Oregon Health Authority

2019 CCO Readiness Review

for

Cascade Health Alliance

September 2019

Interim Report

HSAG HEALTH SERVICES ADVISORY GROUP

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

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 the CCOs' health information systems.
- 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 Cascade Health Alliance (CHA), 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.

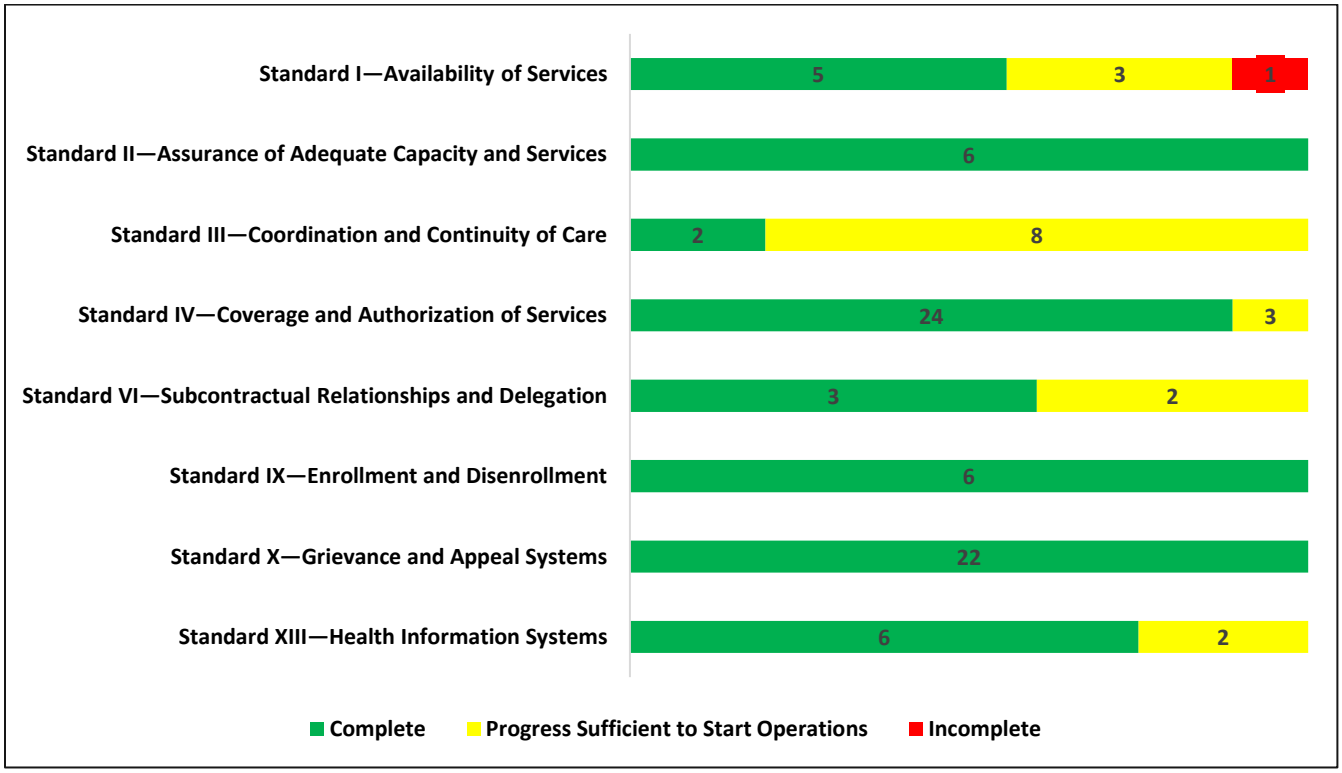
2. Phase 1 Results

Across all eight standards, CHA's overall percentage of complete elements is 79.6 percent. The CCO demonstrated:

- *Complete* ratings for 74 of the 93 total elements.
- *Progress Sufficient to Start Operations* ratings for 18 elements across five standards.
- *Incomplete* ratings for one element, indicating and area of greater deficiency. This area will *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—CHA Phase 1—Critical Areas Readiness Review Results



