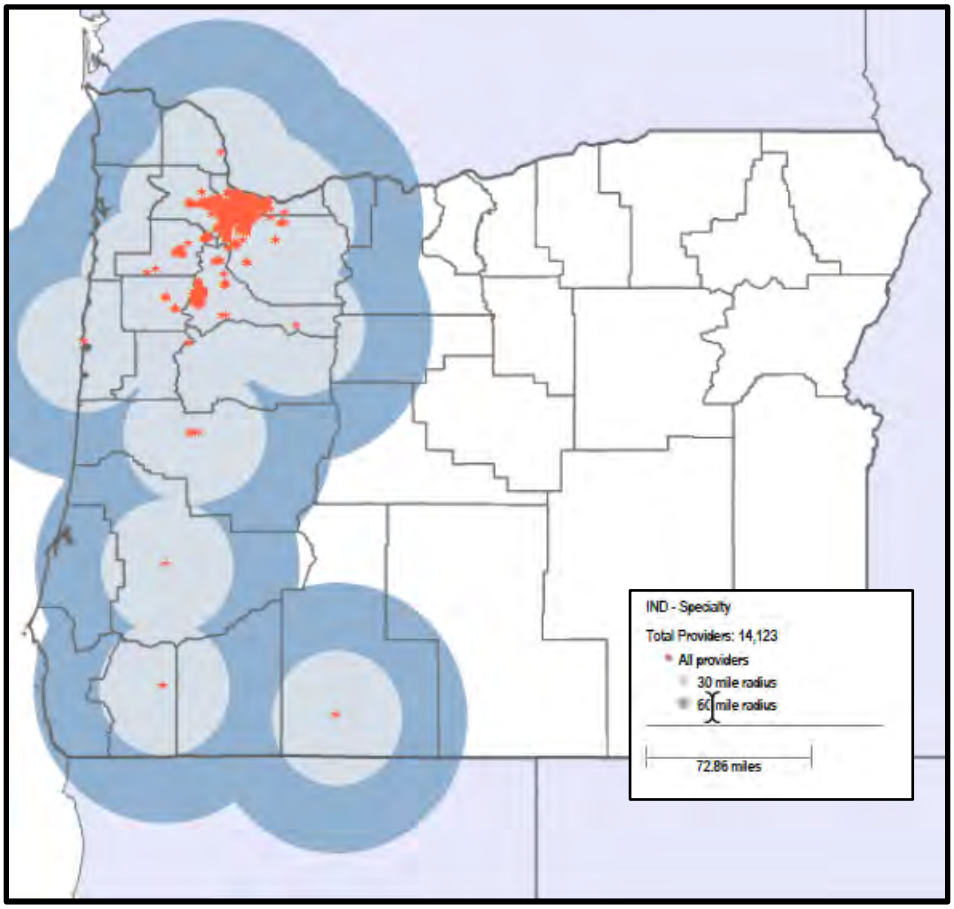
The geographic distribution of providers relative to member populations assessed whether or not the practitioner and facility locations were spread proportionately across the beneficiary population. Since beneficiary data was not available at the time of this analysis, the geospatial maps display the 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. While all the zip codes within YCCO's main service area (i.e., Yamhill County) are classified as rural, the CCO's partial service areas in Polk County and Washington County are a mix of urban and rural areas.

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



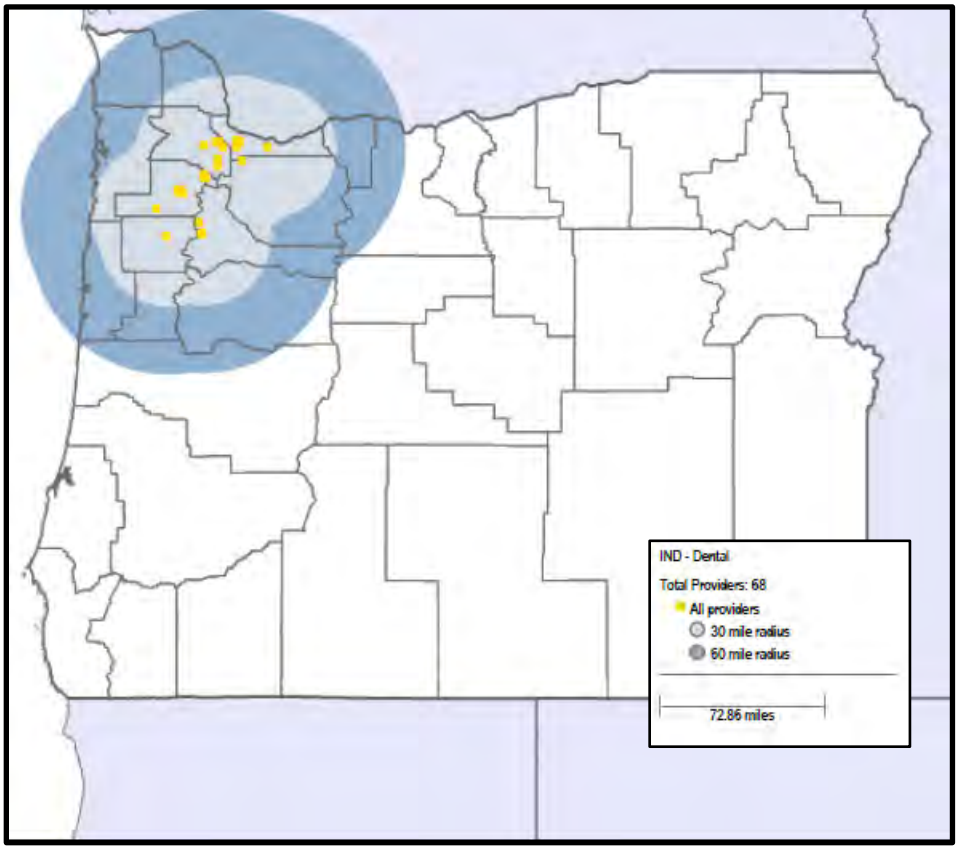
As shown in Figure B-1, the distribution of YCCO's network of PCPs is sufficient to cover the CCO's service area. All regions of the service area are within 30 miles of a primary care provider including rural areas.

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



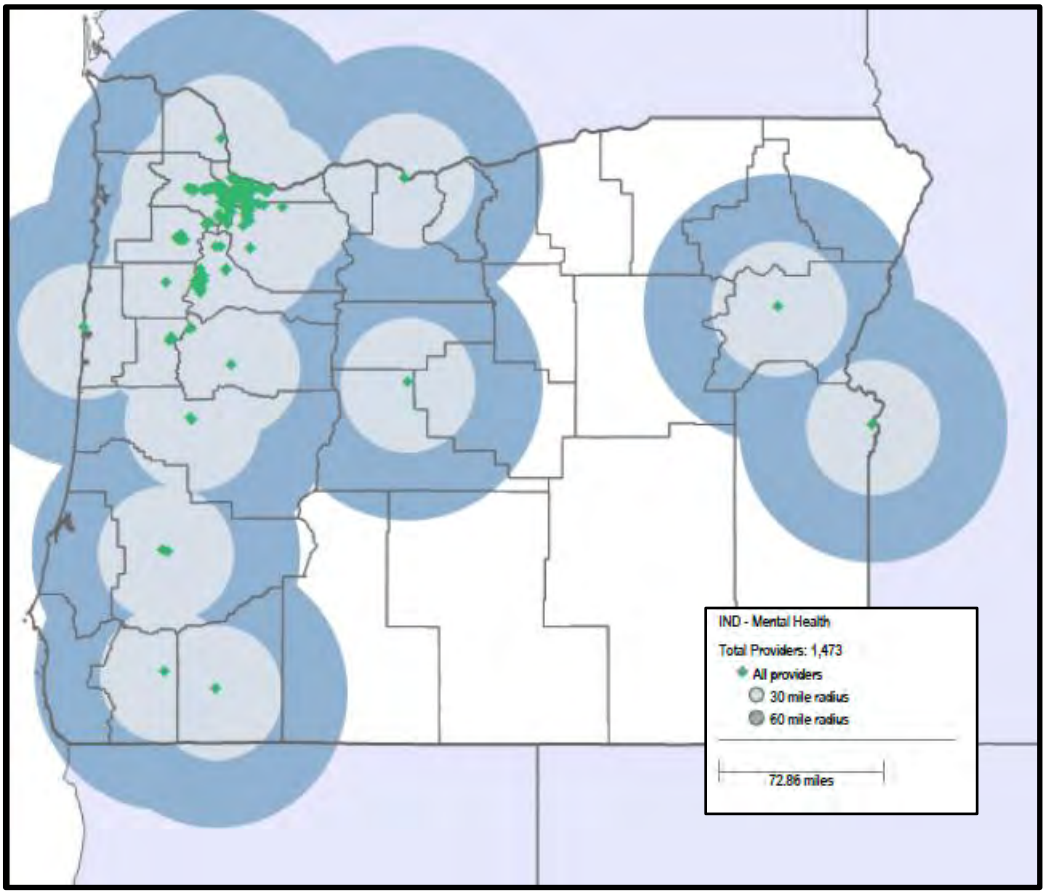
As shown in Figure B-2, the distribution of YCCO's specialty providers is sufficient to cover the CCO's service area. All regions of the service area are within 30 miles of a specialty provider including rural areas.