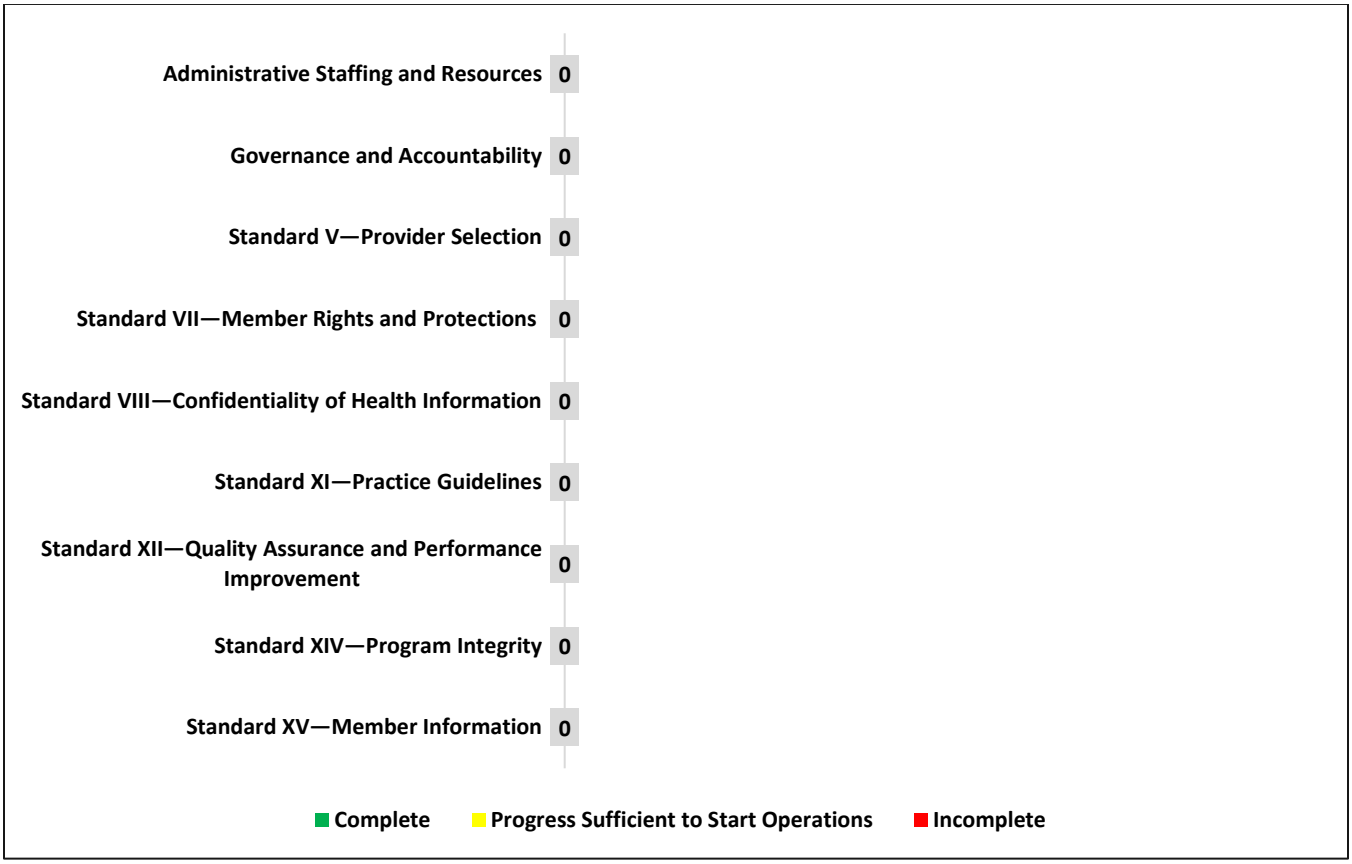
3. Phase 2 Results

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

Across all eight standards, CHA'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—CHA 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 CHA'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)*	**Provider.Network.Timely.Access.PP07002.pdf – pages 1-4**	☒ 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)*	• **PNMC.Charter.pdf – page 1** • **DSN.Capacity.Report.xls – tabs 1 & 2** • **DSN.Provider.pdf – page 2** • **GeoMap.Alt.Providers.pdf** • **Roadmap.Alt.Providers.pdf** The "PNMC.Charter.pdf" describes the role of CHA's Provider Network Management Committee (PNMC) in monitoring and evaluating the network monthly to ensure adequate access to services for all members, including those with special needs, disabilities or limited English proficiency. We have provided the "DSN.Capacity.Report.xls" and "DSN.Provider.pdf" documents to demonstrate our current network adequacy. NEMT related grievances and utilization is monitored to ensure sufficient access is available for all members. The "GeoMap.Alt.Providers.pdf" specifically outlines local providers for alternative therapies and traditional health workers, and we have provided the	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	"Roadmap.Alt.Providers.pdf" document to outline our plan to expand the provider network for them.	
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)*	• **Provider.Directory.pdf – page 6**	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: Based on a review of the CCO's member handbook and Prior Authorization policy, the CCO covers women's exams and allows one initial and two follow-up visits with specialists without requiring a referral. However, during the interview, CHA staff members further clarified that claims for those services are not denied. As such, while the CCO's policies allow limited direct access to women's healthcare services, they also place an administrative burden on providers and members by requiring referral after three visits even though claims submitted for a fourth visit would be paid.		
Required Actions: The CCO should update its policies and procedures to ensure they align with its processes and remove any barriers for women seeking direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive healthcare, including initial and follow-up care.		
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)*	• **Second.Opinion.PP06015.pdf** • **Member.Handbook.pdf – page 18** • **Auth.Grid.pdf – page 2** Our "Second.Opinion.PP06015.pdf" policy and procedure outlines our mechanism to allow members to obtain a second opinion at no cost. This is also mentioned in our Member Handbook ("Member.Handbook.pdf") on page 18 and outlined in our Authorization Grid ("Auth.Grid.pdf") on page 2.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	• **Non-Participating.Providers.PP07020.pdf – page 1** The "Non-Participating.Providers.PP07020.pdf" policy and procedure outlines that CHA works with non-contracted (i.e., participating) providers when needed – including coordinating payment and no incurred costs to the member – to ensure members always receive medically necessary covered services in a timely manner.	☒ 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)*	• **DSN.Provider.pdf – pages 1-2** • **GeoMap.Provider.Network.pdf – page 2** • **DSN.Capacity.Report.xls – tabs 1 & 2** • **Member.Handbook.pdf – pages 6, 14** The "DSN.Provider.pdf", "DSN.Capacity.Report.xls" and "GeoMap.Provider.Network.pdf" documents demonstrate that our network includes sufficient family planning providers to ensure timely access for covered services. Additionally, our handbook states that CHA members may choose their providers for family planning services and may self-refer to out of network providers who will take the Oregon Health ID card for these services.	☒ 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,	• **KBBH.Card.Email.pdf** • **KBBH.Access.Policy.pdf** • **Non.Discriminiation.PP07014.pdf**	☐ 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.	• **KBBH.Master.Policy.pdf** CHA contracts with multiple providers for specialty behavioral health services with the vast majority of services being rendered by Klamath Basin Behavioral Health (KBBH). KBBH has an open access scheduling system and doesn't waitlist patients, see "KBBH.Card.Email.pdf" While most of the priority populations and accompanying timeframes are not explicitly listed in "KBBH.Access.Policy.pdf", KBBH access meets these standards and the KBBH entry and assessment 309-019-0135 language and CHA's policy "Non-Discrimination.PP07014" cover these populations. Supporting documentation also includes "KBBH.Master.Policy.pdf".	☒ 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*		
HSAG Findings: The CCO's Behavioral Health Access policy and information provided during the remote interview session defined appointment availability to behavioral health services without the need for waitlists, including access to walk-in assessments. However, no documentation was provided to address timeliness for priority populations accessing covered specialty behavioral health services.		
Required Actions: The CCO should update its policies to include timeliness provisions for providing specialty behavioral health services to priority populations as required.		
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.	• **Provider.Network.Timely.Access.PP07002.pdf** • **Grievance.Reporting.DP2001.pdf** • **Dashboard.Samples.pdf**	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
e. *Urgent oral care:* Within one (1) to two (2) weeks or as indicated in the initial screening. f. *Routine oral care:* Within eight (8) to twelve (12) weeks, or the community standard, whichever is less. g. *Non-urgent behavioral health treatment:* Seen for an intake assessment within two (2) weeks of the request. *42 CFR §438.206(c)(1)(i)* *Contract Exhibit B Part 4 (2)(a)*		
HSAG Findings: While the CCO's Provider Network Timely Access policy included the required timeliness standards, its Behavioral Health Access policy defined emergency care timeliness as appointments being provided within 24 hours of initial contact and did not include the provision of immediate emergency care.		
Required Actions: HSAG recommends that the CCO update its Behavioral Health Access policy to include immediate timeliness provisions for emergency care, and ensure all CCO policies are aligned and consistent.		
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)*	• **CLAS.Roadmap.pdf** • **Training.Roadmap.pdf** • **HE.Roadmap.pdf** • **Interpretive. Services.PP13002.pdf – pages 1-2** • **Member.Handbook.pdf – page 2, 4, 5, 7, 21, 23** CHA is developing a multi-layer plan – including staffing, training, tools, and policy development – for stronger alignment with the State's efforts and to help promote the delivery of services to all members in a culturally competent manner that meet their unique needs. CHA's plan will include all member needs including English proficiency, cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard I—Availability of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Our Member Handbook ("Member.Handbook.pdf") provides further evidence of CHA's participation in the State's efforts to promote services in cultural and language appropriate manners for all members.	
HSAG Findings: While CHA documentation identified the promotion of culturally competent care via health equity planning efforts, training opportunities for providers and staff members, and statements in the member handbook, the CCO's provider materials and operational policies (i.e., Nondiscrimination, Cultural Competency, and Behavioral Health Access policies, and the Provider Manual) did not all include provisions related to sexual orientation or gender identity.		
Required Actions: HSAG recommends that the CCO update its policies and provider manual to include all nondiscrimination protected classes.		
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	**5**
Progress Sufficient	**3**
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*	• **DSN.Capacity.Report1.xls – tabs 1 & 2** • **DSN.Provider.Narrative.pdf – pages 1-2** • **GeoMap.Provider.Network.pdf. – pages 1,2,5,7** • **DSN.Reporting.PP07018.pdf – pages 1-2** • **GeoMap.Process.pdf** Following OHA's specified formatting and timing, CHA submits provider network documentation within the required Delivery System Network (DSN) Report ("DSN.Provider.pdf"). CHA uses Provider Network Adequacy Mapping tools ("GeoMap.Provider.Network.pdf") to evaluate network access based on physical locations of both members and providers. This data is analyzed to ensure CHA maintains a sufficient panel of providers throughout the service area to meet the needs of members. Our "DSN.Reporting.PP07018.pdf" and "GeoMap.Process.pdf" provide details on our processes to follow OHA's specifications for documentation submission regarding adequacy standards.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
2. The CCO submits the documentation described above as specified by the State, but no less frequently than the following: a. At the time it enters into a contract with the State. b. On an annual basis.	• **DSN.Reporting.PP07018.pdf – pages 1-2** The "DSN.Reporting.PP07018.pdf" policy and procedure outlines that CHA follows OHA's specified timing requirements when submitting provider network documentation via the Delivery System Network (DSN) Report to the State.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
c. At any time there has been a significant change (as defined by the State) in the CCO's operations that would affect the adequacy of capacity and services, including: i. Changes in the CCO's services, benefits, geographic service area, composition of or payments to its provider network; or ii. Enrollment of a new population. *42 CFR §438.207(c)(1-3)* *Contract: Exhibit G*		
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)*	• **GeoMap.Provider.Network.pdf. – pages 1,2,5,7** • **DSN.Provider.pdf – pages 1&2** As a CCO in a rural community, CHA uses Provider Network Adequacy Mapping tools ("GeoMap.Provider.Network.pdf") to evaluate time and distance access standards based on locations of both members and providers. This ensures our PCP (adult, pediatric, PCPCH) OB/GYN, BH and Oral Health providers are within 60 minutes or 60 miles for nearly all our members. The DSN Provider report narrative ("DSN.Provider.pdf") includes CHA's evaluation details on all required access standards. All are over the 90% threshold.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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.	• **GeoMap.Provider.Network.pdf. – pages 1,2,5,7** • **DSN.Provider.pdf – pages 1&2** As a CCO in a rural community, CHA uses Provider Network Adequacy Mapping tools	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	("GeoMap.Provider.Network.pdf") to evaluate time and distance access standards based on locations of both members and providers. This ensures our PCP (adult, pediatric, PCPCH) OB/GYN, BH and Oral Health providers are within 60 minutes or 60 miles for nearly all our members. The DSN Provider report narrative ("DSN.Provider.pdf") includes CHA's evaluation details on all required access standards. All are over the 90% threshold.	☐ 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)*	• **GeoMap.Provider.Network.pdf. – pages 1,2,5,7** • **DSN.Provider.pdf – pages 1&2** As a CCO in a rural community, CHA uses Provider Network Adequacy Mapping tools ("GeoMap.Provider.Network.pdf") to evaluate time and distance access standards based on locations of both members and providers. This ensures our hospital and emergency services are within 60 minutes or 60 miles for nearly all our members. The DSN Provider report narrative ("DSN.Provider.pdf") includes CHA's evaluation details on all required access standards. All are over the 90% threshold.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
6. Pharmacy—Time and Distance: a. In urban areas - Thirty (30) minutes or thirty (30) miles from the personal residences of members.	• **GeoMap.Provider.Network.pdf. – pages 1,2,5,7** • **DSN.Provider.pdf – pages 1&2** As a CCO in a rural community, CHA uses Provider Network Adequacy Mapping tools ("GeoMap.Provider.Network.pdf") to evaluate time	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete

Standard II—Assurance of Adequate Capacity and Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	and distance access standards based on locations of both members and providers. This ensures our pharmacy services are within 60 minutes or 60 miles for nearly all our members. The DSN Provider report narrative ("DSN.Provider.pdf") includes CHA's evaluation details on all required access standards. All are over the 90% threshold.	☐ NA

Standard II—Assurance of Adequate Capacity and Services	
	Total #
Complete	**6**
Progress Sufficient	**0**
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)*	• **Coordination.Members.Web.pdf** • **New.Member.Out.DP13001.pdf – pages 1-2** • **Care.Coordination.PP06009.pdf – pages 1-4** • **Case.Closure.PP06003.pdf – pages 1-2** Our New Member Outreach process "New.Member.Out.DP13001.pdf" demonstrates that we provide the member with information on how to contact their designated person or entity. Additionally, we have included a screenshot from our website "Coordination.Members.Web.pdf" showing we have made the phone number for case management publicly available. Our Care Coordination policy and procedure "Care.Coordination.PP06009.pdf" and case management closure policy "Case.Closure.PP06003.pdf" demonstrate that we have a standardized approach in place for transition planning and follow-up.	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: According to the New Member Outreach policy, members will receive a letter identifying their primary care provider (PCP) and primary dental provider assignment along with contact phone numbers. The phone number for case management/care coordination was available to members via the CHA website. The Care Coordination policy and procedure stated that, for transitional care coordination, including appropriate discharge planning for short-term and long-term hospital and institutional stays, the case manager will assess the level of care to which the member is transitioning to assure it meets the member's needs; work with the provider, community resources, and State agencies to ensure the needs of the member are met; and coordinate with other health plans serving the member. No other policies, procedures, or workflows related to transitions of care were provided by the CCO.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Required Actions: HSAG recommends that the CCO develop and implement specific transition of care policies and procedures consistent with the requirements in the OHA contract.		
2. The CCO coordinates the services it furnishes to the member: a. Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays; b. With the services the member receives from any other MCO, PIHP, or PAHP; c. With the services the member receives in FFS Medicaid; and d. With the services the member receives from community and social support providers. *42 CFR §438.208(b)(2)* *Contract: Exhibit B Part 4 (1)(c)*	• **Care.Coordination.PP06009.pdf – pages 1-4** • **Case.Closure.PP06003.pdf – pages 1-2** Our care coordination policy and procedure "Care.Coordination.PP06009.pdf" address these requirements on pages 1-4. Our Case Management Closure Policy "Case.Closure.PP06003.pdf" provides further support on pages 1 and 2.	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: The Care Coordination policy and procedure provided by the CCO was general in nature and included contract language but no specific processes for actually conducting care coordination activities. While staff members could speak to it, the CCO did not have any policies, procedures, or workflows related to transitions of care.		
Required Actions: HSAG recommends that the CCO revise or create policies and procedures that describe the processes for coordinating services for members and coordinating transitions of care.		
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)*	• **HRA.Follow.DP06002.pdf** • **HRA.Screening.Tool.pdf** • **CM.HRA.Screenshot.pdf** Our Health Readiness Assessment Desktop Process "HRA.Follow.DP06002.pdf" outlines our process for	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	conducting the initial screening of member needs within 30 days of the effective date of enrollment. We have included our Health Risk Assessment Screening tool, "HRA.Screening.Tool.pdf" which is used to capture member needs upon enrollment. We have included a screenshot from our Essette tool (CM.HRA.Screenshot.pdf) to demonstrate that we document subsequent attempts for cases in which the initial attempt to contact the member is unsuccessful.	
HSAG Findings: The Health Risk Assessment Follow-Up Desktop Process described processes used by the CCO once a health risk assessment (HRA) is returned by a member, but it did not explain the processes for actually conducting the initial screening. Following the remote interview session, CHA provided several newly created policies describing the HRA process. During the remote interview session, CHA staff members stated that they mail the HRA with the new enrollment packet and conduct a welcome call to the member within 30 days of enrollment to explain benefits and answer any questions, and remind the member to return the HRA. The CCO does not do any subsequent outreach attempts to get the HRA completed. The mailing of the survey and welcome call were documented in the Essette care management system. Any returned surveys are reviewed by nurse case managers and referred to case management if any needs are identified.		
Required Actions: While the CCO has a process for conducting the initial screening, HSAG recommends that the CCO revise processes to ensure subsequent attempts are made to get the initial survey completed.		
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	• **Contract.Review.Roadmap.HS.pdf – pages 1-3** Our service agreements with specialty and hospital providers do not currently include the requirements listed; however, we will be adding these requirements into our service agreements by 1/1/2020; additional detail can be found in the Specialty Providers Contract Roadmap and Hospital Contract Roadmap (Contract.Review.Roadmap.HS.pdf). listed; however, we will be adding these requirements into our service agreements by 1/1/2020.	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
– At the time of Hospital discharge for the purpose of facilitating after-Hospital follow up appointments and care. *Contract: Exhibit B Part 4 (9)*		
HSAG Findings: CHA provided roadmaps and timelines for updating the service agreements with specialty and hospital providers to include the required language as specified in the OHA contract. During the remote interview session, CHA staff members stated that they are on track to have the provider agreements updated and executed by January 1, 2020.		
Required Actions: While it is clear that CHA understands the requirements, HSAG recommends that the CCO provide evidence that the hospital and specialty provider contracts have been updated to include the coordination role of patient-centered primary care, processes for requesting hospital admission or specialty services, and performance expectations for communication and medical record sharing at the time of hospital admission and discharge.		
5. The CCO has processes in place to ensure that: a. Hospitals and specialty service providers are accountable for achieving successful transitions of care. b. Primary care teams are responsible for transitioning members out of hospital settings into the most appropriate, independent, and integrated care settings, including home and community-based as well as hospice and other palliative care settings. *Contract: Exhibit B Part 4 (9)*	• **Readmissions.PP03006.pdf** • **Contract.Review.Roadmap.HS.pdf - pages 1-3** • **PCPCH_Transitions.pdf – pages 70-71** • **Contract.Review.Roadmap.PCP.pdf** a. Hospitals are held accountable for successful transitions of care by nonpayment for readmission for related diagnoses within 30 days. See "Readmissions.PP03006.pdf" b. CHAs PCPs are all PCPCH level 3 or higher and as such are required to coordinate hospital transitions through a documented-- 1. Process and performance expectations for communication at the time of hospital discharge.	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	2. Process and performance expectations for scheduling after-hospital follow up appointments. (See pages 70-71 of the OHA PCPCH standards) CHA will be adding explicit language to our hospital, specialty, and PCP contracts by 1/1/2020 to mandate these requirements, details of which can be found in the three roadmaps indicated above.	
HSAG Findings: The CCO did not have any defined processes for ensuring that hospital, specialty, or PCPs were accountable for achieving successful transitions of care. During the remote interview session, CHA staff members stated they are in the process of updating provider agreements to include the CCO's expectations related to transitions of care. CHA is on track to have the updated provider agreements executed by January 1, 2020.		
Required Actions: While it is clear that the CCO understands the requirements, HSAG recommends that CHA implement processes to monitor and ensure that specialty and hospital providers, and primary care teams are accountable for achieving successful transitions of care.		
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)*	• **ICCM.PP06006.pdf – pages 1-3**	☒ 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)*	• **Privacy.Notice.pdf** • **Member.Handbook.pdf– pages 24-27** Our Privacy Notice (Privacy.Notice.pdf) covers these requirements. In addition, our Member Handbook (Member.Handbook.pdf) contains language supporting this requirement on pages 24 through 27.	☒ 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)*	• **ICCM.PP06006.pdf – pages 1-3** • **ICCM.Plan.pdf** • **HRA.Screening.Tool.pdf** Our ICCM P&P (ICCM.PP06006.pdf) provides detail on our mechanisms to assess members needing LTSS or special health care services. Additionally, our ICCM.Plan.pdf describes our commitment to increase our staffing levels to best meet the needs of this population. OHA has approved the attached Health Risk Assessment screening tool, see HRA.Screening.Tool.pdf.	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: Based on the documentation provided, it did not appear that CHA had a process in place to conduct a comprehensive assessment on each member identified as needing long-term services and supports (LTSS) or having special healthcare needs. During the remote interview session, staff members stated that they are in the process of implementing a comprehensive assessment process using the Essette care management system. The CCO was able to demonstrate the care management system and the assessment tool being implemented was comprehensive. The CCO expects to fully implement the assessment process in December 2019. Following the remote interview session, CHA provided a revised Care Coordination Policy and Procedure which included more information about the comprehensive assessment process but was still missing specific information such as timeframes for completing the comprehensive assessment, how the assessment is completed (telephonically, face-to-face), and where the assessment information is captured (care management system).		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Required Actions: HSAG recommends that the CCO revise policies and procedures for conducting the comprehensive assessment to include specificity as to who conducts the assessment, the time frames for completion, and tracking and reporting mechanisms to ensure assessments are being completed timely and accurately.		
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)*	• **ICCM.PP06006.pdf – pages 1-3** • **ICCM.Plan.pdf** Our ICCM P&P (ICCM.PP06006.pdf) provides detail on our policies and procedures for identifying, assessing and producing a treatment plan for members identified as having a special healthcare need. Additionally, our ICCM Plan describes our commitment to increase our staffing levels to best meet the needs of this population.	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: The Intensive Care Coordination and Case Management policy and procedure provided by CHA did not explain the processes for identifying, assessing, and producing a treatment plan for each member with special healthcare needs. Following the remote interview session, CHA provided an updated Care Coordination Policy and Procedure and an updated Intensive Care Coordination and Case Management Policy and Procedure which included more detailed information related to the identification of members with special health care needs and the comprehensive assessment process. Additional information about the treatment planning process was also included however it was general in nature and timeframes for updating the treatment plans was not consistent with the OHA contract and federal regulations.		
Required Actions: HSAG recommends that the CCO revise policies and procedures to include more specificity related to the treatment planning process and ensure that timeframes for updating the treatment plans are consistent with State and federal regulations.		
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.		

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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.		
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.	• **ICCM.PP06006.pdf – pages 1-3** • **ICCM.Plan.pdf** • **Auth.Grid.pdf** Our ICCM P&P (ICCM.PP06006.pdf) provides detail on our policies and procedures in place to allow members to directly access a specialist as appropriate. Our Authorization Grid (Auth.Grid.pdf) further	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard III—Coordination and Continuity of Care		
Requirement	**Evidence as Submitted by the CCO**	**Score**
42 CFR §438.208(c)(4) *Contract: Exhibit B Part 4 (2)(f)(2)*	demonstrates that members can directly access a specialist without a referral or approved number of visits. Finally, our ICCM Plan (ICCM.Plan.pdf) describes our commitment to increase our staffing levels to best meet the needs of this population.	
HSAG Findings: The Intensive Care Coordination and Case Management policy and procedure provided by CHA did not explain the CCO's policies and procedures for ensuring direct access to specialists for members identified as having a special healthcare need. The CCO provided a Prior Authorization Grid that indicated an initial specialist visit and two follow-up appointments are allowed without prior authorization. Any subsequent specialist visits require a prior authorization request be submitted by the PCP or specialist. During the remote interview, CHA staff members stated that the utilization management department and the case management department work together to ensure members with special healthcare needs have direct access to specialists. Following the remote interview session, CHA provided a document describing how the CCO will monitor to ensure direct access to specialists for ICCM members, but it still does not explain how direct access processes are implemented by the CCO.		
Required Actions: HSAG recommends that the CCO revise policies and procedures to describe the processes implemented by the CCO to ensure all members with special healthcare needs have direct access to a specialist.		

Standard III—Coordination and Continuity of Care	
	Total #
Complete	**2**
Progress Sufficient	**8**
Incomplete	**0**
Not Applicable (NA)	**3**

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. In accordance with 42 C.F.R. §438.210, the CCO has processes in place to provide covered services outlined in the Contract that is no less than the amount, duration, and scope of the same services to beneficiaries under FFS Medicaid, as set for in 42 C.F.R. §440.230, and for members under the age of 21, as set forth in 42 C.F.R. subpart B of part 441. The CCO: a. Must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished. b. May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary. *42 CFR §438.210(a)(3)(i-ii)* *Contract: Exhibit B Part 2 (2)(a-b)*	• **Coverage.Services.PP06021.pdf – pages 1-2** • **Non.Discrimination.PP07014** The "Coverage.Services.PPXX.pdf" and "(Non.Discrimination.PP07014)" policies and procedures are in place to ensure that CHA provides covered services per the contract – at the same level or better than FFS Medicaid beneficiaries in amount, duration, and scope – regardless of diagnosis, type of illness or condition.	☒ 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 iii. Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose	• **Coverage.Services.PP06021.pdf – pages 1-2**	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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*		
HSAG Findings: The documentation submitted by the CCO did not describe how prior authorization requests for individuals with chronic conditions or who require LTSS are authorized in a manner that reflects the member's ongoing need for such services and supports. However, during the remote interview session with HSAG, the CCO explained how it identifies such individuals and gave an overview of the case management process.		
Required Actions: HSAG recommends that the CCO revise the applicable policies and procedures to include information that specifically addresses the authorization process for members with chronic conditions or who require LTSS.		
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)*	• **MH.Parity.PP06022.pdf – pages 1-2** • **Auth.Grid.pdf** • **BH.Auth.Grid.pdf** • **OHA.Parity.Analysis.pdf – page 13** The MH.Parity.PP06002.pdf policy and procedure is in place to ensure that CHA's utilization and prior-authorizations for Behavioral Health benefits and access are no more restrictive than those applied to physical health benefits. For further evidence, we have included our medical/surgical Authorization Grid (Auth.Grid.pdf) and Behavioral Health Authorization Grid (BH.Auth.Grid.pdf). Lastly, we have included a summary page from OHA's Parity Analysis (OHA.Parity.Analysis.pdf) that indicates we fully met all parity requirements at the time of analysis and did not require any corrective action.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	• **Coverage.Services.PP06021.pdf – pages 1-2** • **MH.Parity.PP06022.pdf – pages 1-2** • **Audit.Roadmap.pdf – page 3** • **Auth.Grid.pdf** • **BH.Auth.Grid.pdf** • **OHA.Parity.Analysis.pdf – page 13** CHA has policies and procedures in place (see "Covered.Services.PPXX.pdf" and "MH.Parity.PP06022.pdf") to ensure that CHA's financial requirements and treatment limits for Behavioral Health – regardless of class – are no more restrictive than those applied to physical health financial requirements and treatment limits in the same class. For further evidence, we have included our medical/surgical Authorization Grid (Auth.Grid.pdf) and Behavioral Health Authorization Grid (BH.Auth.Grid.pdf). Lastly, we have included a summary page from OHA's Parity Analysis (insert name) that indicates we fully meet all parity requirements at the time of analysis and did not require any corrective action.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
5. The CCO must furnish medically necessary services as defined in the Contract and in a manner that: a. Is no more restrictive than that used in the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and	• **Coverage.Services.PP06021.pdf – pages 1-2** • **Audit.Roadmap.pdf – page 3**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*		☐ NA
6. The CCO establishes and adheres to written policies and procedures for both the initial and continuing service authorization requests consistent with utilization control requirements of 42 CFR Part 456. Policies and procedures must include: a. Mechanisms to ensure consistent application of review criteria for authorization decisions; b. Consultation with the requesting provider for medical services when appropriate. c. A process to ensure that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an 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)*	• **Coverage.Services.PP06021.pdf – pages 1-2**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
7. The CCO's utilization management policies are not structured in a way to provide incentives for its provider network, employees or other utilization reviewers to inappropriately deny, limit or discontinue medically appropriate services to any member. *42 CFR §438.210(e)* *Contract: Exhibit B Part 2 (2)(d)*	• **Authorization.PP06001.pdf – pages 1-3** • **Utilization.Review.PP06005** We have provided two policies and procedures that provide evidence that our utilization management policies are in compliance with this requirement.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
8. The CCO operates a drug utilization review program that complies with the requirements described in section 1927(g) of the Act and 42 CFR part 456, subpart K. *42 CFR §438.3(s)(4)* *Contract: Exhibit B Part 2 (4)(g)(2)*	• **cDUR.ProDUR.pdf** • **POS.DUR.Logic.pdf** • **FAX.Blast.ProDUR.pdf** • **DUR.Survey.pdf** • **Provider.Letter.pdf** • **Retrospective.DUR.ED.pdf** • **DUR.Board.Activities.pdf** CHA utilizes MedImpact's Point of Sale Concurrent and Prospective Drug Utilization Review (cDUR and ProDUR) alerts. By default, most MedImpact ProDur alerts are informational including one-level messages and do not require a pharmacist's response. A few DUR alerts are configured to stop or deny a claim (i.e. Refill-Too-Soon). In limited denial cases, pharmacists are allowed to override a denial using the appropriate NCPDP drug evaluation codes. MedImpact subscribes to First Data Bank to administer (cDUR) and (ProDUR) functions.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	Please find attached the following supporting documentation: – A description of cDUR and ProDUR screening. – POS Logic used during claims processing. – DUR Annual Report for FFY 2018. – Provider letter supporting a Retrospective DUR initiative to reduce morbidity/mortality in patients with Heart Failure. – Retrospective DUR Educational Outreach Summary for 2018. – A Summary of DUR Board Activities conducted in 2018. FAX Blast highlights six components screened for potential drug therapy concerns	
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)*	• **Turnaround.Time.PP06014.pdf – pages 1-2** • **Audit.Roadmap.pdf – page 1** • **Authorization.PP06001.pdf** Members receive written notice of all denials or reductions of services as noted in Authorization.PP06011.pdf and Turnaround.Time.PP06014.pdf. This will be audited as per the 2020 audit plan. Providers are notified of all denials or reductions of services via fax as noted in Authorization P&P.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