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



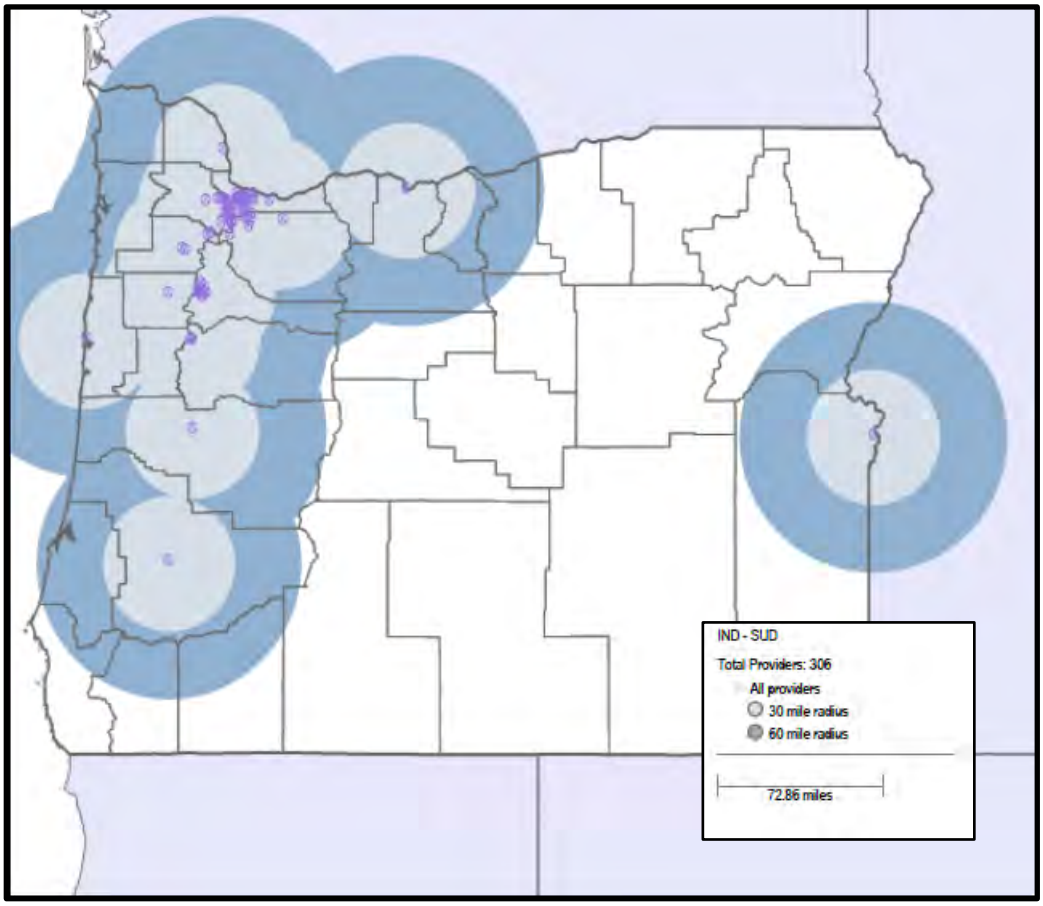
As shown in Figure B-3, the distribution of YCCO's dental service providers is sufficient to cover the CCO's service area. All regions of the service area are within 30 miles of a dental provider including rural areas.