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

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
documents, records, and other information relevant to the member's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. l. The member's right to request an appeal with the CCO within 60 days of the CCO's adverse benefit determination, including information on exhausting the CCO's one level of appeal described at §438.402(b) and the right to request a State fair hearing (contested case hearing) within 120 days after issuance of the CCO's Notice of Appeal Resolution or where the CCO failed to meet appeal timelines as outlin4ed in 410-141-3230; and the procedures for exercising these rights described in 410-141-3245. m. The circumstances under which an appeal process can be expedited and how to request it. n. The procedures for exercising the rights specified in this standard. o. The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the member may be required to pay the costs of these services. *42 CFR §438.404(b)* *Contract: Exhibit I (3)(b)*		
11. For standard authorization decisions, the CCO shall provide notice as expeditiously as the member's condition requires and within 14 calendar days following receipt of the request for	• **Audit.Roadmap.pdf** • **Aging.Auth.Report.xls** • **Authorization.PP06001.pdf – pages 1-3**	☐ Complete ☒ Progress Sufficient to Start Operations

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
service, with a possible extension of up to 14 additional calendar days: a. The member, or the provider, requests extension; or b. The CCO justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest. *42 CFR §438.210(d)(1)(i-ii)* *Contract: Exhibit B Part 2 (3)(h)*	Our Authorization policy and procedure ("Authorization.PP06011.pdf") outlines that we will provide notice that meets the standards of the requirement. Additionally, we have provided a report (AgingAuth.Report.xls) that indicates the status of an authorization along with the requested and created dates. Compliance with the policy will be monitored in 2020 as per the Audit.Roadmap.pdf	☐ Incomplete ☐ NA
HSAG Findings: The CCO's Authorization policy indicated that standard authorization requests must be processed within 14 days. The correct reference for a standard authorization request is as expeditiously as the member's condition requires and within 14 calendar days. The CCO's Turnaround Time policy included the correct time requirements.		
Required Actions: HSAG recommends that the CCO revise its Authorization policy to include the correct time frame for providing notice on a standard authorization decision. HSAG also recommends that the CCO review all policies that contain this requirement to ensure the information is complete and accurate.		
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)*	• **Audit.Roadmap.pdf** • **Aging.Auth.Report.xls** • **Timely.Auth.Issues.pdf** • **Authorization.PP06001.pdf – pages 1-3** • **Turnaround.Time.PP06014.pdf – pages 1-2** Our Authorization policy and procedure ("Authorization.PP06011.pdf") outlines that we will provide notice that meets the standards of the requirement. Additionally, we have provided a report (Aging.Auth.Report.xls) that indicates the status of an authorization along with the requested and created dates. The "Expedited" authorizations are all handled within 72 hours. Compliance with the policy will be monitored in 2020 as per the Audit.Roadmap.pdf	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	CHA viewed a demonstration of MedImpact's Prior Auth processing program's capability to provide the necessary reporting for the timeliness of responses to all Prior Authorization requests. CHA will convert to this program and eliminate the need for entering information into non-integrated platforms. The new reporting details the date/time of receipt of request, actions performed, and the date/time of response. The program also alerts the user of any pending requests that are approaching the 24/72-hour deadline. CHA will finalize the decision and plans to implement the program in Q4 2019.	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: The CCO did not submit documentation for the requirements of this element but, in the remote interview session with HSAG, described its internal process and how it assures timeliness standards are met for all covered outpatient drug authorization decisions.		
Required Actions: HSAG recommends that the CCO document in policy that, for all covered outpatient drug authorization decisions, it provides a response within 24 hours in addition to how it assures that the timeliness standard is met.		
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.	• **Prior.Authorization.Term.DP06001.pdf**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
– The member has been admitted to an institution where he/she is ineligible under the plan for further services. – The member's whereabouts are unknown, and the post office returns agency mail directed to him/her indicating no forwarding address. – The agency establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth. – A change in the level of medical care is prescribed by the member's physician. – The notice involves an adverse determination made with regard to the preadmission screening requirements. • If probable member fraud has been verified, the CCO gives notice five (5) calendar days before the date of action. *42CFR438.404(c), 42CFR431.211, 42CFR431.213(a)-(g), 42CFR431.214(a)* *Contract: Exhibit I (3)(c)*		
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)*	• **Em.Post.Stabi.PP06020.pdf – pages 1-2**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
16. The CCO defines Poststabilization Care Services as covered services, related to an emergency medical condition that are provided after a member is stabilized to maintain the stabilized condition, or to improve or resolve the member's condition. *42 CFR §438.114(a)* *Contract: Exhibit A (H)(109)*	• **Em.Post.Stabi.PP06020.pdf – pages 1-2**	☒ 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)*	• Emergent.Services.pdf – pages 1-2 • Emergent.Services.Report.pdf This report pulls emergent services for claims received during a specified time when the report is run. It pulls the claim number(claim_ud) the providers payment contract payment_contract_ud), adjudication at the header and detail (claim_header_status,claim_detail_status), Net payment on the line (net), adjustment/denial reason code with a description (result_code_ud, long_message) and the examiner who adjudicated the claim (claim_examiner_username). Claim_examiner_user name is only identified on claims that have been adjudicated within the last 30 days. This report can be used to identify if emergent services have been denied, and if so, the specific reason the report is run during check write review and incorrectly denied claims are corrected during this time. The report can be filtered using the claim_header_status with the following values: • Approved -Will be moved to accounting during check write. • Closed – The claim has already been paid. • Pend – Claims that are pended for review. • Error – Claims that encounter a technical or processing error.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	• **Em.Post.Stabi.PP06020.pdf – pages 1-2**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
19. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. *42 CFR §422.114(d)(2)* *Contract: Exhibit B Part 2 (4)(a)(9)*	• **Emergent.Services.pdf – pages 1**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
20. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the entities identified in 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)*	• **Em.Post.Stabi.PP06020.pdf – pages 1-2**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
21. Poststabilization care services are covered and paid for in accordance with provisions set forth at 42 C.F.R. §422.113(c). a. The CCO is financially responsible (consistent with §422.214) for post-stabilization care services obtained within or outside the CCO's network that are pre-approved by a plan provider or other organization representative; b. The CCO is financially responsible for post-stabilization care services obtained within or outside the CCO's network that are not pre-approved by a plan provider or other organization representative, but administered to maintain the member's stabilized condition within 1 hour of a request to the CCO for pre-approval of further post-stabilization care services; c. The CCO is financially responsible for post-stabilization care services obtained within or outside the CCO's network that are not pre-approved by a plan provider or other organization representative, but administered to maintain, improve, or resolve the member's stabilized condition if: i. The CCO does not respond to a request for pre-approval within 1 hour; ii. The CCO cannot be contacted; or iii. The CCO's representative and the treating physician cannot reach an agreement concerning the member's 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	• **Em.Post.Stabi.PP06020.pdf – pages 1-2** • **Emergent.Services.pdf – pages 2** • **Emergent.Services.Report.pdf**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
with care of the patient until a plan physician is reached or one of the criteria in §422.113(c)(3) is met. d. Must limit charges to members for post-stabilization care services to an amount no greater than what the organization would charge the member if he or she had obtained the services through the CCO's network. For purposes of cost sharing, post-stabilization care services begin upon inpatient admission. *42 CFR §438.114(e)* *42 CFR §422.113(c)(2)(i-iv)* *Contract: Exhibit B Part 2 (4)(a)(6&8)*		
22. The CCO's financial responsibility for post-stabilization care services it has not pre-approved ends when: a. A plan physician with privileges at the treating hospital assumes responsibility for the member's care; b. A plan physician assumes responsibility for the member's care through transfer; c. A CCO representative and the treating physician reach an agreement concerning the member's care; or d. The member is discharged. *42 CFR §438.114(e)* *42 CFR §422.113(c)(3)(i-iv)* *Contract: Exhibit B Part 2 (4)(a)(7)*	• **Em.Post.Stabi.PP06020.pdf – pages 1-2**	☒ 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)*	• **NEMT.Oversight.PP02019.pdf** • **NEMT.Audit.xls**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

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)*	• **NEMT Program Guide.pdf – page 9**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
25. The CCO has written policies and procedures for Emergency Dental Services and Urgent Care Services for Emergency Dental Conditions that describe when treatment of an emergency or urgent dental condition should be provided in an ambulatory dental office setting and when emergency dental services should be provided in a hospital setting. *Contract: Exhibit B Part 2 (4)(k)(2)*	• **Emergency.Dental.PP06019**	☒ 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)*	• **BH.Monitoring.PP06010 – pages 2** • **MCT.Hospital.Response.pdf** • **MCT.Dispatch.pdf** • **MCT.Community.Assessments.pdf** • **Crisis.Response.Report.1Q_Redacted.pdf** CHA provides 24/7 access to behavioral health crisis management and post stabilization services to its members through its contracted clinical partners as follows: 1. Telephone access to triage and in some cases evaluation 24/7 a. Primary care nurse triage or on call provider b. Klamath Basin Behavioral Health (KBBH)	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
	c. Sky Lakes Medical Center Emergency Room d. Mobile Crisis Team e. Lutheran Community Services Northwest 2. Face to face encounters a. Klamath Basin Behavioral Health walk in services available Monday – Friday b. Lutheran Community Services Northwest c. Primary care provider face to face encounter d. Mobile Crisis Team 24/7 e. Sky Lakes Medical Center Emergency Room 24/7 The majority of crisis management services are provided by the Mobile Crisis Team and KBBH. Mobile Crisis Team practice guidelines for hospital assessment "MCT.Hospital.Response.pdf" and the Mobile Crisis Team encounter log "Crisis.Response.Report.1Q_Redacted.pdf" are attached. CHA monitors all members receiving BH services through Sky Lakes Medical Center Emergency Room and case manages those members to assure that they receive post stabilization services if needed. See "BH.Monitoring.PP06010.pdf".	
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.	• **MCT.Hospital.Response.pdf** • **MCT.Dispatch.pdf** • **MCT.Community.Assessments.pdf** • **MCT.Custody.pdf** • **MCT.Hold.pdf**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard IV—Coverage and Authorization of Services		
Requirement	**Evidence as Submitted by the CCO**	**Score**
Contract: Exhibit M (2)(g)(2)	• **Crisis.Response.Report.1Q_Redacted.pdf** Our Mobile Crisis Services vendor, Klamath Basin Behavioral Health, has guidelines in place to ensure all members have access to Mobile Crisis Services. We have also included a report of Q1 2019 mobile crisis instances that includes response time, source of referral, and disposition.	

Standard IV—Coverage and Authorization of Services	
	Total #
Complete	**24**
Progress Sufficient	**3**
Incomplete	**0**
Not Applicable (NA)	**0**

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. Notwithstanding any relationship(s) that the CCO may have with any subcontractor, the CCO maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with the State. *42 CFR §438.230(b)(1)* *Contract: Exhibit B Part 4(13)*	• **Sub.Delegated.PP07021.pdf – pages 1-3**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
2. All contracts or written arrangements between the CCO and any subcontractor must be submitted to OHA annually and within 30 days of addition of a subcontractor and must include: • The delegated activities or obligations, and related reporting responsibilities. Contractor shall not fully subcontract the provision of Behavioral Health services and Care Coordination to another entity. • The subcontractor agreement to perform the delegated activities and reporting responsibilities specified in compliance with the CCO's obligations. • The contract or written arrangement must either provide for revocation of the delegation of activities or obligations or specify other remedies in instances where the State or CCO determine that the subcontractor has not performed satisfactorily. • The requirements for written agreements as outlined in the CCO's contract with OHA, including fully integrated service delivery and funding (as defined in ORS 414.025). *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)*	• **Sub.Delegated.PP07021.pdf – pages 1-3,8** • **Subcontract.Roadmaps.pdf** Policies and Procedures are in place to ensure CHA's written agreements with subcontractors are submitted to OHA annually or within 30 days of any changes. Contract addendum. The written agreements meet OHA requirements and include the subcontractors' obligations, reporting responsibilities, and compliance standards. All written agreements either provide for revocation of the delegation activities or provide for other remedies if needed.	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: CHA's Subcontractors and Delegated Entities policy and procedure outlines the requirements for written subcontractor agreements. CHA also provided a roadmap and timeline for amending current subcontractor agreements to include all required elements as specified in the OHA contract. A base/template subcontractor agreement was not provided by the CCO. During the remote interview session, CHA staff members stated that they are on track to have the subcontractor agreements updated and executed by January 1, 2020.		
Required Actions: While the submitted policies and procedures provided evidence that CHA understands the requirements of the subcontractor written agreements, HSAG was unable to confirm that all required elements are contained in the agreements as a base/template agreement was not provided. HSAG recommends that CHA provide evidence to OHA that subcontractor agreements have been updated to include all State and federal requirements.		
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)*	• **Sub.Delegated.PP07021.pdf – pages 2, 3, 5, 8** • **Sub.Cred.Audit.Tool.pdf** • **Credentialing.PP09002.pdf** Policies and Procedures are in place for CHA to perform readiness audits of all prospective contractors to ensure the scope of work detailed in the subcontractors' written agreements can be met prior to the contract effective date. These evaluations are submitted to OHA with the Subcontractor and Delegated Entity Report within 30 days of a subcontractor being added.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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)*	• **Sub.Delegated.PP07021.pdf** • **Sub.Cred.Audit.Tool.pdf** Policies and procedures are in place for CHA to monitor subcontractors' performance on an ongoing basis ("Sub.Delegated.PP07021.pdf"). We've included our auditing tool to demonstrate specific monitoring tasks ("Sub.Cred.Audit.Tool.pdf")	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
HSAG Findings: The Subcontractors and Delegated Entities policy and procedure stated that the CCO's Compliance Department, in collaboration with other departments responsible for overseeing subcontractor and delegate activities, monitors each subcontractor's performance on an ongoing basis. Formal reviews shall be conducted at least annually. The policy described specific processes for conducting the annual audit but did not describe processes,, tools, or types and frequency of ongoing monitoring activities of its delegates. During the remote interview session, CHA staff members were able to provide examples of ongoing monitoring activities conducted by the CCO.		
Required Actions: HSAG recommends that the CCO revise policies and procedures to include more specificity as to the processes implemented for ongoing monitoring of its delegates.		
5. Whenever deficiencies or areas of improvement are identified, the CCO and subcontractor shall take corrective action. *Contract: Exhibit B Part 4(13)(a)(15-17)*		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		
6. The Contractor must provide to OHA, annually and within 30 days of any change in subcontractor, the Subcontractors and Delegated Entities Report. The report should identify any activities the Contractor has agreed to perform under the contract that have been subcontracted or delegated, and include information related to the subcontracted work including: • The legal name of the Subcontractor; • The scope of work being subcontracted; • Copies of ownership disclosure form, if applicable; • Copies of all written agreements with Subcontractors to ensure all contracts meet the requirements outlined in 42 CFR 438.230;	• **Sub.Delegated.PP07021.pdf – pages 2, 3,** 8 Policies and Procedures are in place for CHA to submit to OHA the updated Subcontractor and Delegated Entity Report within 30 days of a subcontractor changes. Per the guidelines and report template supplied by the State, reported data lists all delegated activities, detailed subcontractor information, copies of written agreements and applicable documents.	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard VI—Subcontractual Relationships and Delegation		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• Any ownership stake between the Contractor and Subcontractor. *Contract: Exhibit B Part 4(13)(a)(5-6)*		
7. The Contractor must notify OHA in writing within 30 days of terminating any Subcontractor and provide an updated Subcontractors and Delegated Entities report. The Contractor must notify OHA in writing within 30 days of terminating any Participating Provider contract when such termination is a for-cause termination, including but not limited to: • Failure to meet requirements under the contract; • For reasons related to fraud, integrity, or quality; • Deficiencies identified through compliance monitoring of the entity; or • Any other for-cause termination. *Contract: Exhibit B Part 4(13)(b)(4)*		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA
HSAG Findings: This element was not applicable for the readiness review.		
Required Actions: None.		

Standard VI—Subcontractual Relationships and Delegation	
	Total #
Complete	**3**
Progress Sufficient	**2**
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)*	• **Enrollment.Disenrollment.PP13007.pdf – pages 1-5** Our Enrollment and Disenrollment policy and procedure provides evidence to support all requirements contained in this standard.	☒ 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)*	• **Enrollment.Disenrollment.PP13007.pdf – page 2**	☒ 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)*	• **Enrollment.Disenrollment.PP13007.pdf – pages 2 & 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.	• **Enrollment.Disenrollment.PP13007.pdf – pages 4-5**	☒ 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)*	• **Enrollment.Disenrollment.PP13007.pdf – page 3**	☒ 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	• **Enrollment.Disenrollment.PP13007.pdf – page 3**	☒ 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*	• **Grievance.Appeal.PP02003.pdf – pages 1-4**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
2. The CCO has internal grievance procedures under which Medicaid members may challenge the denial of coverage of, or payment for medical assistance (adverse benefit determination). • The CCO may have only one level of appeal for members. • A member may request a State fair hearing (contested care hearing) after receiving an appeal resolution notice from the CCO that the adverse benefit determination has been upheld. • If the CCO fails to adhere to required timeframes for processing appeals, the member is deemed to have exhausted the CCO's appeal process and the member may initiate a State fair hearing (contested case hearing). *42 CFR §438.402(a-c)* *42 CFR §438.400(a)(3), (b)* *Contract: Exhibit I (1)(a-b)*	• **Grievance.Appeal.PP02003.pdf – pages 1, 12, 19, 20**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
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,	• **Grievance.Appeal.PP02003.pdf – page 24**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
appropriateness, setting, or effectiveness of a covered benefit. b. The reduction, suspension, or termination of a previously authorized service. c. The denial, in whole or in part, of payment for a service. d. The failure to provide services in a timely manner, as defined by the State. e. The failure of the CCO to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. f. For a resident of a rural area with only one CCO, the denial of a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network. g. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities. *42 CFR §438.400(b)* *42 CFR §438.52(b)(2)(ii)* *RFA: Appendix A (C)*		☐ NA
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)*	• Grievance.Appeal.PP02003.pdf – pages 4, 8	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*		☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
6. A member may file a grievance with the CCO at any time, either orally or in writing. Grievances can be submitted to the State or the CCO. *42 CFR §438.402(c)(2)(i), (c)(3)(i)* *Contract: Exhibit I (2)(a)*	• Grievance.Appeal.PP02003.pdf – page 7	☒ 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)*	• **Grievance.Appeal.PP02003.pdf – pages 12, 13**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
8. The CCO must acknowledge receipt of each grievance and appeal. *42 CFR §438.406(b)(1)* *Contract: Exhibit I (4)(a)(1)*	• **Grievance.Appeal.PP02003.pdf – pages 8, 13** • **Grievance.Acknowledgment.Letter.pdf** • **Grievance.Resolution.Letter.pdf** • **Grievance.Provider.Change.Letter.pdf** • **Grievance.Capture.DP02001.pdf** • **Expedited.Appeal.Letter.pdf** • **Appeal.Acknowledgment.Letter.pdf**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
9. A member may file an appeal within 60 calendar days from date on the notice of adverse benefit determination. • The member may request an appeal either orally or in writing. Unless the member requests an expedited resolution, an oral appeal must be followed by a written, signed appeal. *42 CFR §438.402(c)(2)(ii), (c)(3)(ii)* *Contract: Exhibit I (1)(b)(2), (1)(c)(2-3)*	• **Grievance.Appeal.PP02003.pdf – pages 12, 13**	☐ Complete ☐ Progress Sufficient to Start Operations ☐ 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	• **Grievance.Appeal.PP02003.pdf – pages 8, 20** • **Grievance.Capture.DP02001.pdf** • **Grievance.Acknowledgment.Resolution.Letter.pdf**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*		
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)*	• **Grievance.Appeal.PP02003.pdf – page 1**	☒ 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.	• **Grievance.Appeal.PP02003.pdf – pages 9, 16**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• 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)*		
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	• **Grievance.Appeal.PP02003.pdf – pages 12, 13**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
free of charge and sufficiently in advance of the resolution timeframe for appeals. d. That included, as parties to the appeal, are: i. The member and his or her representative, or ii. The legal representative of a deceased member's estate. *42 CFR §438.406(b)(3-6)* *Contract: Exhibit I (4)(b)*		
14. The CCO must resolve each appeal and provide written notice of the disposition, as expeditiously as the member's health condition requires, but not to exceed the following time frames: • For standard resolution of appeals, no later than 16 days from the day the CCO receives the appeal. • For expedited resolution of an appeal and notice to affected parties, within 72 hours after the CCO receives the appeal. • 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)*	• **Grievance.Appeal.PP02003.pdf – pages 13, 14** • **Appeals.Resolution.Dashboard.pdf** • **Appeal.Resolution.Letter.Eng.Spa.pdf – pages 1, 3**	☒ 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	• **Grievance.Appeal.PP02003.pdf – pages 7, 13** • **Appeal.Extension.Letter.pdf**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• The CCO shows (to the satisfaction of the State, upon request) that there is need for additional information and how the delay is in the member's interest. • If the CCO extends the timeframes, it must—for any extension not requested by the member: – Make reasonable efforts to give the member prompt oral notice of the delay. – Within 2 calendar days, give the enrollee written notice of the reason for the delay and inform the enrollee of the right to file a grievance with the CCO if he or she disagrees with that decision. – Resolve the appeal as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. • 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)*		☐ NA
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.	• **Grievance.Appeal.PP02003.pdf – pages 13, 14** • **Appeal.Resolution.Letter.Eng.Spa.pdf – pages 1, 3**	☒ 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 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)*		
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)*	• **Grievance.Appeal.PP02003.pdf – pages 21** • **Appeal.Resolution.Letter.Eng.Spa.pdf – pages 1, 3** • **Member.Handbook.pdf – pages 20, 21**	☒ 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:	• **Grievance.Appeal.PP02003.pdf – pages 14, 15** • **Member.Handbook.pdf – pages 20, 21**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• The CCO ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. • If the CCO denies a request for expedited resolution of an appeal, it must: – Transfer the appeal to the time frame for standard resolution. – Make reasonable efforts to give the member prompt oral notice of the denial to expedite the resolution and follow-up within two calendar days with a written notice. *42 CFR §438.410* *Contract: Exhibit I (4)(c)(3)(e)*		
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.	• **Grievance.Appeal.PP02003.pdf – pages 15, 20, 21** • **COB.Denial.Letter.Eng.Spa.pdf – pages 1, 2**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• 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)*		
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)*	• **Grievance.Appeal.PP02003.pdf – pages 15, 20, 21** • **COB.Denial.Letter.Eng.Spa.pdf – pages 1, 2**	☒ 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	• **Grievance.Appeal.PP02003.pdf – page 21**	☒ Complete ☐ Progress Sufficient to Start Operations