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



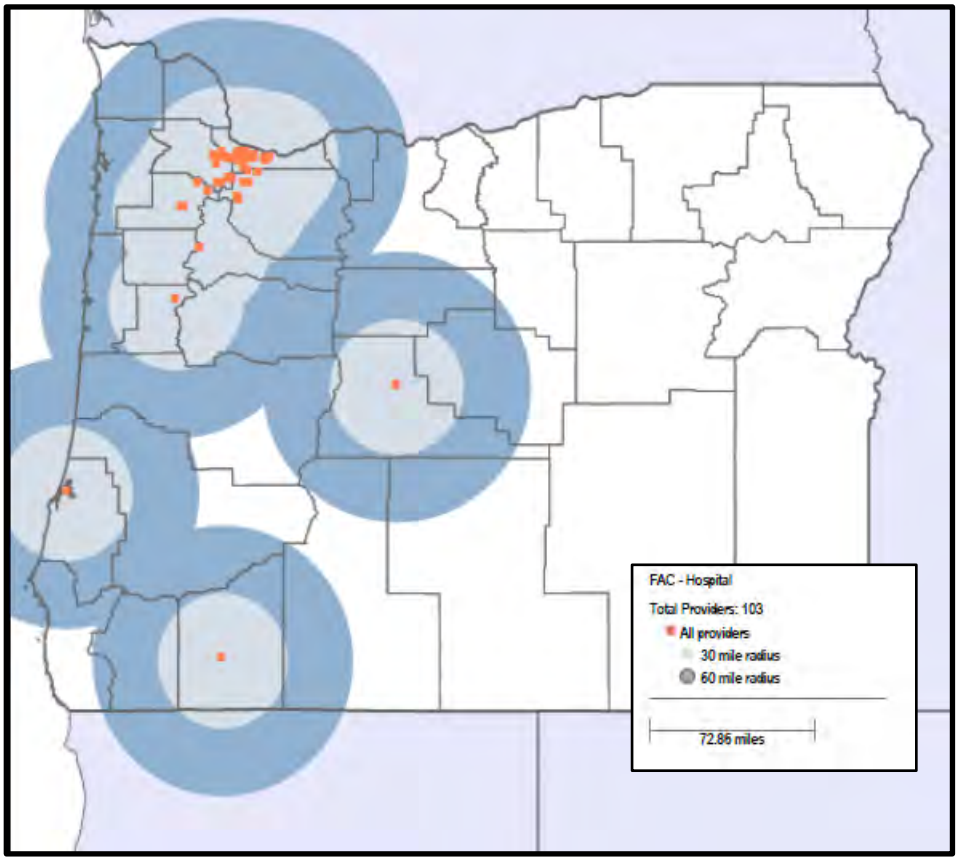
As shown in Figure B-4, the distribution of YCCO's mental health providers is sufficient to cover the CCO's service area. All regions of the service area are within 30 miles of a mental health provider including rural areas.