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
were furnished solely because of the requirements of this section. *42 CFR §438.420(d)* *Contract: Exhibit I (6)(d)*		☐ Incomplete ☐ NA
22. Effectuation of Reversed appeal resolutions: • If the CCO or the State fair hearing (contested case hearing) officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the CCO must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires but no later than seventy-two (72) 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)*	• **Grievance.Appeal.PP02003.pdf – page 21**	☒ 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: • A general description of the reason for the appeal or grievance;		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• 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. • 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.	• **Grievance.Appeal.PP02003.pdf – pages 7, 8, 9** • **Credentialing.Application.Letter.pdf** • **Welcome.Provider.Letter.pdf** • **Welcome.Subcontractor.Letter.pdf**	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard X—Grievance and Appeal Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
• 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)*		

Standard X- Grievance and Appeal Systems	
	Total #
Complete	**22**
Progress Sufficient	**0**
Incomplete	**0**
Not Applicable (NA)	**2**

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
1. The Contractor shall maintain a health information system that collects, analyzes, integrates, and reports data sufficient to support program requirements, including but not limited to: Utilization of services a. Claims and encounters b. Grievances, appeals and hearing records c. Disenrollment for other than loss of Medicaid eligibility d. Member characteristics i. Race ii. Ethnicity iii. Preferred Language iv. Names and phone numbers of the member's PCP or clinic v. Attestation of member rights and responsibilities e. Client Process Monitoring Systems Forms data using the Measures and Outcome Tracking System (MOTS) f. LTPC Determination Forms *42 CFR §438.242(a)* *Contract: Exhibit J (1)*	HIS-1 Data Flow Diagram HIS-1 Report Dissemination Our major behavioral health providers Klamath Basin Behavioral Health (KBBH) and Lutheran Community Services (LCS) handles the majority of our Medicaid behavioral health services. They utilize MOTS to collect data on all clients that have received behavioral health and/or substance use services. Also, utilizing MOTS to collect data on crisis visits and involuntary services (Civil Commitments). On a monthly basis KBBH and LCS receive updates on current active clients that they have reported. Additional requests for data from MOTS can be requested through the Office of Health Analytics Data Request Form	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: Through its Information Systems Capabilities Assessment (ISCA) documentation and remote demonstrations, the CCO provided evidence of its ability to capture, analyze, and report the required Medicaid program elements except Measures and Outcome Tracking System (MOTS) information. While the CCO currently requires its behavioral health providers (via contracts) to collect, store, and report MOTS data, the CCO does not have a mechanism to collect, store, or report these data.		
Required Actions: HSAG recommends that the CCO develop policies and procedure to support the collection, storage, and reporting of MOTS data. At a minimum, CCO policies and procedures should describe how MOTS data are used by the CCO to support the management of members' health along with mechanisms used to access the data (e.g., direct extracts [when available], provider-level data extracts, patient-level documentation from providers).		

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
2. Contractor's claims processing and retrieval systems shall collect data elements necessary to enable the mechanized claims processing and information retrieval systems operated by the State. *42 CFR §438.242(b)(1)*	HIS-2 Data Flow Diagram	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
3. Contractor shall collect data at a minimum on: a. Member and provider characteristics as specified by OHA and in Exhibit G b. Member enrollment c. All services furnished to members through an encounter data system, pharmacy, or other methods as specified by OHA *42 CFR §438.242(b)(2)* *Contract: Exhibit J(2)*	HIS-3 Data Flow Diagram HIS-3 Member Redetermination Report	☐ Complete ☒ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA
HSAG Findings: Remote demonstration provided evidence of the CCO's ability to collect data on member enrollment and services furnished to members via Plexis Quantum Choice, as well as provider characteristics. However, the CCO is not currently capturing provider information related to . However, the CCO is currently not consistently collecting provider characteristics related to Americans with Disabilities Act (ADA) accessibility for members with special needs. Although CCO staff members demonstrated the ability to define limitations associated with providers practices within the Cactus system, no limitation had been developed to capture providers without ADA accessible sites. Further, the CCO stated that currently practice assumes ADA accessibility and is only documented when practice sites are not accessible.		
Required Actions: HSAG recommends the CCO develop a process for capturing and storing data on ADA accessibility for providers as defined in Exhibit G.		
4. Contractor shall ensure that data received from providers, either directly or through a third party, is accurate, truthful, and complete in accordance with OAR 410-120-1280 and OAR 410-141-3420 by: a. Verifying the accuracy and timeliness of data reported	Provider.Billing .PP03007, Audit Tool, 45-Day Service Letter Examples;	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	45 Day Service Letter Desktop Process, Claims/Encounter Validation Process (DP03008) Our Provider Billing PP and Encounter Claim Validation Process describes our policies and procedures to ensure that data received from providers, either directly or through a third party, is accurate, truthful, and complete. We have included a Desktop Process describing our processes to ensure all service letters are handled within 45 days. Additionally, we have included examples of service letters.	☐ 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)*	HIS-5: Compliance Master Deliverable Calendar HIS-5: Report Dissemination CHA is currently compliant with OHA requirements for state reporting outlined in the OHA deliverable document. Additional reports listed in the Report Dissemination document, or on an ad-hoc basis, can be made available to OHA upon request.	☒ 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*	Business Continuity and Disaster Recovery Plan	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	HIS-10.CHA.HIT.Roadmap	☐ 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.		
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		☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☒ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*		
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	HIS-12 Agreement-HIT MOU CHA is confident in our participation in the 2020 HIT Commons MOU and fulfilling its terms within. We are currently participating in the current	☐ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*	Commons MOU and are certain that the partnership requirements and responsibilities assigned to us as a CCO will also be satisfied. CHA is eager to continue working with OHA, OHLC, and other affiliates involved in a collaborative environment to engage in statewide solutions. CHA does not foresee any challenges or obstacles in signing the 2020 HIT Commons MOU at this time.	☒ 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.		
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	HIS-14 Data Flow Diagram HIS-14.Scorecard Practice HIS-14 Report Dissemination HIS-14.VBP.ARrangements HIS-Dental Dashboards HIS-PHTECH Metrics Manager Interface Screenshot_REdacted	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems		
Requirement	**Evidence as Submitted by the CCO**	**Score**
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)*		
15. The CCO shall document and report to OHA, annually, on how HIT is used to support population health management, including: a. The ability to identify and report on member characteristics (e.g., past diagnoses and services) b. The capability of risk stratifying members c. The ability to provide risk stratification and member characteristics to contracted providers with VBP arrangements for the population(s) addressed in the arrangement(s). *Contract: Exhibit J (2)(k)(8)*	HIS-15 Data Flow Diagram HIS-15 Milliman.PRM.Analytics.Screenshot HIS-15Pareto Intelligence Interface Screenshot HIS-PHTECH Metrics Manager Interface Screenshot HIS-15 Scorecards Practice	☒ Complete ☐ Progress Sufficient to Start Operations ☐ Incomplete ☐ NA

Standard XIII—Health Information Systems	
	Total #
Complete	**6**
Progress Sufficient	**2**
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 CHA's Provider Capacity Reports were good with minor errors identified in both the individual practitioner and facility and service provider files.

Table B-1—CHA 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	16.7	100.0	
Address #1	100.0		
Provider's Capacity	80.5	100.0	
City	100.0		
Status of Medicaid Contract	100.0	100.0	
County	100.0		
Credentialing Date	60.0	100.0	100.0

DSN Data Field	DSN Quality Metrics		
	% Present	% Valid Format	% Valid Values
DMAP (Medicaid ID)	99.9	90.5	
Provider First Name	100.0		
Group/Clinic Name	100.0		
Non-English Language 1	3.3		
Non-English Language 2			
Non-English Language 3			
Provider Last Name	100.0		
Provider Network Status	100.0	100.0	
Provider NPI	100.0	100.0	99.3
Number of Members Assigned to PCPs	9.3	100.0	
PCP Indicator	100.0	100.0	
PCPCH Tier	13.7	100.0	
Phone Number	98.1		
Provider Category	100.0	0.0	0.0
Provider Service Category	100.0	100.0	100.0
Provider TIN	100.0	100.0	
Provider Taxonomy	100.0	99.7	99.7
Zip Code	100.0		

In general, all key DSN data fields in the individual practitioner capacity report were populated except for Credentialing Date for which only 60.0 percent of the records contained a value. However, of the records with a credentialing date, 100 percent contained valid formats and values (i.e., date within three years). Conversely, while 100 percent of the records included a Provider Category, zero percent were correctly formatted. The overall average completeness was 81.8 percent across both required and conditional[B-1] fields and increased to 95.3 percent when excluding conditional fields. Of note, only 3.3 percent of providers were associated with a non-English language.

[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).

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

DSN Data Field	DSN Quality Metrics		
	% Present	%Valid Format	% Valid Values
Address #1	100.0		
Facility or Business Name	100.0		
City	100.0		
Status of Medicaid Contract	100.0	100.0	
County	100.0		
DMAP (Medicaid ID)	98.1	99.0	
Facility NPI	99.0	100.0	100.0
Phone Number	100.0		
Provider Category	100.0	0.0	0.0
Provider Service Category	83.8	100.0	100.0
Facility TIN	100.0	100.0	
Facility or Business Taxonomy	99.0	97.1	97.1
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 the exception of two data fields. While the Provider Category field was fully populated, zero percent of the values were in the correct format. Similarly, only 83.8 percent of the records were populated with a Provider Service Category. Overall, the average completeness across all data fields was 98.5 percent.

Provider Network Capacity

The provider network capacity domain addressed the underlying infrastructure of the CCO's provider network and assessed whether or not required health services were available to beneficiaries through a sufficient supply and variety of providers. Table B-3 provides the number and percent of providers by provider specialty category and contract status. All providers presented in the DSN were contracted or had a contract pending at the time of submission with multiple exceptions including primary care providers (6), specialty providers (43), dental service providers (3), mental health providers (10), SUD providers (6), ambulance and emergency medical transportation (9), hospitals (2), IHS/THS (1), and durable medical equipment providers (4).

Table B-3—CHA 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	140	21.6	126	90.0	8	5.7
Specialty Provider	255	39.4	208	81.6	4	1.6
Dental Service Provider	24	3.7	21	87.5	0	0.0
Mental Health Provider	166	25.7	151	91.0	5	3.0
SUD Provider	40	6.2	33	82.5	1	2.5
Certified or Qualified Health Care Interpreters	0	0.0	0	0.0	0	0.0
Traditional Health Workers	20	3.1	20	100.0	0	0.0
Alcohol/Drug	0	0.0	0	0.0	0	0.0
Health Education, Health Promotion, Health Literacy	2	0.3	2	100.0	0	0.0
Palliative Care	0	0.0	0	0.0	0	0.0
Facility/Service Practitioners						
Hospital, Acute Psychiatric Care	1	2.1	1	100.0	0	0.0
Ambulance and Emergency Medical Transportation	9	18.8	0	0.0	0	0.0
Federally Qualified Health Centers	4	8.3	4	100.0	0	0.0
Home Health	2	4.2	2	100.0	0	0.0
Hospice	0	0.0	0	0.0	0	0.0
Hospital	6	12.5	4	66.7	0	0.0
Imaging	0	0.0	0	0.0	0	0.0
Indian Health Service and Tribal Health Services	1	2.1	0	0.0	0	0.0
Mental Health Crisis Services	2	4.2	2	100.0	0	0.0
Community Prevention Services	1	2.1	1	100.0	0	0.0
Non-Emergent Medical Transportation	1	2.1	1	100.0	0	0.0
Pharmacies	11	22.9	11	100.0	0	0.0

Provider Specialty Category	Total		Contract Status = Yes		Contract Status = PEND	
	Number	Percent	Number	Percent	Number	Percent
Durable Medical Providers	7	14.6	3	42.9	0	0.0
Post-Hospital Skilled Nursing Facility	1	2.1	1	100.0	0	0.0
Rural Health Centers	1	2.1	1	100.0	0	0.0
School-Based Health Centers	1	2.1	1	100.0	0	0.0
Urgent Care Center	0	0.0	0	0.0	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, CHA's individual provider capacity demonstrated network coverage of required physical health (primary and specialty), oral health, and mental health and substance use disorder providers. Provider data, however, did not include documentation of three specialty categories—i.e., certified or qualified health care interpreters, alcohol/drug providers, and palliative care providers. Additionally, of the 17 required facilities and services, three provider service categories had a count of zero—i.e., hospice, imaging services, and urgent care centers.

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—CHA 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	140	71	50.7	5	3.6
Specialty Provider	255	0	0.0	3	1.2
Dental Service Provider	24	11	45.8	2	8.3
Mental Health Provider	166	1	0.6	10	6.0
SUD Provider	40	1	2.5	2	5.0

Provider Specialty Category	Total Providers[1]	Accepting New Patients		Speak Non-English Language	
		Number	Percent	Number	Percent
Certified or Qualified Health Care Interpreters	0	0	0.0	0	0.0
Traditional Health Workers	20	0	0.0	0	0.0
Alcohol/Drug	0	0	0.0	0	0.0
Health Education, Health Promotion, Health Literacy	2	0	0.0	0	0.0
Palliative Care	0	0	0.0	0	0.0
TOTAL	**647**	**84**	**13.0**	**22**	**3.4**

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

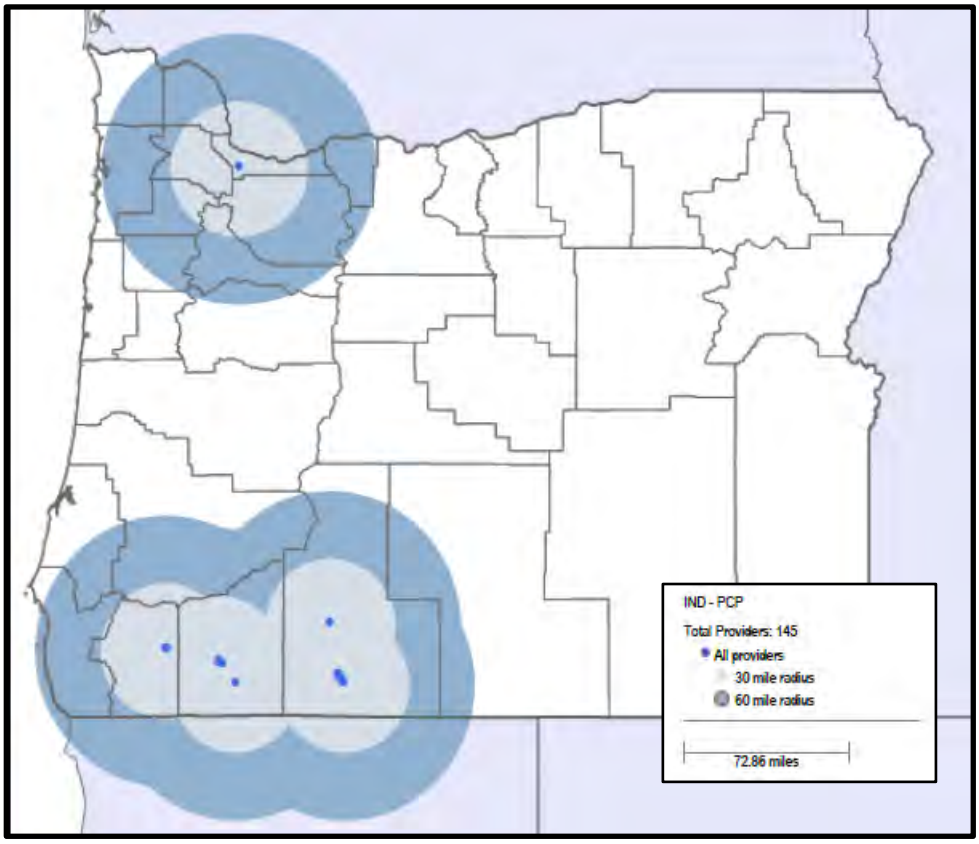
[1] Provider counts are based on unique providers deduplicated by NPI and Service Category.
[2] Specialty Category designations specifying *adult* and *pediatric* providers were combined and deduplicated by NPI to preventing counting providers within a specialty category more than once.

Overall, only 13.0 percent of CHA's provider network was accepting new patients with the percentage of practitioners accepting new patients within three core specialty categories falling below 10 percent—i.e., specialty providers (0.0 percent), mental health providers (0.6 percent), and SUD providers (2.5 percent. Approximately have of CHA's primary care and dental providers were accepting new patients (i.e., 50.7 percent and 45.8 percent, respectively). Of its individual practitioners, CHA identified 3.4 percent who spoke a language other than English.

Geographic Distribution

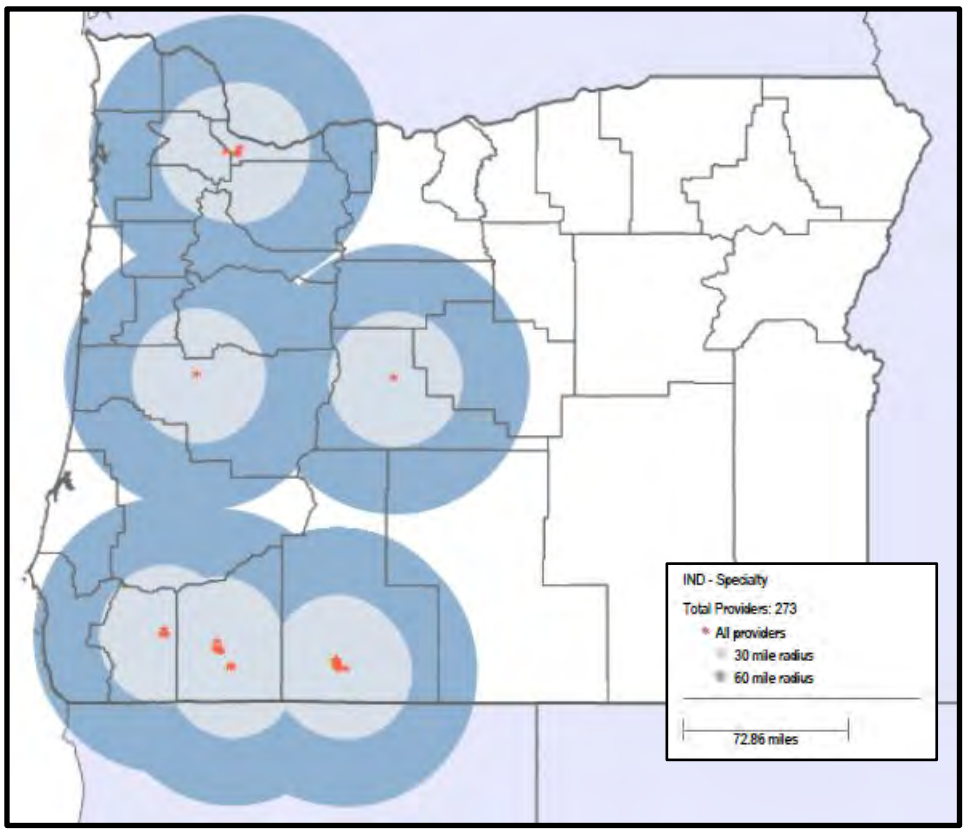
The geographic distribution of providers relative to member populations assessed whether or not the practitioner and facility locations were spread proportionately across the beneficiary population. Since beneficiary data was not available at the time of this analysis, the geospatial maps display the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

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



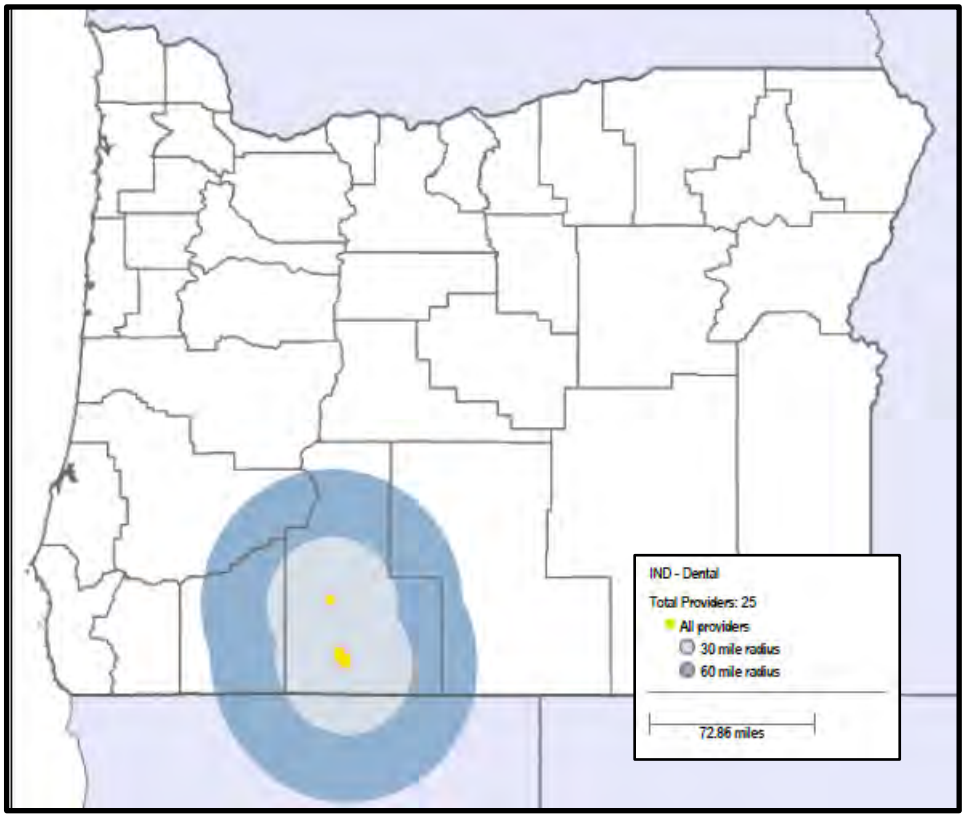
As shown in Figure B-1, the distribution of CHA's network of PCPs is sufficient to cover the CCO's service area. Most of the CCO's service area is within 30 miles of a primary care provider and all areas are within 60 miles.