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



As shown in Figure B-5, the distribution of YCCO's SUD providers is sufficient to cover the CCO's service area. All regions of the service area are within 30 miles of a SUD provider including rural areas.

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



As shown in Figure B-6, the distribution of YCCO's hospital facilities is sufficient to cover the CCO's service area. All regions of the service area are within 30 miles of a hospital including rural areas.

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

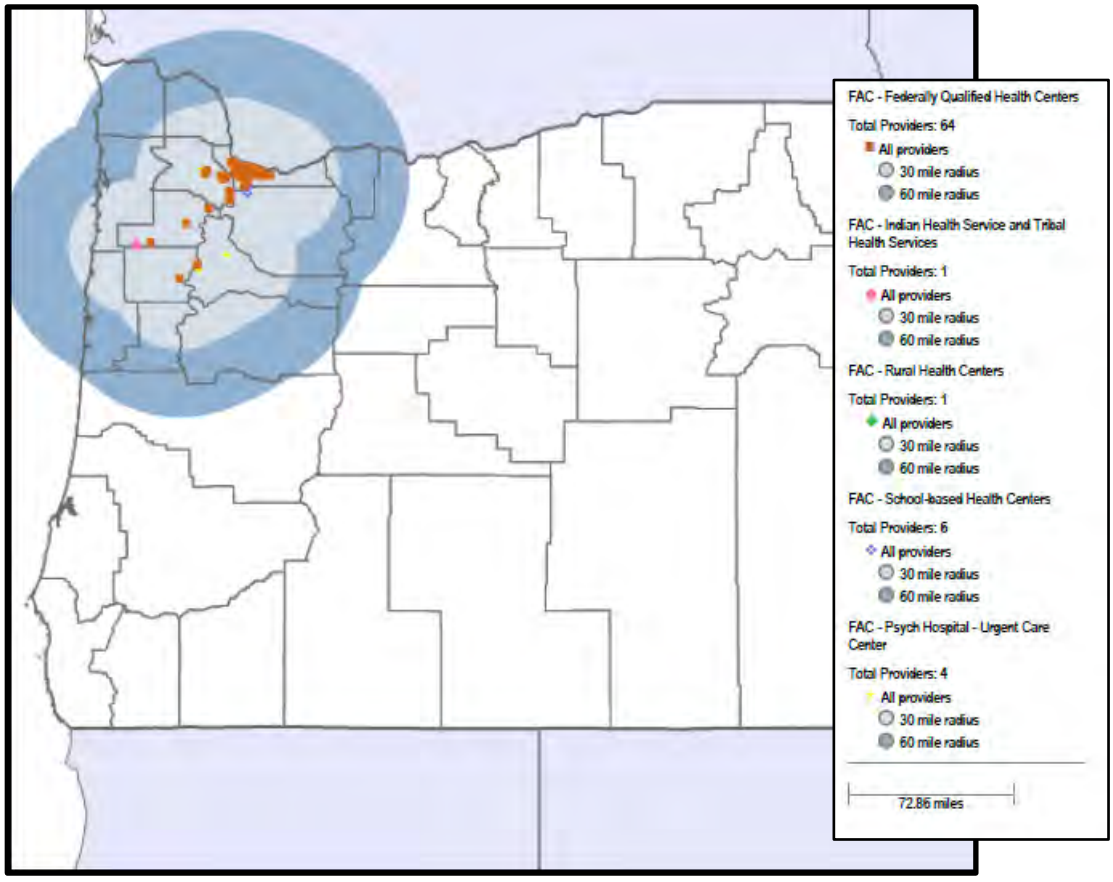


Figure B-7 displays the distribution of several clinic-based facilities within YCCO's service areas, including FQHCs, Indian Health Services and Tribal Health Services, Rural Health Centers, School-Based Health Centers, and Urgent Care Centers. The map shows that the distribution of clinic-based facilities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

Appendix C. Phase 2 Evaluation Tool

[Pending completion of the Phase 2 RR]