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



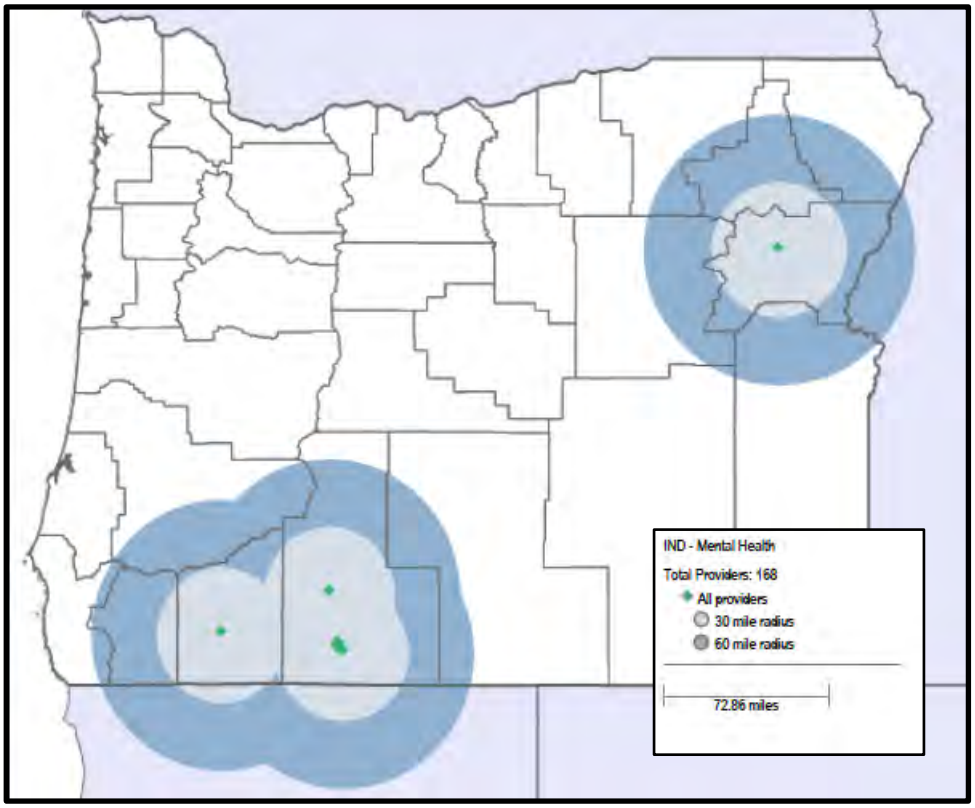
As shown in Figure B-2, the distribution of CHA's specialty providers is sufficient to cover the CCO's service area. Much of the CCO's service area is within 30 miles of a specialty provider and all areas are within 60 miles.

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



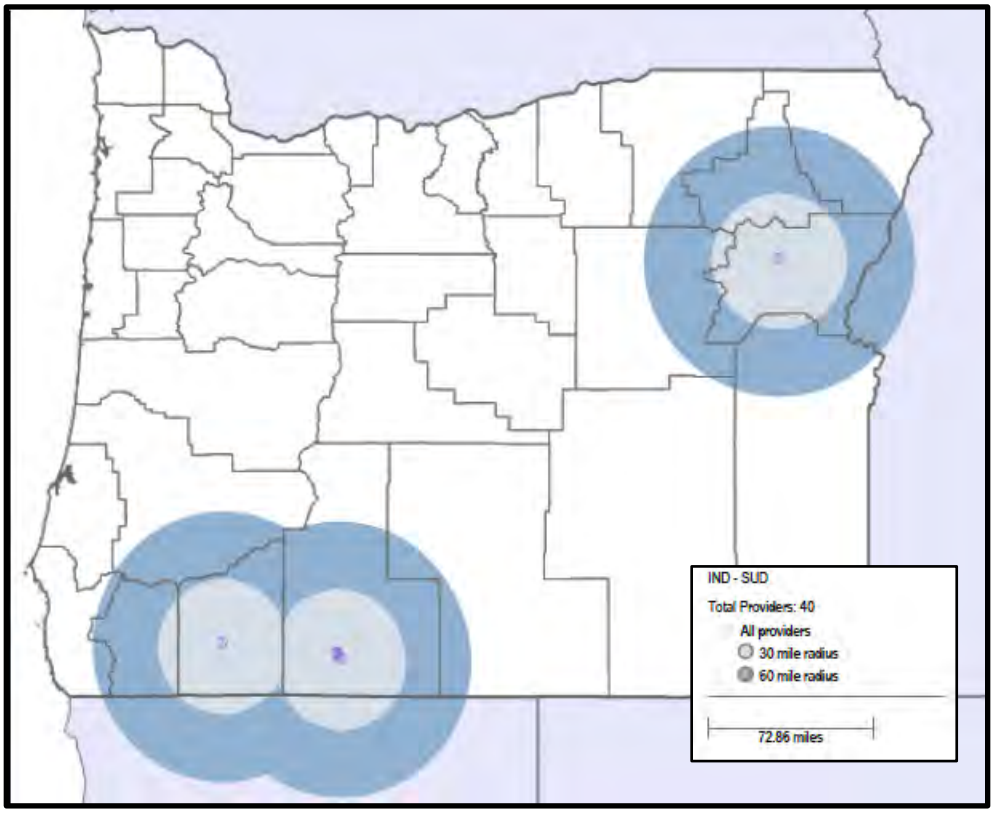
As shown in Figure B-3, the distribution of CHA's dental service providers is sufficient to cover the CCO's service area. Most of the CCO's service area is within 30 miles of a dental service provider and all areas are within 60 miles.

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



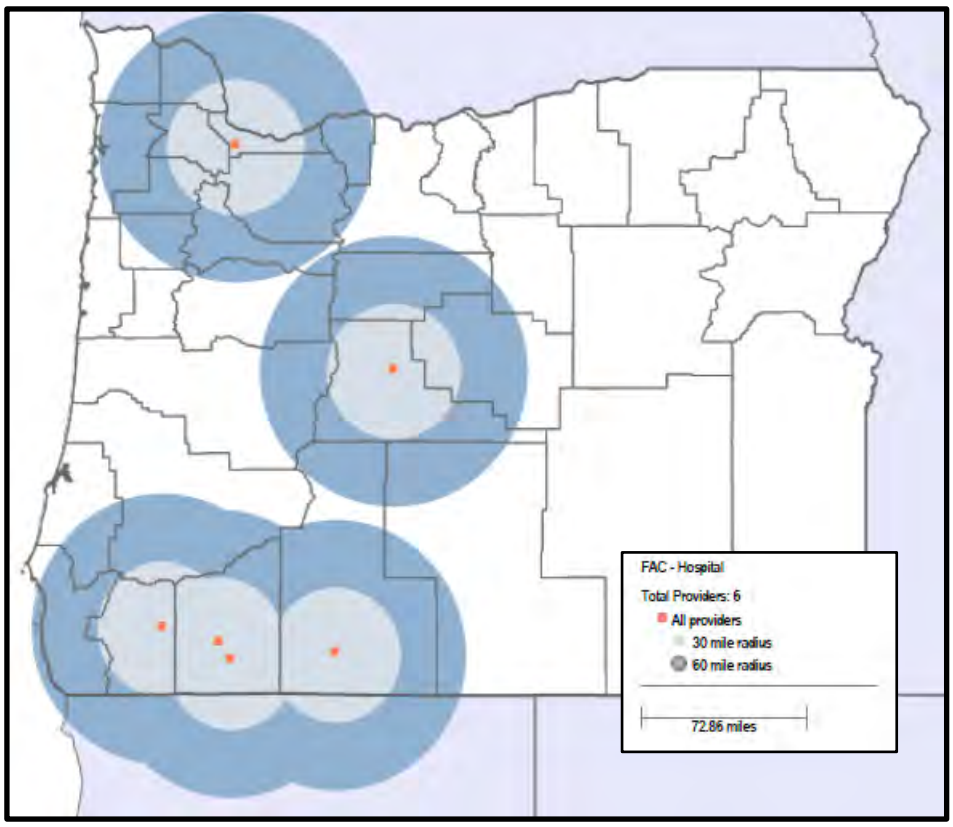
As shown in Figure B-4, the distribution of CHA's mental health providers is sufficient to cover the CCO's service area. Most of the CCO's service area is within 30 miles of a mental health provider and all areas are within 60 miles.

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



As shown in Figure B-5, the distribution of CHA's SUD providers is sufficient to cover the CCO's service area except. Most of the CCO's service area is within 30 miles of a SUD provider and all areas are within 60 miles.

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



As shown in Figure B-6, the distribution of CHA's hospital facilities is sufficient to cover the CCO's service area. Most of the CCO's service area is within 30 miles of a hospital and all areas are within 60 miles.

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

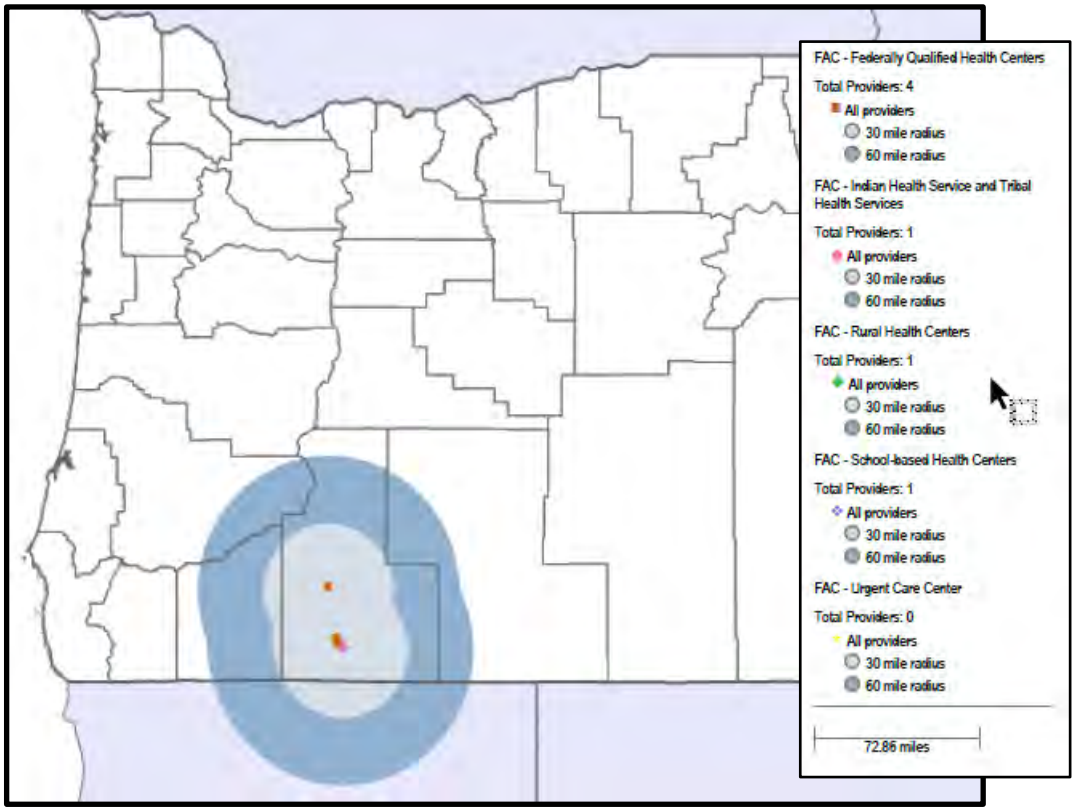


Figure B-7 displays the distribution of several clinic-based facilities within CHA's service areas, including FQHCs, Indian Health Services and Tribal Health Services, Rural Health Centers, School-Based Health Centers, and Urgent Care Centers. The map shows that the distribution of clinic-based facilities is sufficient to cover the CCO's service area. Nearly all of the service area is within 30 miles of a clinic-based facility and all areas are within 60 miles of the nearest facility.

Appendix C. Phase 2 Evaluation Tool

[Pending completion of the Phase 2 RR]